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Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.



President

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Cert. Base: **3**
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Dental Expense Coverage

Dental Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Dental Care Plan

What Are The Benefits?

This coverage pays for many of the charges incurred for the preventive and corrective dental care a covered person receives. Not all charges are eligible. Some charges are eligible only to a limited extent. There is no annual or lifetime maximum.

Aetna has arranged for **Primary Care Dentists** and **Participating Specialist Dentists** to furnish the necessary dental services under this coverage.

These services and supplies must be:

- given by the person's **Primary Care Dentist** at the dental office location; or
- given by a **Participating Specialist Dentist** for a dental condition requiring specialized care if the care is not available from the person's **Primary Care Dentist**, and if the **Primary Care Dentist** has referred the covered person to the **Participating Specialist Dentist**, and provided Aetna approves coverage for the treatment. This care is called **Referral Care**; or
- given by a **Non-Participating Dental Provider** in the case of **Out-of-Area Emergency Dental Care**.

Benefits

This coverage pays benefits for **Covered Dental Expenses** for dental services. Aetna pays the benefits to **Primary Care Dentists** and **Participating Specialist Dentists** as mutually agreed with them. Other benefits are payable to you.

Copayment

A copayment applies to some dental services. You are responsible for making the copayment to the **dentist**. The copayment is determined as follows:

Primary Care Provided by Primary Care Dentists

A copayment applies to Primary Care Services shown on the Dental Care Schedule. The copayment is a percent of the **Primary Care Dentists** usual fee for that service, reviewed by Aetna for reasonableness. The copayment percent that applies is shown on the Dental Care Schedule.

“Usual fee” means the fee the **Primary Care Dentist** charges to patients in general. Your **Primary Care Dentist** will give you a copy of the usual fee schedule, upon request. It is not a part of this Booklet-Certificate and may be changed from time to time. It is used only for the purpose of calculating a copayment and is not the basis for compensation to the **Primary Care Dentist**. Aetna compensates a **Primary Care Dentist** based on separate, negotiated agreements that may be less than or unrelated to the **Primary Care Dentist’s** usual and customary charges. These agreements may vary among **Primary Care Dentists**.

Specialty Services Provided by Participating Specialist Dentists

A copayment applies to Specialty Services shown on the Dental Care Schedule. The Copayment is a percent of the **Participating Specialist Dentist’s** fee for that service.

The “fee” may be a fee negotiated with the **Participating Specialist Dentists** and approved by Aetna. In that case, the copayment will be based on the actual, negotiated fee.

If Aetna compensates **Participating Specialist Dentists** on another basis, the “fee” will be the **Participating Specialist Dentist’s** usual fee, reviewed by Aetna for reasonableness. “Usual fee” means the fee **Participating Specialist Dentists** charges to patients in general. It is not a part of this Booklet-Certificate and may be changed from time to time. Then it is used only for the purpose of calculating a copayment and is not the basis for compensation to the **Participating Specialist Dentists**. Aetna compensates a **Participating Specialist Dentist** based on separate, negotiated agreements that may be less than or unrelated to the **Participating Specialist Dentists** usual and customary charges. These agreements may vary among **Participating Specialist Dentists**.

You will be informed of the fee when you visit the **Participating Specialist Dentists**. The copayment percent that applies is shown on the Dental Care Schedule.

Dental Care Schedule

This Dental Care Schedule applies to covered services provided by **Primary Care Dentists** and **Participating Specialist Dentists**. It includes only services in the list below.

The next sentence applies if:

- a charge is made for an unlisted service given for the dental care of a specific condition; and
- the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Primary Care Dentist Services Type A Expenses

VISITS AND EXAMS

- Office visit for oral examination (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one treatment per year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to one application every 3 years for permanent molars only), and to covered persons under age 16)
- Pulp vitality test
- Diagnostic casts

X-RAYS AND PATHOLOGY

- Bitewing X-rays (limited to 1 set per year)
- Entire series, including bitewings, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*

- Fixed, band type
- Removable acrylic with round wire clasp

Type B Expenses

ENDODONTICS

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
 - Anterior
 - Bicuspid

RESTORATIONS AND REPAIRS

- Amalgam restoration
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces
- Resin restoration (other than for molars)
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures

PERIODONTICS

- Emergency treatment (abscess, acute periodontitis, etc.)
- Subgingival curettage (limited to 4 separate quadrants, every 2 years)
- Scaling and root planing (limited to 4 separate quadrants, every 2 years)

-
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

ORAL SURGERY *Includes local anesthetics and routine post-operative care*

- Extractions, uncomplicated
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Suture of soft tissue injury

Type C Expenses

RESTORATIONS

- Inlays
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces
- Onlays
 - 2 surfaces
 - 3 surfaces
 - 4 or more surfaces
- Crowns (including build-ups when necessary)
 - Resin
 - Resin with noble metal
 - Resin with base metal
 - Porcelain
 - Porcelain with noble metal
 - Porcelain with base metal
 - Base metal (full cast)
 - Noble metal (full cast)
 - Metallic (3/4 cast)
 - Post and core
- Pontics
 - Base metal (full cast)
 - Noble metal (full cast)
 - Porcelain with noble metal
 - Porcelain with base metal
 - Resin with noble metal
 - Resin with base metal
- Dentures and Partials (includes relines, rebases, and adjustments within six months after installation).
 - Full (upper and lower)
 - Partial
 - Stress breakers (per unit)
 - Stayplates
 - Crown and bridge repairs
 - Adding teeth to an existing denture
 - Full and partial denture repairs
 - Relining/rebasing dentures (including adjustments within six months after installation)
 - Occlusal guard (for bruxism only) limited to 1 every 3 years

Participating Specialist Dentist Services Type B Expenses

ENDODONTICS *Includes local anesthetics where necessary*

- Apexification/recalcification
- Apicoectomy (per tooth) - first root
- Apicoectomy (per tooth) - each additional root
- Retrograde Filling
- Root Amputation
- Hemisection

ORAL SURGERY *Includes local anesthetics where necessary and post-operative care*

- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula

PERIODONTICS

- Gingivectomy or gingivoplasty - per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty - per tooth (limited to 1 per site, every 3 years)
- Gingival flap procedure - per quadrant
- Occlusal adjustment (other than with an appliance or by restoration)

Type C Expenses

ENDODONTICS *Includes local anesthetics where necessary*

- Molar root canal therapy, including necessary X-rays

INTRAVENOUS SEDATION AND GENERAL ANESTHESIA

ORAL SURGERY *Includes local anesthetics where necessary and post-operative care*

- Surgical removal of impacted teeth
 - Partially bony
 - Completely bony
 - Completely bony with unusual surgical implications

PERIODONTICS

- Osseous surgery (including flap entry and closure), per quadrant, limited to 1 per quadrant, every 3 years

ORTHODONTICS

- Comprehensive **orthodontic treatment** of adult or adolescent dentition
- Post Treatment Stabilization
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits

Out-of-Area Emergency Dental Care

Out-of-Area Emergency Dental Care consists of **necessary** covered dental services given to covered persons by a **Non-Participating Dental Provider** for the palliative (pain relieving; stabilizing) treatment of an **emergency condition**. The emergency care is rendered outside of the 50 mile radius of the covered person's home address. Coverage for **Out-of-Area Emergency Dental Care** is subject to specific limitations described in the **Dental Care Plan**.

When care of an **emergency condition** is received, a benefit will be paid for the **reasonable charges** incurred by a covered person for such care.

Payment will be made only if all of the following rules are met:

- The care meets the definition of **Out-of-Area Emergency Dental Care**. Care is given more than 50 miles from the covered person's home address.
- The care given is for the speedy relief of the **emergency condition** until the person can be seen by the **Primary Care Dentist**.
- The person provides an itemized bill to Aetna. It must describe the care given.
- The dental service given is listed on the Dental Care Schedule that applies.

Exclusions and Limitations

Coverage is not provided for the following charges:

- Those for services or supplies which are covered in whole or in part:
 - under any other part of this Plan; or
 - under any other plan of group benefits provided by or through your Employer.
- Those for services and supplies furnished to diagnose or treat a disease or injury that is not a **non-occupational disease** or **non-occupational injury**.

However, if proof is furnished that the individual is covered under any Workers' Compensation Act or Occupational Disease Law, or by the United States Longshoremen's or Harbor Workers' Compensation Act but is not covered for a particular disease under such law, that disease will be considered "non-occupational" regardless of cause.

- Those for services not listed in the Dental Care Schedule, unless otherwise specified.
- Those for replacement of a lost, missing, or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

Facings on molar crowns and pontics will always be considered cosmetic.

- Those for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental, or still under clinical investigation by health professionals.
- Those for:
 - dentures;
 - crowns;
 - inlays;

onlays;
bridgework; or
other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.

- Those for any of the following services:

an appliance, or modification of one, if an impression for it was made before the person became a covered person;
a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

- Those for services which Aetna defines as not **necessary** for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending **physician** or **dentist**.
- Those for services intended for treatment of any **jaw joint disorder**, unless otherwise specified.
- Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; unless otherwise specified.
- Those for general anesthesia and intravenous sedation, unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.
- Those for a crown, cast, or processed restoration unless:

it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
the tooth is an abutment to a covered partial denture or fixed bridge.

- Those for pontics, crowns, cast, or processed restorations made with high noble metals, unless otherwise specified.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

the service must be listed on the Dental Care Schedule;
the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a **Participating Dental Provider** and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

the copayment for the approved less costly service; plus

the difference in cost between the approved less costly service and the more costly covered service.

Replacement Rule

The replacement of; addition to; or modification of:

existing dentures;
crowns;
casts or processed restorations;
removable bridges; or
fixed bridgework
is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. **Dental Care Plan** must have been in force for the covered person when the extraction took place.

The existing denture, crown, cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures, removable bridges, and fixed bridgework is subject to the requirements that such dentures, removable bridges, and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture, removable bridge, or fixed bridge installed during the prior 5 years.

Orthodontic Treatment

Coverage for **orthodontic treatment** is limited to those services and supplies listed on the Dental Care Schedule that applies.

Aetna has arranged for **Participating Specialist Dentists** to furnish the Orthodontic Procedures. A copayment applies to the Orthodontic Procedures done on a covered person.

Comprehensive **orthodontic treatment** is limited to a lifetime maximum of:

24 months of active; usual and customary **orthodontic treatment** on permanent dentition; plus an extra 24 months of post-treatment retention.

Coverage for services and supplies are not provided for any the following:

replacement of broken appliances;
re-treatment of orthodontic cases;
changes in treatment necessitated by an accident;
maxillofacial surgery;
myofunctional therapy;
treatment of cleft palate;
treatment of micrognathia;

treatment of macroglossia;
treatment of primary dentition;
treatment of transitional dentition; or
lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”).

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.

Benefits After Termination of Coverage

Dental services given after the covered person’s coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

“Ordered” means that prior to the date coverage ends:

As to a denture:

impressions have been taken from which the denture will be prepared.

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

the teeth which will serve as retainers or support; or
which are being restored; have been fully prepared to receive the item; and
impressions have been taken from which the item will be prepared.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:
 - A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
 - B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
 - secondary to the plan covering the person as a dependent; and
 - primary to the plan covering the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

- covers the person as other than a dependent; and
- is secondary to Medicare.

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3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
 - a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
 - b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
 - c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and

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- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan, not including Medicaid and blanket student accident insurance plans, of medical or dental expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by any law other than Pennsylvania law, and provided on other than a group basis. Only the level of benefits required by the law will be counted.
- "First Party" automobile repairation insurance or benefits required by or provided under the Pennsylvania Motor Vehicle Financial Responsibility Law and provided on other than a group basis. Included are any such benefits provided or required to be provided by an approved or qualified self-insurer.

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen dental coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Dental Expense Coverage on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change dental coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

Any extension of dental benefits under this Plan will not apply on or after the date of a change to an HMO Plan.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
 - having refused it;
 - having dropped it;
 - having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

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- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
 - Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Employer for this definition.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

A "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this Plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership. In that event, you should provide your Employer with a completed and signed Declaration of Termination of Domestic Partnership.

Handicapped Dependent Children

Dental Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Dental Expense Benefits After Termination

If a person is totally disabled when his or her Dental Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that due to injury or disease:

- You are prevented during the first 24 months from performing your occupational duties and are prevented beyond the first 24 months from engaging in any employment or any other gainful activity.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Dental Care Plan benefits will be available to him or her while disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 12 month period.

Dental Care Plan benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational accidental injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are unable to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when claim is made.

Very important are:

Names of **dentists** who furnish services.

Dates expenses are incurred.

Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Covered Dental Expenses

Those expenses incurred for covered dental services and supplies provided to a covered person, while the person is a covered person. Those expenses are subject to the limitations and exclusions of the **Dental Care Plan**.

Covered Orthodontic Expenses

Those expenses incurred for covered orthodontic services and supplies given to a covered person; while the person is a covered person. These expenses are subject to the limitations and exclusions of the **Dental Care Plan** and the terms of the Dental Care Schedule.

Dental Care Plan

This is the plan of benefits provided under the Dental Care Plan Coverage.

Dental Provider

This is:

- any **dentist**;
- group;
- organization;
- dental facility; or
- other institution or person;

legally qualified to furnish dental services or supplies.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Emergency Condition

This is any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment in order to stabilize the condition; and
- is characterized by symptoms such as severe pain and bleeding.

Jaw Joint Disorder

This is:

- a Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint;
or
- a Myofascial Pain Dysfunction (MPD); or

-
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, mental health or dental professional;
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office or other less costly setting.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Participating Dental Provider

A **Dental Provider** who has not entered into a written agreement with Aetna to provide Dental Care Plan coverage to covered persons.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Out-of-Area Emergency Dental Care

Necessary care or treatment given to covered persons by a **Non-Participating Dental Provider** for the palliative (pain relieving; stabilizing) treatment of an **emergency condition** that is rendered outside the 50 mile radius of the covered person's home address. Such care is subject to specific limitations set forth in this **Dental Care Plan**.

Participating Dental Provider

Any **Dental Provider** who has entered into a written agreement with Aetna to provide dental care described under the **Dental Care Plan** to covered persons.

Participating Specialist Dentist

Any **dentist** who, by virtue of advanced training:

- is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry, and
- who has entered into a written agreement with Aetna to provide the dental care described under the **Dental Care Plan** to covered persons.

Physician

This means a legally qualified physician.

Primary Care Dentist

A **Participating Dental Provider** currently chosen by you to provide dental care to a covered person.

A Primary Care Dentist chosen by you takes effect as a covered person's Primary Care Dentist on the effective date of that person's coverage.

If you do not choose a Primary Care Dentist, Aetna will have the right to make a selection for you. Aetna will notify you of the selection.

You may change a covered person's Primary Care Dentist by notifying Aetna by telephone or in writing.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Referral Care

Covered services given to a covered person by a **Participating Specialist Dentist** after referral by the covered person's **Primary Care Dentist** and provided Aetna approves coverage for the treatment.

Privacy Notice

The information in this Notice is not a part of either the group contract, your Certificate of Coverage or the Booklet. It is important to you as a covered person under the group contract. We have bound it into this document only as an aid to you in keeping insurance related material together.

This Notice describes certain aspects of Aetna U.S. Healthcare's insurance privacy policy which apply to you as a covered person in a plan of group insurance insured by Aetna. The policy does not apply where a different approach is required by law.

Information Which May be Collected

Aetna, in providing insurance services to you, relies mainly on the information you give on your group enrollment form and when you file claims.

Aetna may also collect information about you from other sources. This is information necessary for Aetna to perform its function with regard to the insurance transaction in question. For example, if the amount or type of coverage you are entitled to depends on your earnings or job class, Aetna would obtain that information from your Employer.

Disclosure of Information To Others

All of this information will be treated as confidential. It will not be disclosed to others without your authorization, except in some instances where such disclosure is necessary for the conduct of Aetna's business. Disclosure cannot be contrary to any law which applies.

The following sets forth the types of disclosure that may be made:

- Financial information (but not medical information) may be made available to your Employer or his or her representative in connection with the administration of the Plan. Information may also be made available in connection with policyholder audits.
- Information may be disclosed to other insurers if there may be duplicate coverage or a need to preserve the continuity of your coverage.
- Information may be disclosed to Peer Review Organizations and other agencies to determine whether health services were necessary and reasonably priced.

In addition, information may be given to regulators of Aetna's business and to others as may be required by law. It may also be given to law enforcement authorities when needed to prevent or prosecute fraud or other illegal activities.

Your Right of Access and Correction

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information which relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment, or deletion of personal information. This can be done in states which provide such rights and which grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna Life Insurance Company
Executive Response Team, MCAF
151 Farmington Avenue
Hartford, Connecticut 06156

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, contact the Member Services number on your ID card, or write to the address shown above.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents (including a named "domestic partner"), or your dependents (other than one who is a named "domestic partner") may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

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- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
 - The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
 - As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

C. Multiple Qualifying Events

If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

D. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

E. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

F. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.