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(Defines the Terms Shown in Bold Type in the Text of This Document.)	

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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Health Expense Coverage

Health 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 health 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.

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features, and stated maximum benefit amounts. These are all described in the Booklet-Certificate.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be \$ 350 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts.

Some services may be given before Advance Claim Review is made. These are oral exams, including prophylaxis and X-rays, and treatment of any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment; and
- is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of

treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Note

As a part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person. This will be done at no cost to you.
- You must give Aetna all diagnostic and evaluative material which it may require. These include X-rays, models, charts, and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage which applies to:

- Type A expenses;
- Type B expenses;
- Type C expenses; and
- Orthodontic Treatment.

The benefit payable for charges made by a **Preferred Care Provider** is an amount equal to the Payment Percentage of the **negotiated charge** for the service or supply, after the applicable **Preferred Care** deductible.

The benefit payable for charges made by a provider that is not a **Preferred Care Provider** is an amount equal to the Payment Percentage of the provider's charge for the service or supply, after the applicable **Non-Preferred Care** deductible.

The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. You are responsible for the deductible.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- **necessary**; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

This Dental Care Schedule includes only services in the list below.

Alternate Treatment

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.

Here is a list of Covered Dental Expenses.

Type A Expenses

VISITS AND X-RAYS

- Office visit during regular office hours, for oral examination
 - Routine comprehensive or recall examination (limited to 2 visits every year)
 - Problem-focused examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to one set per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)

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

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

Type B Expenses

VISITS AND EXAMS

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

X-RAY AND PATHOLOGY

- Single films (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

ORAL SURGERY

- Extractions
 - Uncomplicated
 - Surgical removal of erupted tooth/root tip
- Impacted Teeth
 - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
 - Incision and drainage of abscess
 - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
 - Alveoplasty, in conjunction with extractions - per quadrant
 - Alveoplasty, not in conjunction with extraction - per quadrant
 - Sialolithotomy: removal of salivary calculus
 - Closure of salivary fistula
 - Excision of hyperplastic tissue
 - Removal of exostosis
 - Transplantation of tooth or tooth bud
 - Closure of oral fistula of maxillary sinus

Sequestrectomy
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

PERIODONTICS

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Occlusal adjustment (other than with an appliance or by restoration)
- Subgingival curettage or root planing and scaling, per quadrant, limited to 4 separate quadrants every 2 years
- Gingivectomy (including post-surgical visits) per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy, treatment per tooth (fewer than 3 teeth), limited to 1 per site, every 3 years
- Gingival flap procedure, including root planing, per quadrant
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

ENDODONTICS

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root Canal Therapy, including necessary X-rays
 - Anterior
 - Bicuspid

RESTORATIVE DENTISTRY *Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)*

- Amalgam Restorations - Primary Teeth
- Amalgam Restorations - Permanent Teeth
- Resin Restorations
- Sedative Fillings
- Pins
 - Pin retention - per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
 - Prefabricated stainless steel
 - Prefabricated resin crown (excluding temporary crowns)
- Recementation
 - Inlay
 - Crown
 - Bridge

Type C Expenses

ORAL SURGERY

- Impacted Teeth
 - Removal of tooth (partially bony)
 - Removal of tooth (completely bony)

PERIODONTICS

- Osseous surgery (including post-surgical visits), per quadrant, limited to 1 per quadrant, every 3 years

ENDODONTICS

- Root Canal Therapy, including necessary X-rays
 - Molar

RESTORATIVE *Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.*

- Inlays/Onlays - Metallic or Porcelain/Ceramic
 - Inlay, one or more surfaces
 - Onlay, two or more surfaces
- Inlays/Onlays - Resin
 - Inlay, one or more surfaces
 - Onlay, two or more surfaces
- Labial Veneers
 - Laminate-chairside
 - Resin laminate - laboratory
 - Porcelain laminate - laboratory
- Crowns
 - 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

PROSTHODONTICS

- Bridge Abutments (see Inlays and Crowns)
- 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
- Removable Bridge (unilateral)
 - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
 - Complete upper denture
 - Complete lower denture
 - Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
 - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
 - Stress breakers
 - Interim partial denture (stayplate), anterior only
 - Office reline
 - Laboratory reline
 - Special tissue conditioning, per denture
 - Rebase, per denture
 - Adjustment to denture more than six months after installation
- Full and Partial Denture Repairs
 - Broken dentures, no teeth involved
 - Repair cast framework
 - Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
 - Each tooth
 - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only) limited to 1 every 3 years

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (*only when provided in conjunction with a covered surgical procedure*).

ORTHODONTICS

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

Special Provisions for Orthodontic Treatments

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

A **dentist's** charges for services and supplies for **orthodontic treatment** are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for **orthodontic treatment**.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

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.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

Dental Emergency

If treatment is received for the speedy relief of a **Dental Emergency**, coverage will be provided for charges incurred during the initial dental visit. Services in connection with a **Dental Emergency** will be covered at the **Preferred Care** level even if care is not provided by a **Preferred Care Provider**. Additional dental services to treat the **Dental Emergency** will be covered at the appropriate payment percentage level.

Limitations

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 both of the following terms are met:

- 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.

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. Comprehensive Dental Expense Coverage 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 8 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 8 years.

Exclusions and Limitations

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and 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 your Employer.
- Those for services and supplies to diagnose or treat a disease or **injury** that is not:
 - a non-occupational disease; or
 - a non-occupational **injury**.
- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.
- 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:
 - 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:
 - (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
 - (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
 - (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any **jaw joint disorder**; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; except as specifically provided.
- 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 services given by a **Non-Preferred Provider** to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
- Those for a crown; cast; or processed restoration unless:
 - (a) it is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or

-
- (b) 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; except as specifically provided.
 - Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
 - 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.

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

Expenses incurred for the following after the person's coverage ceases under this benefit section will be deemed to be incurred when ordered:

- Dentures.
- Fixed bridgework.
- Crowns.

This applies only if the item is finally installed or delivered no more than 30 days after coverage ends.

"Ordered" means:

- impressions have been taken from which the dentures, crowns, or fixed bridgework will be made; and
- as to fixed bridgework and crowns; the teeth must have been fully prepared if:
 - they will serve as retainers or support; or
 - they are being restored.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 - if required by the FDA, approval has not been granted for marketing; or

- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

Furthermore, this exclusion will not apply with respect to non-approved indications for FDA approved drugs if the indication is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:

the American Medical Association Drug Evaluations;

the American Hospital Formulary Service Drug Information;

the United States Pharmacopeia Drug Information;

or, it is recommended by a clinical study or review article in a major peer-reviewed professional journal.

- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a national government or agency or under a state or provincial government or agency. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.)

- Those for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided in your Booklet-Certificate.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- 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.

This exclusion does not apply to services or supplies of a cosmetic nature needed in the care and treatment of medically diagnosed congenital defects and birth abnormalities that are provided to dependent children from the moment of birth covered under the Policy.

- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply.

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

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

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.
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
- 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 of health 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 law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

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 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.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has 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.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health 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:

- You are prevented because of injury or disease from engaging in your customary occupation and are performing no work of any kind for pay or profit.
- Your dependent is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Comprehensive Dental Expense 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.

Health Expense 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	<p>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.</p> <p>Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.</p>
Physical Examinations	<p>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.</p>
Legal Action	<p>No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.</p> <p>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.</p>
Additional Provisions	<p>The following additional provisions apply to your coverage:</p> <ul style="list-style-type: none">• 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. <p>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, or if you have a complaint against a provider, you may obtain more information from your Employer who may direct you to a local Aetna office. Otherwise, you may write to the following address:</p> <p>Aetna Life Insurance Company 151 Farmington Avenue Hartford, Connecticut 06156 Attention: Law Department, State Government Affairs, RW4A</p> <p>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.</p>
Assignments	<p>Coverage may be assigned only with the written consent of Aetna.</p>

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.

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 you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Otherwise, late claims will not be covered.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. For all benefits except any Temporary Disability Benefit, written proof must be provided.

All benefits are payable to you. However, Aetna will pay any health benefits to the service provider if you have told Aetna to do so before or when you file the claim.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

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.

Denied Claims Appeal Process

If your claim is denied, in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted, in writing, to Aetna or your Employer, within 60 days after you receive notice of the denial. You should include your reasons for requesting a review.

A provider of services or supplies may also request a review of a denied claim on your behalf.

Within 90 days of the receipt of your request, Aetna will:

- review the claim; and
- notify you of the final decision; and
- if necessary, make an appropriate adjustment or claim payment.

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.

Dentist

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

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

Jaw Joint Disorder

This is:

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

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- 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 healthcare 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, a mental health or a dental professional; or
- 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.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

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-Preferred Care

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **Preferred Care Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

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.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician

This means a legally qualified physician.

Preferred Care

This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider that is not a **Preferred Care Provider** for a **dental emergency** when travel to a **Preferred Care Provider** is not feasible.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

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.

Semiprivate Rate

This is the **charge for board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

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, or your dependents 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.
- 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.