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

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

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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 this Plan 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.

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 at its own expense.
- 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.

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 for oral examination (limited to 2 visits per 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 18)
- Bitewing X-rays (limited to two sets 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)

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 *Includes local anesthetics and routine postoperative care.*

- Extractions
 - Uncomplicated
 - Surgical removal of erupted tooth
 - Postoperative visit (sutures and complications) after multiple extractions and impaction
- Impacted Teeth
 - Removal of tooth
- Alveolar or Gingival Reconstructions
 - Alveolectomy (edentulous) per quadrant
 - Alveolectomy (in addition to removal of teeth) per quadrant
 - Alveoplasty with ridge extension, per arch
 - Removal of exostosis
 - Excision of hyperplastic tissue per arch
 - Excision of pericoronal gingiva
- Odontogenic Cysts and Neoplasms
 - Incision and drainage of abscess
 - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
 - Sialolithotomy: removal of salivary calculus
 - Closure of salivary fistula
 - Dilation of salivary duct
 - Transplantation of tooth or tooth bud
 - Removal of foreign body from bone (independent procedure)
 - Maxillary sinusotomy for removal of tooth fragment or foreign body
 - Closure of oral fistula of maxillary sinus
 - Sequestrectomy for osteomyelitis or bone abscess, superficial
 - Condylectomy of temporomandibular joint
 - Menisectomy of temporomandibular joint
 - Radical resection of mandible with bone graft
 - Crown exposure to aid eruption
 - Removal of foreign body from soft tissue
 - Frenectomy
 - Suture of soft tissue injury

Injection of sclerosing agent into temporomandibular joint
Treatment of trigeminal neuraglia by injection into second and third divisions

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

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 per year
- Gingivectomy (including post-surgical visits) per quadrant
- Gingivectomy, treatment per tooth (fewer than 3 teeth)
- Gingival flap procedure, including root planing, per quadrant
- Osseous surgery (including post-surgical visits), per quadrant

ENDODONTICS

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

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
- *Repairs: crowns and bridges*

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

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

Type C Expenses

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)
 - Base 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
- Occlusal guard (for bruxism only) limited to 1 every 3 years

ORTHODONTICS

- Comprehensive **orthodontic treatment**
- Post Treatment Stabilization
- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**

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.)

A deductible applies to **orthodontic treatment**. A deductible is the amount of Covered Orthodontic Expenses that you pay before benefits are payable. There is a separate orthodontic deductible for each person.

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.

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.

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 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.

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;

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- (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 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.

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.

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.

- 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 government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by 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.
- 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.

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- 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 to the extent they are not **reasonable charges**, as determined by Aetna. 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 first day of the contract period which follows 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.

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 calendar month after the calendar month in which the absence started.

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.

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.

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.

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.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

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 no cost to you.

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 Plan Document on file with your Employer. 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.

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

Assignments

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

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, this Plan 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 this Plan 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, through no fault of your own, you are not able 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, this Plan 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.

This Plan 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.

Dentist

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

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.

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 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.

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.

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.

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

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- 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 some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider 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.

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.

Continuation of Coverage under Federal Law

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 will 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 is 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.

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- 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.

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 will 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 is 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 determined by 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.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage 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 this Plan 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 this Plan 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 this Plan only if and when this Plan 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.