Notice to Employees of

Sarah Lawrence College
(the "Customer")

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French

Services d'interprétation et de traduction

Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຟຣີທີ່ປາກົດເທິງບັດປະຈຳໂຮງສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍละເອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະບໍລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງແພນກບໍລິການລູກຄ້າຂອງບໍລິສັດແອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານການແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ນອກນີ້ຍັງມີເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິນສຽງບໍ່ຄົມໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

សេវាកម្មផ្នែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្នែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្នែកសេវាកម្មនៃអតិថិជនរបស់ Aetna មានមធ្យោបាយរកសេវាកម្មបកប្រែតាមរយៈខ្សែទូរស័ព្ទភាសា AT&T ។ លេខ TDD# សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتك للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية. فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

Your Group Plan

Sarah Lawrence College

New Jersey
Freedom of Choice DMO
Primary Care Dentists

Foreword

The Plan is described in:

Part I – The DMO Dental Coverage – Primary Care Dentist Services

Part IA – The DMO Dental Coverage – Specialty Dentist Services

Part II – The Alternate Dental Coverage (Comprehensive Dental Expense Coverage)

- Under the DMO Dental Coverage, Primary Care and Specialty Dentists furnish the services. There is no deductible and no annual maximum when Primary Care or Specialty Dentists furnish the services. There are copayments for certain dental services.
- The Alternate Dental Coverage provides benefits for many of the charges incurred for dental care. A deductible and an annual maximum may apply. There are copayments for certain dental services.
- You may choose either Coverage if you are included in the Eligible Classes. You can become covered for the DMO Dental Coverage or the Alternate Dental Coverage, **but you cannot be covered for both at the same time**. To get further information about either plan, or to change from one plan to the other, you must call the number shown on your ID card. The change will be effective as follows:

  If Aetna receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month.

  If Aetna receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.

  Once the change is effective, all the terms and conditions of the plan under which you and any eligible dependents are covered will apply in lieu of the terms and conditions of the plan under which you and any eligible dependents were covered immediately before the change in coverage. However, dollar maximums or frequency limitations for services or supplies obtained under the prior plan will also be applied to coverage under the current plan. For further details, call the number shown on your ID card.

- The rules of any Effective Date of Coverage provision may delay the start of your coverage.

We believe this Program provides worthwhile protection for you and your family.

Part I
The DMO Dental Coverage

AETNA DENTAL INC.
NEW JERSEY

GROUP CERTIFICATE

Cover Sheet

Contract Holder: **Sarah Lawrence College**

Group Number: **A-875727**

Contract Effective Date: **November 1, 2010**

AETNA DENTAL INC.
NEW JERSEY

GROUP CERTIFICATE

This Certificate is part of the Group Dental Contract ("Contract") between Aetna Dental Inc. ("Dental Plan") and the Contract Holder. The Contract determines the terms and conditions of coverage. The Certificate describes covered dental care benefits. Provisions of this Certificate include any riders, and any amendments, endorsements, inserts or attachments. Riders amendments, endorsements, inserts or attachments may be delivered with the Certificate or added thereafter.

Aetna Dental Inc., operates a prepaid dental care program, which provides dental care services and benefits to Members who are covered under this Certificate. Subscribers covered under this Certificate are subject to all the conditions and provisions of the Contract.

Dental Plan agrees with the Subscriber, subject to all the conditions and provisions of this Certificate to provide the services and benefits and other rights and privileges which are set forth in this Certificate.

This Certificate and all attachments and endorsements incorporated herein by reference are delivered by Dental Plan in consideration of the Contract Holder's payment of premiums and shall take effect on the Contract Effective Date. No services are deliverable under this Certificate in the absence of current payment of such premiums.

Dental Plan will rely upon the statements of each Subscriber in his/her Enrollment Application.

This Certificate is governed by the laws of the State of New Jersey.

SECTION I - DEFINITIONS

A. The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. Contract - The Group Dental Contract issued to the Contract Holder by Dental Plan.

2. Contract Holder - An employer or organization who agrees to remit the premiums for coverage payable to Dental Plan. The Contract Holder shall act only as an agent of Dental Plan Members in the Contract Holder's group, and shall not be an agent of Dental Plan for any purpose.

3. Contract Year - One (1) year period commencing on the effective date of the Contract or any anniversary date thereof, during which the Contract is in effect.

4. Copayment - The amount required to be paid by or on behalf of a Member in connection with the services set forth in Section II of this Booklet-Certificate.

5. Covered Dental Services - Those dental services and supplies set forth in this Certificate provided to a Member, while the person is covered. Those services and supplies are subject to the limitations and exclusions of the Dental Plan.

6. Dependent - Any person in a Subscriber's family who meets all the eligibility requirements of Section IV. B, has enrolled in Dental Plan, and is subject to premium requirements set forth in the Contract.

7. Effective Date - The commencement date of coverage under this Certificate as shown on the records of Dental Plan.

8. Emergency Condition - Any traumatic injury or condition which occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and has symptoms such as severe pain and bleeding.

9. Group - Those employees in the eligible class(es) as shown in Section IV under this Certificate who are enrolled in Dental Plan and whose premiums are remitted to Dental Plan by the Contract Holder.

10. Identification Card - Card issued to each Dental Plan Member which displays the name of Member and the telephone number of the Primary Dentist chosen by the Member.

11. Jaw Joint Disorder - 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 related muscles and nerves.

12. Member - A Subscriber or Dependent as defined in this Section.

13. Non-Participating (Non-Par) Dentist - A Dentist who has not entered into a written agreement with the Dental Plan to provide covered services to covered persons.

14. Open Enrollment Period - A period of not less than ten (10) consecutive working days, each calendar year, when eligible employees of Contract Holder may enroll in Dental Plan without a waiting period or exclusion or limitation based on health status or, if already enrolled in Dental Plan, may transfer to an alternative health plan offered by Contract Holder.

15. Out-Of-Area Emergency Dental Care - Dental Care that is given to a Member by a Non-Par Dental Provider for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the Member's home address. Coverage for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this Dental Care Plan.

16. Primary Care Dentist (PCD) - A state licensed dentist whose area of practice and training is general dentistry, and who has contracted with DPO (Dental Plan Organization) to provide dental services to Members. A PCD chosen by a Member takes effect as a Member's PCD on the Effective Date of that person's coverage.

    If a Member does not choose a PCD, Dental Plan will have the right to make a selection for that Member. Dental Plan will notify the Member of the selection.

    Members may change their PCD by notifying Dental Plan by telephone or in writing.

    The change will be effective as follows:

    If the Dental Plan receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month.

    If the Dental Plan receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.

17. Subscriber - A person who meets all applicable eligibility requirements of Section IV.A, has enrolled in Dental Plan, and is subject to premium requirements set forth in the Premiums section of the Contract.

SECTION II - DENTAL BENEFITS

SCHEDULE OF COVERED SERVICES AND COPAYMENTS

Applies to Covered Services Provided by Primary Care Dentists (PCD's)

Copayment:

PCD Services

Type A Services	The Copayment percentage is 0%
Type B Services	The Copayment percentage is 20%
Type C Services	The Copayment percentage is 40%

This Dental Care Schedule applies to covered services provided by **PCDs**. It includes only services in the list below.

The next sentence applies if:

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

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

Primary Care Dentist Services
Type A Expenses

VISITS AND X-RAYS

- Office visit for oral examination (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to one application every 3 years for permanent molars only)
- Pulp vitality test

X-RAYS AND PATHOLOGY

- Bitewing X-rays (limited to 2 sets per year)
- Entire series, including bitewings, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

Type B Expenses

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

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

PERIODONTICS
- Emergency treatment (abscess, acute periodontitis, etc.)
- Subgingival curettage (limited to 4 separate quadrants, every year)
- Scaling and root planing (limited to 4 separate quadrants, every year)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

ORAL SURGERY *Includes local anesthetics and routine post-operative care*
- Extractions, uncomplicated
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Suture of soft tissue injury

Type C Expenses

RESTORATIONS

- Inlays
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Onlays
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Crowns (including build-ups when necessary)
- Post and core
- Pontics
- Dentures and Partials (includes relines, rebases, and adjustments within six months after installation).
  - Complete (upper and lower)
  - Partial
  - Stress breakers (per unit)
  - Interim partial denture (stayplate), interior only
  - Crown and bridge repairs
  - Adding teeth to an existing denture
  - Full and partial denture repairs
  - Relining/rebasing dentures (including adjustments within six months after installation)
  - Occlusal guard (for bruxism only)

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

- Fixed, band type
- Removable acrylic with round wire clasp
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits

PERIODONTICS

- Full mouth debridement (limited to 1 per lifetime)

OUT-OF-AREA EMERGENCY CARE

"**Out-Of-Area Emergency Dental Care**" consists of Dental care that is given to a **Member** by a **Non-Par Dentist** for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the **Member's** home address. Coverage for **Out-Of-Area Emergency Dental Care** is subject to specific limitations described in this Dental Care Plan.

When care for an Emergency Condition is received; a benefit will be paid for the reasonable charges incurred by a **Member** for such care. The amount paid will not be more than $100; regardless of the number of treatments needed for each separate Emergency Condition.

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

- The care meets the definition of **Out-Of-Area Emergency Dental Care**. Care is given more than 50 miles from the **Member's** home address.
- The care is for the temporary relief of the Emergency Condition until the **Member** can be seen by the **PCD**.
- The person provides an itemized bill to the Dental Plan. It must describe the care given.
- The dental service given is listed on the Dental Care Schedule that applies.

SECTION III - EXCLUSIONS AND LIMITATIONS

A. Coverage is not provided for the following charges:

- Those for 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 or through your Employer.

- Those for services and supplies furnished to diagnose or treat a disease or injury that is not a non-occupational disease or injury.
- Those for services and supplies not furnished by a **Primary Care Dentist**; except if provided as **Out-of-Area Emergency Dental Care**.
- Those for plastic, reconstructive, or cosmetic surgery or other dental services or supplies which are primarily intended to:

  improve;
  alter; or
  enhance appearance;

  whether or not for psychological or emotional reasons.

  Facings on molar crowns or pontics will always be considered cosmetic.
- Those for or in connection with services or supplies that are, as determined by the Dental Plan, 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 which the Dental Plan defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending **PCD**.
- Those for services not listed as Covered Dental Expenses.
- Those for services intended for treatment of any **Jaw Joint Disorder**.
- Those for dental services given after the person's coverage in the Dental Plan ends.
- Those for out-of-area charges that the Dental Plan determines are not reasonable.
- 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 individual 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 does not include a plan established by a government for its own employees or their dependents or Medicaid).

- Those for replacement of lost or stolen appliances; or extra sets of dentures; or other appliances.
- Those for dental services given after the person's coverage in the Dental Plan ends. However, the following will be covered if ordered prior to the date coverage ends and installed or delivered no more than 30 days after coverage ends:

  onlays; inlays; crowns; removable bridges; cast or processed restorations; dentures; root canals; and fixed bridgework.

  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.

- Those for any of the following services:

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

- 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 in connection with a service given to a person age 5 or more if that person becomes a **Member** other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and the Dental Plan. This does not apply to charges incurred:

  (a) After the end of the twelve month period starting on the date the person became a **Member**; or
  (b) As a result of accidental injuries sustained while the person was a **Member**; or
  (c) For a Primary Care Service in the Dental Care Schedule that applies shown under the headings Visits and Exams; and X-rays and Pathology.

- Those for services needed solely in connection with non covered services.
- Those for a crown; cast; or processed restoration unless:

  it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or

  the tooth is an abutment to a covered partial denture or fixed bridge for orthodontic treatment; except when shown in the Dental Care Schedule.

- Those for services done where there is no evidence of pathology; dysfunction; or disease other than covered preventive services.
- General anesthesia and intravenous sedation; unless otherwise specified by the Dental Plan and used in conjunction with another covered Necessary Service or Supply that is listed on the applicable Dental Care Schedule.

Any exclusion above will not apply to the extent that:

coverage is specifically provided by name in your Group Certificate; or
coverage of the charges is required under any law that applies to the coverage.

Dental Care Plan coverage is subject to the following rules:

Replacement Rule
The replacement of; addition to; or modification of:

existing dentures;
crowns;
casts or processed restorations;
removable bridges; or
fixed bridgework

is covered only if one of the following terms is met:

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

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

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

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

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

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

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

the copayment for the approved less costly service; plus
the difference in cost between the approved less costly service and the more costly covered service.

SECTION IV - MEMBERSHIP ELIGIBILITY REQUIREMENTS

A. **Subscriber** Eligibility

To be eligible to enroll as a **Subscriber**, a person must:

On the Effective Date of this Contract:

a. be a regular full-time employee; and
b. be a resident of or work in the Dental Plan service area.

After the Effective Date of this Contract:

a. be a regular full-time employee; and
b. be a resident of or work in the Dental Plan service area.

B. Dependent Eligibility

1. To be eligible to enroll as a Dependent, a person must be: a) the spouse of a Subscriber under this Contract; or b) a dependent unmarried child (includes natural, foster, step and legally adopted children) residing with Subscriber or with Subscriber's former spouse in the Dental Plan service area who is:

   i. under nineteen years of age, or
   ii. nineteen years of age or older but incapable of self-support due to mental retardation or physical handicap, either of which commenced prior to age nineteen, or
   iii. under twenty-five and attending a recognized college or university, trade or secondary school on a regular basis.

2. Newborn children will be treated as Dependents from birth subject to enrollment requirements described in Section VI.B of this Booklet-Certificate.

3. You may also cover as your dependent a person who is your domestic partner, as defined below. A domestic partner is a person:

   - who is of the same or opposite gender;
   - who is engaged in a spouse-like relationship with you;
   - who is at least 18 years of age and mentally competent to consent to a contract;
   - who is not related to you by blood;
   - who is not married to or legally separated from anyone else;
   - who has been residing with you in the same household for at least 6 months and intends to so reside indefinitely;
   - who is engaged in a committed relationship of mutual caring and support with you (This means that you are jointly responsible for each other's common welfare and living expenses.); and
   - who is not in the relationship solely for the purpose of obtaining insurance.

   You must complete and sign a "Declaration of Domestic Partnership" which is acceptable to your Employer. In addition, you must submit proof of at least three of the items from the following List of Items that May Serve as Proof of a Domestic Partnership:

   - a joint deed, a mortgage agreement, or a common leasehold interest in property;
   - common ownership of a motor vehicle;
   - a driver's license listing a common address;
   - status as the other's primary beneficiary for life insurance, for retirement benefits, or under a will;
   - power of attorney for property or health care.

C. Change of Group Eligibility Rules

The eligibility of the Group, the composition of the Group and the eligibility requirements used to determine membership in the Group which exist at the effective date of this Contract are material to the execution of this Contract by Dental Plan. No change in the eligibility or participation requirements of the Group shall be permitted to affect eligibility or enrollment under this Contract unless such change is agreed to by Dental Plan and the Contract Holder, and is not otherwise contrary to State law, rules or regulations. Breach of this provision is considered a material breach of this Contract and may be the basis for termination under Section XII.B.3 of the Contract.

SECTION V - ENROLLMENT AND ENROLLMENT ELIGIBILITY DATES

A. Enrollment Procedure

Any person who satisfies the membership eligibility requirements described in Section IV of this Booklet-Certificate is eligible to enroll in Dental Plan in accordance with Subsection B, below by submitting a completed Dental Plan enrollment application form to Dental Plan.

B. Enrollment Eligibility Date

The Enrollment Eligibility Date is the date that a person who satisfies the membership eligibility requirements described in Section IV of this Booklet-Certificate is eligible to enroll in Dental Plan.

1. The Enrollment Eligibility Date for any person who satisfies the membership eligibility requirements described in Section IV of this Booklet-Certificate on the Effective Date of this Contract shall be the same date as the Effective Date of the Contract.

2. The Enrollment Eligibility Date for any person who first satisfies the membership eligibility requirements described in Section IV of this Booklet-Certificate after the Effective Date of this Contract shall be the first Premium Due Date following the date that such person satisfied the membership eligibility requirements.

SECTION VI - EFFECTIVE DATE OF COVERAGE

A. Effective Date of Coverage Other Than of a Newborn Child

Subject to payment of applicable premiums as provided by the Premiums section of the Contract and in accordance with the applicable provisions and conditions of this Contract, the effective date of a Member's coverage hereunder is:

1. The Member's Enrollment Eligibility Date (Section V.B above) provided that his or her completed Dental Plan enrollment application form is received by Dental Plan within 30 days of the Member's Enrollment Eligibility Date; or

2. If a completed Dental Plan enrollment application form is not received by Dental Plan within 30 days of the Member's Enrollment Eligibility Date (Section V.B above), the effective date of Member's coverage is the next Open Enrollment Period during which Member's completed Dental Plan enrollment application form is received by Dental Plan.

B. Effective Date of Coverage of a Newborn Child. Coverage of a newborn child of a Member is effective at the time of birth and shall automatically extend for a period of 31 days following birth. The Subscriber shall have the right, within the 31 day period following the birth of the newborn child, to continue coverage for the child beyond the 31 day period by enrolling the newborn child as a Dependent Member in Dental Plan, provided that the Member eligibility requirements as described in Section IV of this Booklet-Certificate are satisfied, all premium payments required by the Premiums section of the Contract are paid for said child, and a completed Dental Plan enrollment application form, specifically naming the newborn child to be added, is received by Dental Plan within 31 days following the birth of the child.

SECTION VII - TERMINATION OF COVERAGE

A. Coverage of a Member or Members under this Contract will terminate under any of the following conditions, and termination will be effective on the date indicated:

1. In the event that a Subscriber ceases to meet the eligibility requirements of Section IV.A of this Group Certificate, coverage of Subscriber and Subscriber's Dependents, if any, will terminate on the next premium due date following the date on which the subscriber ceased to meet the eligibility requirements.

2. In the event that a Subscriber's Dependent ceases to meet the eligibility requirements of Section IV.B of this Booklet-Certificate of this Contract or, in the case of a domestic partner, the relationship ends as indicated on the completed and signed Declaration of Termination of Domestic Partnership, coverage of such Dependent will terminate on the next premium due date following the date on which the subscriber ceased to meet the eligibility requirements.

3. In the event that Group coverage under this Contract terminates pursuant to Section VII, coverage of any Member under this Contract will terminate as provided in Section VII.

4. In the event that a Subscriber becomes covered under an alternative dental plan or under any other plan, which is offered by, through or in connection with the Group in lieu of coverage under this Contract, coverage of Subscriber and Subscriber's Dependents, if any, will terminate under this Contract.

5. In the event that a Member acts fraudulently or makes a material misrepresentation in applying for or obtaining coverage under this Contract, or misuses the Dental Plan Identification Card, including but not limited to allowing a person other than the Member named on the Identification Card to use Dental Plan services, Member's coverage under this Contract shall be terminated not less than 15 days from the date written notice is mailed to Subscriber. In the absence of fraud or material misrepresentation, all statements made by any Member or any person applying for coverage under the Contract will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to Member.

6. In the event that Dental Plan or Primary Care Dentists, after reasonable efforts, are unable to establish and maintain what it and Member agree to be a satisfactory relationship with each other, then the rights of such Member under this Contract may be terminated on not less than 30 days written notice to Member and Contract Holder, subject to the Appeals Procedure described in Section VIII.H of this Booklet-Certificate. At the effective date of such termination, prepayments received on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the Contract Holder, and Dental Plan shall have no further liability or responsibility under this Contract with respect to such Member or Members.

7. In the event the coverage of a Subscriber terminates for any reason listed in this section, coverage of Subscriber's dependents, if any under this Contract, will also terminate.

Reinstatement After Your Coverage Terminates: If your coverage terminates because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage terminates. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be effective as described in the Effective date of Coverage section of the Booklet-Certificate. Your dental coverage will be subject to any rules that apply to a person who enrolls after the first 31 days the person is eligible for the coverage.

DENTAL BENEFITS AFTER TERMINATION

A. If a Subscriber is totally disabled when his or her dental care benefits cease, benefits will be available to such Subscriber while he or she continues to be totally disabled for up to the applicable period shown below.

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

- The Subscriber is not able to engage in their customary occupation and are not working for pay or profit.
- The Subscriber's Dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

B. Dental Plan benefits will be available to the Subscriber while disabled for up to 90 days. The benefits will be available for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 90 day period.

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

SECTION VIII - GENERAL PROVISIONS

A. Identification Card

The Identification Card issued by Dental Plan to Member pursuant to this Contract is for identification purposes only. Possession of a Dental Plan Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card may be grounds for termination of Member's coverage pursuant to Section VII.A.6. If the Member who misuses the card is the Subscriber, coverage may be terminated for the Subscriber as well as any dependents. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Dental Plan Identification Card by any other person, such card may be retained by Dental Plan, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedure set forth in Section VIII.H.

B. Necessary Care

Members will receive benefits under the Contract only for necessary care. Dental Plan may determine, following Utilization Review, whether any benefit provided under the Contract was necessary care.

C. Reports and Records

Dental Plan is entitled to receive from any provider of services to Member, information reasonably necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose all facts pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Dental Plan upon request and to permit copying of Member's records by Dental Plan.

D. Refusal of Treatment

Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Primary Care Dentist. If such Primary Care Dentist (after a second Primary Care Dentist's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to follow the recommended treatment or procedure, Member will receive no further treatment for the condition involved. In such case neither the Dentist, nor Dental Plan, will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition. Dental Plan will provide written notice to Member of a decision not to render further treatment for a particular condition. The decision is subject to the Appeals Procedure set forth in this Contract. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

E. Legal Action

No action at law or in equity may be maintained against Dental Plan for any expense or bill unless brought within the statute of limitations for such cause of action.

F. Inability to Provide Service

In the event that due to circumstances not within the control of Dental Plan including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Dental Plan's Primary Care Dentists or entities with whom Dental Plan has arranged for services under this Contract, or similar causes, the rendition of dental benefits or other services provided under this Contract is delayed or rendered impractical, Dental Plan shall not have any liability or obligation on account of such delay or failure to provide services except to refund the amount of the unearned prepaid premiums held by Dental Plan on the date such event occurs. Dental Plan is required only to make a good-faith effort to provide or arrange for the provision of service, taking into account the impact of the event.

G. Confidentiality

Information contained in the dental records of Members and information received from Dentists incident to the dentist-patient relationship shall be kept confidential and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract, or in the compiling of aggregate statistical data, may not be disclosed without the consent of the Member.

H. Appeals Procedure

Dental Plan has established a procedure for resolving complaints by covered persons. If you have a complaint, please follow this procedure:

- An Appeal is defined as a written request for review of a decision that has been denied in whole, or in part, for: claim payment, certification, eligibility, or referral, etc. This will be done after consideration of any relevant information.
- An Appeal must be submitted to Dental Plan within 60 days of the date Dental Plan provides notice of denial.
- An acknowledgement letter will be sent to you within 5 days of Dental Plan's receipt of the Appeal. This letter may request additional information. If so, it must be submitted within 15 days of the date of the letter.
- You will be sent a response within 30 days of Dental Plan's receipt of the Appeal. The response will be based on the information provided with or right after the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Dental Plan after receipt of Dental Plan's response, the decision is considered Dental Plan's final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is submitted to Dental Plan after receipt of Dental Plan's response, it must be submitted within 15 days of the date of Dental Plan's response letter.
- Dental Plan's final response will be sent within 30 days from the date of Dental Plan's first response letter.
- If additional time is needed to resolve the Appeal, Dental Plan will send you a letter indicating that additional time is needed; explaining why such time is needed; and setting a new date for a response. The additional time will not be extended beyond another 30 days.
- In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Dental Plan's Member services telephone number is on your ID card. A verbal response to the Appeal will be given to the provider within 2 business days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Dental Plan's verbal response. If you are dissatisfied with Dental Plan's response, the Appeal procedure outlined above may be utilized.
- Dental Plan will keep records of your complaint for 3 years.

I. Clerical Records

1. Dental Plan shall keep records of all Members.
2. The Group shall forward the information required by Dental Plan in connection with the administration of this Contract.
3. All records of the Group which are incident to the coverage provided under this Contract shall be available for inspection by Dental Plan at any reasonable time.
4. Dental Plan shall not be liable for the fulfillment of any obligation dependent upon such information prior to its receipt in a form satisfactory to Dental Plan.
5. Incorrect information furnished to Dental Plan may be corrected, provided that Dental Plan has not acted to its prejudice in reliance thereon. Coverage under this Contract shall not be invalidated by failure of the Group due to clerical error, provided all premiums are properly adjusted. However in no case will any changes, additions, or deletions in Dental Plan's Member list be made effective more than two (2) Premium Due Dates prior to the date Dental Plan is notified, in a written form satisfactory to Dental Plan, of the requested change, addition, or deletion.

J. Limitation on Services

Services are available only from Primary Care Dentists and Dental Plan shall not have any liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any, dentist or other person, institution or organization unless prior arrangements are made by Dental Plan.

K. Coordination of Benefits With Other Group Health Plans

None of these coordination of benefits rules will serve as a barrier to the Member first receiving direct health services from DPO (Dental Plan Organization) which are covered under this Contract.

The rules establishing the order of benefit determination between this Contract and any other plan covering the Member are as follows:

1. The benefits of a plan which does not have a coordination of benefits with other health plans provision shall in all cases be determined before the benefits of this Contract.

2. For those plans which have applicable Coordination of Benefit clauses, the following rules will apply:

   a. The benefits of a plan which cover the Member as other than dependent will be determined before the benefits of a plan which cover the Member as a dependent;
   b. Except as stated in subparagraph (c) below, when a plan and another plan cover the same child as a dependent of different parents:

      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

      2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

      3) If the other plan does not have the rule described above, but instead has a rule based upon 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) The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

   c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

      1) First, the plan of the parent with custody of the child;
      2) Then, the plan of the spouse of the parent with custody of the child;
      3) Finally, the plan of the parent not having custody of the child; and
      4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.

   d. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (d) shall be ignored;

   e. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, Member, or Subscriber longer are determined before those of the plan which covered that person for a shorter time.

3. If a Member who has enrolled under this Contract is entitled to maternity benefits under another contract or policy of insurance (such as extended benefits for pregnancies which began while the Member was enrolled under a previously held policy), DPO (Dental Plan Organization) will pay, subject to Copayments under this Contract, the difference between entitlements under this Contract and entitlements under the other contract or policy of insurance.

4. Member agrees to permit DPO (Dental Plan Organization) to coordinate its obligations under this Contract with payment under any other contract or policy of insurance that covers Member.

5. For purposes of these provisions, DPO (Dental Plan Organization) may release to or obtain from any insurance company or other organization any necessary information, subject to applicable confidentiality requirements, as defined in Section VIII.G of this Booklet-Certificate. Any Member claiming benefits under this Contract must furnish to DPO (Dental Plan Organization) all information deemed necessary by it to implement this provision.

SECTION IX - CONTINUATION OF COVERAGE

A.1. The continuation of coverage rules of this section, do not apply to any Contract Holder who normally employed fewer than 20 employees on a typical business day during the preceding calendar year. This exception applies to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

If a Member's coverage terminates due to termination of Subscriber's employment (other than by reason of Subscriber's gross misconduct) or reduction of hours of Subscriber's employment, Member may elect to continue coverage for 18 months after eligibility for coverage under this Contract would otherwise cease.

If Member's coverage terminates due to a) divorce or legal separation, b) Subscriber's death, c) Subscriber's entitlement to Medicare benefits, or d) cessation of dependent child status of this Certificate, Member may elect to continue coverage for 36 months after eligibility for coverage under this Contract would otherwise cease.

Continuation coverage ends at the earliest of the following events:

a. The last day of the 18-month period.
b. The last day of the 36-month period.
c. The first day on which timely payment of premium is not made.
d. The first day on which the Contract Holder ceases to maintain any group health plan.
e. The first day on which a Member is actually covered by any other group health plan. In the event the Member has a pre-existing condition, and the Member would be denied coverage under the new plan for a pre-existing condition, continuation coverage will not be terminated until the last day of the 18-month continuation period, or the date upon which the Member's pre-existing condition becomes covered under the new plan, whichever occurs first.
f. The date the Member is entitled to Medicare.
g. The date the Member no longer resides in the service area.

The 18-month coverage period may be extended if an event which would otherwise qualify the Member for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the Member for continuation coverage initially.

In the event a Member becomes disabled within the meaning of the Social Security Act, and notifies the employer before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to members who are disabled at the time of their qualifying event and only when the qualifying event is the employees reduction in hours or termination. The member may be charged a higher rate for the extended period.

Contract Holder is responsible for providing the necessary notification to Members as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. Coverage for the sixty (60) day period will be extended only where the Subscriber or Dependent pays the applicable premium charges due within forty-five (45) days of submitting the application to the Contract Holder and Contract Holder in turn remitting same to DPO.

Premiums payable to DPO for the continuation of coverage under this Section shall be due in accordance with the procedures of Premiums section of the Contract and shall be calculated in accordance with applicable federal law and regulations.

CONFIDENTIALITY NOTICE

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your Booklet-Certificate. Your Plan Administrator has determined that this information together with the information contained in your Booklet-Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Employer Identification Number:

23-7223216

Plan Number:

509

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Dental, Inc.
980 Jolly Road
Post Office Box 1109
Blue Bell, Pennsylvania 19422

Plan Administrator:

Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999

Agent For Service of Legal Process:

Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999

End of Plan Year:

December 31

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator

ERISA RIGHTS

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADDITIONAL INFORMATION

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at **www.aetna.com**.

AETNA DENTAL, INC.
(NEW JERSEY)

CIVIL UNION AMENDMENT

Contract Holder Group Agreement Effective Date: **November 1, 2010**

The Aetna Dental Inc. Certificate of Coverage is hereby amended as follows:

1. The Dependent Eligibility provision under the Membership Eligibility Requirements is hereby revised to add the following:

   The term "spouse" shall include a Civil Union partner as defined by New Jersey State Law. In addition, if applicable, any references under this Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a Civil Union. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be valid in New Jersey.

   A Subscriber, who is a Civil Union partner, who is eligible for COBRA continuation of coverage may elect COBRA continuation of coverage for the Subscriber and the Subscriber's Dependent, including a Civil Union partner. However, a Dependent who is a Civil Union partner, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

All other terms and conditions of the Certificate shall remain in full force and effect except as amended herein.

AETNA DENTAL INC.
(NEW JERSEY)

DOMESTIC PARTNER AMENDMENT

Contract Holder Group Agreement Effective Date: **November 1, 2010**

The Aetna Dental Inc. Certificate of Coverage is hereby amended as follows:

1. The Domestic Partner Eligibility (Item 3) appearing in the Dependent Eligibility provision under the Membership Eligibility Requirements is hereby deleted and replaced with the following:

   3. Opposite Gender Domestic Partner: You may also cover as your dependent a person who is your opposite gender domestic partner, as defined below. A opposite gender domestic partner is a person:
      - who is of the opposite gender;
      - who is engaged in a spouse-like relationship with you;
      - who is at least 18 years of age and mentally competent to consent to a contract;
      - who is not related to you by blood;
      - who is not married to or legally separated from anyone else;
      - who has been residing with you in the same household for at least 6 months and intends to so reside indefinitely;
      - who is engaged in a committed relationship of mutual caring and support with you (This means that you are jointly responsible for each other's common welfare and living expenses.); and
      - who is not in the relationship solely for the purpose of obtaining insurance.

      You must complete and sign a "Declaration of Domestic Partnership" which is acceptable to your Employer. In addition, you must submit proof of at least three of the items from the following list of items that may serve as proof of a domestic partnership:

      - a joint deed, a mortgage agreement, or a common leasehold interest in property;
      - common ownership of a motor vehicle;
      - a driver's license listing a common address;
      - status as the other's primary beneficiary for life insurance, for retirement benefits, or under a will;
      - power of attorney for property or health care.

      Same Gender Domestic Partner: You may also cover as your dependent a person who is your same gender domestic partner if you and your partner have jointly executed and filed an Affidavit of Domestic Partnership with the local registrar and have been issued a copy of the Affidavit marked "filed".

      A domestic partnership shall be established when all of the following requirements are met:

      (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:

         (a) a joint deed, mortgage agreement or lease;
         (b) a joint bank account;
         (c) designation of one of the persons as a primary beneficiary in the other person's will;
         (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
         (e) joint ownership of a motor vehicle;

      (2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;

(3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;

(4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;

(5) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;

(6) Both persons are at least 18 years of age;

(7) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;

(8) Both persons file jointly an Affidavit of Domestic Partnership; and

(9) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died.

Those same-sex relationships entered into outside the State of New Jersey that most closely approximate New Jersey domestic partnerships that is, relationships that provide some, but not all of the rights and obligations of marriage, will be treated as domestic partnerships under New Jersey state law.

All other terms and conditions of the Certificate shall remain in full force and effect except as amended herein.

AETNA DENTAL INC.
(NEW JERSEY)

DENTAL BENEFITS COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: **November 1, 2010**

The Aetna Dental Inc. Group Agreements, Certificates of Coverage, Schedules of Benefits, riders, amendments, endorsements, inserts and attachments (the "Plan Documents") are hereby amended as follows:

The following dental services will be considered Covered Dental Services under the Dental Benefits under certain conditions as follows.

Additional dental services are provided for a covered person who:

- is pregnant; or
- has coronary artery disease/cardiovascular disease; or diabetes; and
- is a covered person for medical coverage insured or administered by Aetna.

Covered Dental Services

If the above conditions are met, the following dental services will be considered Covered Dental Services

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy.)

With respect to the additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

With respect to the other dental services above, the Copayment will be waived and will not be subject to any frequency limits except as shown above.

This Amendment shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.

BENEFIT PLAN

Prepared Exclusively for
Sarah Lawrence College

New Jersey - Freedom of Choice DMO - Specialty Dentists

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

We want you to know℠

Aetna®

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

Preface *(GR-9N-02-005-02 NJ)*

Aetna is pleased to provide you with this *Booklet-Certificate*. Your *Booklet-Certificate* (which includes the *Schedule of Benefits* and any amendments or riders), describes what the plan covers and how benefits are paid for that coverage.

The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* (certificate) under the group policy issued as follows:

Group Policyholder:	Sarah Lawrence College
Group Policy Number:	GP-875727-NJ
Effective Date:	November 1, 2010
Issue Date:	February 9, 2011
Booklet-Certificate Number:	1

This certificate supersedes all certificates describing similar coverage that **Aetna** previously issued to you. This certificate is subject to the laws of the State of New Jersey.

Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-005-02 NJ)*

No benefits are covered under this *Booklet-Certificate* in the absence of payment of current premiums by the Group Policyholder subject to the *Grace Period* provision and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

Except as provided for under the sections *Termination of Coverage (Extension of Benefits)* and *Continuation of Coverage,* this plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury** or **illness** that occurred, began or existed while coverage was in effect.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* if the service or supply is furnished on or after the effective date of the plan modification.

Coverage for You and Your Dependents (GR-9N-02-005-02 NJ)

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Only **non-occupational injuries** and **non-occupational illnesses** are covered. Conditions that are related to the complications of pregnancy will be covered under this plan.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N 29-010 01)*

You may also cover as your dependent a person who is your domestic partner if you and your partner have jointly executed and filed an Affidavit of Domestic Partnership with the local registrar and have been issued a copy of the Affidavit marked "filed".

A domestic partnership shall be established when all of the following requirements are met:

(1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
   (a) a joint deed, mortgage agreement or lease;
   (b) a joint bank account;
   (c) designation of one of the persons as a primary beneficiary in the other person's will;
   (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
   (e) joint ownership of a motor vehicle;
(2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
(3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
(4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
(5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older may establish a domestic partnership if they meet the requirements set forth in this section;
(6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
(7) Both persons file jointly an Affidavit of Domestic Partnership; and
(8) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died.

Those same-sex relationships entered into outside the State of New Jersey that most closely approximate New Jersey domestic partnerships that is, relationships that provide some, but not all of the rights and obligations of marriage will be treated as domestic partnerships under New Jersey law.

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 25, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.
- Newborn children from the moment of birth; however if payment of premium is required to provide coverage for the newborn child, **Aetna** may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

* Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 6-18 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Children of **civil union partners**;
- Children of domestic partners;
- Your stepchildren;

- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N 29-015-02)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins *(GR-9N-29-025-02 NJ)*

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under *Rules and Limits That Apply to the Dental Plan* section will apply.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions.

Dependents' coverage will be effective:

- In the case of marriage, on the date of the marriage;
- In the case of civil union, on the date of the civil union;
- In the case of a newborn, on the date of birth;
- In the case of adoption, on the date of the child's adoption or placement for adoption;
- In the case of court ordered coverage of a spouse/**civil union partner** or child, on the date specified in the court order;
- In the case of loss of COBRA coverage under another plan, on the date the COBRA coverage ends; and
- In the case of loss of coverage for other reasons, the date on which the applicable life event occurs.

Requirements For Coverage *(GR-9N 09-005 01 NJ)*

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

(GR-9N-27-005-01 NJ)

3. The service or supply must be **medically necessary**. To meet this requirement, the dental services, supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   - In accordance with generally accepted standards of dental practice;
   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   - Not primarily for the convenience of the patient, **physician** or **dental provider** or other health care provider;
   - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Important Note

- Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain dental services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

How Your Aetna Dental Plan Works

(GR-9N 16-005-01)

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

Understanding Your Aetna Dental Plan

It is important that you have the information and useful resources to help you get the most out of your **Aetna** dental plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage and general administration of the plan.

Important Notes:
Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to the Eligibility section for a complete definition of "you".

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental plan.

Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms *(GR-9N S 16-010-01)*

Many terms throughout this Booklet-Certificate are defined in the *Glossary* Section at the back of this Booklet-Certificate. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About the Comprehensive Dental Plan *(GR-9N 16-030 01)*

This dental plan covers a wide range of necessary dental services and supplies. You have the freedom to choose the **dental provider** of your choice.

The comprehensive dental plan begins to pay benefits after you satisfy a **deductible**.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).

If your **dentist** charges more than the **recognized charge**, you must also pay any expenses above the **recognized charge**.

You must file a claim to receive reimbursement from the plan.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductibles, coinsurance** and maximums that apply.

What The Plan Covers *(GR-9N-S-18-005-01 NJ)*

Comprehensive Dental Plan
Schedule of Benefits for the Comprehensive Dental Plan

Comprehensive Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care expenses you incur.

Important Reminder
Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule as shown in the *Schedule of Benefits*.

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 of 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.

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

This Dental Care Schedule applies to covered services and supplies provided by **specialty care dentists**. The plan covers only the services and supplies in the list below.

Specialty Dental Services *(GR-9N-S-20-031-01)*

Type B Expenses

Endodontics - Includes local anesthetics where necessary
Apexification/recalcification
Apicoectomy/periradicular surgery (per tooth) - first root
Apicoectomy (per tooth) - each additional root
Retrograde filling
Root amputation
Hemisection

Oral Surgery - Includes local anesthetics where necessary and post-operative care
Surgical removal of root tip, root recovery
Removal of residual root
Removal of odontogenic cyst
Closure of oral fistula
Removal of foreign body from bone
Sequestrectomy
Frenectomy
Transplantation of tooth or tooth bud
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty not in conjunction with extractions - per quadrant
Removal of exostosis
Sialolithotomy, removal of salivary calculus
Closure of salivary fistula

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

Type C Expenses

Endodontics - Includes local anesthetics where necessary
Molar root canal therapy, including necessary X-rays

Oral Surgery - Includes local anesthetics where necessary and post-operative care
Surgical removal of impacted tooth
- Partially bony
- Completely bony
- Completely bony with unusual surgical complications

Periodontics
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years
Osseous surgery (including flap and closure), per quadrant (limited to 1 per site, every 3 years)
Soft tissue graft procedure
Clinical crown lengthening - hard tissue

Intravenous Sedations and General Anesthesia

Orthodontics
Orthodontic screening exam
Orthodontic diagnostic records
Orthodontic retention
Comprehensive orthodontic treatment of adolescent and adult dentition
Post treatment stabilization

Rules and Limits That Apply to the Dental Plan *(GR-9N-S-20-005-01 NJ)*

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Orthodontic Treatment Rule

Orthodontic coverage is only for covered dependent children who are under age 20 on the date active orthodontic treatment begins.

The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Orthodontic Limitation for Late Enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the two year-period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

Replacement Rule *(GR-9N-S-20-010-03 NJ)*

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to **Aetna** that:

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance bridge must include the replacement of an extracted tooth or teeth.
- The tooth that was removed was not an abutment to a fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule *(GR-9N-20-015-01)*

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Begun Before You Are Covered by the Plan *(GR-9N-S-20-020-03 NJ)*

The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Late Entrant Rule *(GR-9N-S-20-025-01 NJ)*

The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:

- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and **Aetna**.

This exclusion does not apply to charges incurred:

- After the person has been covered by the plan for 12 months, or
- As a result of **injuries** sustained while covered by the plan, or
- For services listed as Visits and X-rays, Visits and Exams, and X-ray and Pathology in the Dental Care Schedule.

What The Comprehensive Dental Plan Does Not Cover *(GR-9N-28-015-01-NJ)(GR-9N 28-025 01)*

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery (except coverage will be provided for covered newborns from the moment of birth for the **medically necessary** care and treatment of medically diagnosed congenital defects and birth abnormalities), personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

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

Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

Except as covered in the *What the Plan Covers* section, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

Orthodontic treatment except as covered in the *What the Plan Covers* section.

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:

- Scaling of teeth; and
- Cleaning of teeth.

Treatment of malignancies, cysts and neoplasm.

Additional Items Not Covered By A Health Plan *(GR-9N-28-015-01-NJ)*

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet-Certificate.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;

- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

When Coverage Ends *(GR-9N 30-005 05) (GR-9N-30-005-HRPA-01 NJ)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;

- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance, except as described in the *Extension of Benefits* and *A Totally Disabled Employee's Right to Continue Health Benefits* section of the Booklet-Certificate. This will be either the end of the month, end of the month following the month in which you stop active work, or the day before the first premium due date that occurs after you stop active work, whichever occurs first. The premium due date is the 30th day of the calendar month. However, if premium payments are made on your behalf, **Aetna** will consider your employment to continue, for purposes of remaining eligible for coverage under this Plan. as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day your are actively at work before the start of the lay-off or leave of absence.

If you are totally disabled you shall be entitled to continue your health insurance in accordance with the *Extension of Benefits* and *A Totally Disabled Employee's Right To Continue Health Benefits* sections.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Reinstatement After Your Dental Coverage Terminates *(GR-9N-30-005-01 NJ)*

If your coverage ends because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage ends. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be subject to the rules under the Late Enrollment section, and will be effective as described in the *Effective Date of Coverage* section.

When Coverage Ends for Dependents *(GR-9N-30-015-03 NJ)*

Coverage for your dependents will end if:

- The date you are no longer eligible for dependents' coverage;
- The date you do not make the required contribution toward the cost of dependents' coverage;
- The date your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (other than exhaustion of your overall maximum lifetime benefit, if included);
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent.

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

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

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N 31-010-03 NJ) (GR 9N 31-015 02)*

Continuing Health Care Benefits *(GR-9N-31-015-03 NJ) (GR-9N DEP30)*

Handicapped Dependent Children *(GR-9N-31-015-03 NJ)*

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 an individual 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 under your plan; 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 under your plan.

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, as stated in the "When Coverage Ends for Dependents" section, other than reaching the maximum age under your plan.

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 under your plan.

Extension of Benefits *(GR-9N-31-020-03 NJ)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled due to discontinuance of the health policy, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit for which you are reasonably fitted by education, training and experience.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N-31-020-03 NJ)*

(GR-9N-31-020-03 NJ)
Dental Benefits (other than Basic Dental benefits): Coverage will be available while you are totally disabled, for up to 12 months. Coverage will be available only if covered services and supplies have been rendered and received, including delivered and installed, prior to the end of that 12 month period.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage *(GR-9N-31-025-02 NJ)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

You and your covered dependents may be eligible to continue group health benefits under the COBRA Continuation of Coverage section and under other continuation sections of the plan at the same time. If an individual is eligible to continue group health benefits under both the plan's COBRA Continuation of Coverage section and certain other continuation provisions of the plan, your rights to elect continuation and the benefits provided may be affected.

Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify the individual for continuation under this section, is covered for group health benefits under the Contract as:

- an active, covered employee;
- the spouse of an active, covered employee; or
- the dependent child of an active, covered employee. Except as stated below, any person who becomes covered under the plan during a continuation provided by this section is not a Qualified Continuee.

Exceptions:

- A child who is born to the covered employee, or who is placed for adoption with the covered employee during the continuation provided by this section is a Qualified Continuee.
- If you are a civil union partner, who is eligible for COBRA continuation of coverage you may elect COBRA continuation of coverage for you and your eligible dependents, including a civil union partner. However, an eligible dependent who is a **civil union partner**, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

If An Employee's Group Health Benefits Ends

If your group health benefits end due to termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, unless you were terminated due to gross misconduct.

A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:

- is covered under another group plan on or before the date of the COBRA election; or
- is entitled to Medicare on or before the date of the COBRA election.

The continuation:

1. may cover you and any other Qualified Continuee; and
2. is subject to the When Continuation Ends section.

Additional Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date their group health benefits would otherwise end due to the employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, the individual and any Qualified Continuee who is not disabled may elect to extend their 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the employer written proof of Social Security's determination of his or her disability before the earlier of:

- the end of the 18 month continuation period; and
- 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, the individual must notify the employer within 30 days of such determination, and continuation will end, as outlined in the When Continuation Ends section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If an employee dies while covered, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the plan, other than the employee's coverage ending, they may elect to continue such benefits. However, such dependent child must be a Qualified Continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

Concurrent Continuations
If a dependent elects to continue group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

- the dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
- the employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to dependents of an employee when the employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a dependent upon the employee's subsequent termination of employment or reduction in work hours will be the longer of the following:

- 18 months from the date of the employee's termination of employment or reduction in work hours; or
- 36 months from the date of the employee's earlier entitlement to Medicare.

Exception: If the employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the employer, in writing, of:

- the legal divorce or legal separation of the Employee from his or her spouse; or
- the loss of dependent eligibility, as defined in the plan, of a covered dependent child.

Such notice must be given to the employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:

- his or her right to continue the plan's group health benefits;
- the monthly premium the individual must pay to continue such benefits; and
- the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:

- the date a Qualified Continuee's group health benefits would otherwise end due to the employee's death or the employee's termination of employment or reduction of work hours; or
- the date a Qualified Continuee notifies the employer, in writing, of the employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered dependent child.

The Employer's Liability
The employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, **Aetna**, if:

- the employer fails to remit a Qualified Continuee's timely premium payment to **Aetna** on time, thereby causing the Qualified Continuee's continued group health benefits to end;
- the employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue health benefits, the Qualified Continuee must give the employer written notice that they elect to continue coverage. An election by a minor dependent child can be made by the dependent child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed covered under the plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the employer.

If the Qualified Continuee fails to give the employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer or **Aetna**.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

- with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
  - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
  - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- with respect to continuation upon the Employee's death, the employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- with respect to a dependent whose continuation is extended due to the employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- the date the plan ends;
- the end of the period for which the last premium payment is made;
- the date the individual becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of Creditable Coverage;
- the date the individual becomes entitled to Medicare;
- termination of a Qualified Continuee for cause on the same basis that the employer terminates coverage of an active employee for cause.

Conversion from a Group to an Individual Plan
You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment;
- When loss of coverage under the group plan occurs;
- When loss of dependent status occurs;
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means the charge for any health care service, supply or other item of expense for which the person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When **This Plan** is coordinating benefits with a Plan that provides benefits only for dental care, vision care, **prescription drugs** or hearing aids, **Allowable Expense** is limited to like items of expense.

Aetna will not consider the difference between the cost of a private **Hospital** room and that of a semi-private **Hospital** room as an **Allowable Expense** unless the **stay** in a private room is **Medically Necessary**.

When **This Plan** is coordinating benefits with a **Plan** that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

"Claim Determination Period" means a calendar year or portion of a calendar year, during which a person is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense**(s) under such **Plans**.

"**Coordination of Benefits (COB)"** means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

"**Plan**(s)" means coverage with which **COB** is allowed. **Plan** includes:

i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
iii. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
iv. Group **hospital** indemnity benefit amounts that exceed $150 per day;
v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

"**Plan**(s)" shall not include:

i. Individual or family insurance contracts or subscriber contracts;
ii. Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;
iii. Group or group-type coverage where the cost of the coverage is paid solely by the Member except when coverage is being continued pursuant to Federal or State continuation law;
iv. Group **hospital** indemnity benefit amounts of $150.00 per day or less;
v. School accident-type coverage;
vi. A State plan under Medicaid.

"**This Plan**" is the part of this Certificate that provides benefits for health care expenses.

"**Primary Plan**(s)" means a **Plan** whose benefits for a person's heath care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A **Plan** will be the **Primary Plan** if:

i. the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this Certificate; or
ii. all **Plans** which cover the person use order of benefit determination rules consistent with those contained in this Certificate and under those rules, the Plan determines its benefit first.

"**Reasonable Charge**" means an amount this is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a provider within the same geographic area.

"**Secondary Plan(s)**" means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this COB section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this Certificate, has its benefits determined before those of that **Secondary Plan**.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered one **plan**.

Primary and Secondary Plan:
This **Plan** considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

Secondary Plan takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determines the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more than it would have paid if it had been the **Primary Plan**. The method the **Secondary Plan** uses to determine the amount to pay is set forth below in the "Procedures to be followed by the **Secondary Plan** to Calculate Benefits" section.

Which Plan Pays First

Rules for the Order of Benefit Determination:
The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree shall be determined before those of the **Plan** that covers the person as a dependent. The coverage as an employee, member, subscriber or retiree is the **Primary Plan**.

The benefits of the **Plan** that covers the person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the **Plan** that covers the person as a laid off or retired employee, or as such a person's dependent. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the **Plan** that covers the person under a right of continuation pursuant to Federal or State law. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are neither separated nor divorced, the following rules apply:

i. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
ii. If both parents have the same birthday, the benefits of the **Plan** which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
iii. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
iv. If the other **Plan** contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are separated or divorced, the following rules apply:

i. The benefits of the Plan of the parent with custody of the child shall be determined first.
ii. The benefits of the Plan of the spouse/**civil union partner** of the parent with custody shall be determined second.
iii. The benefits of the Plan of the parent without custody shall be determined last.
iv. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that **Plan** has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the **Plan** of the other parent shall be considered as secondary. Until the entity providing coverage under the **Plan** has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which **Plan** is the **Primary Plan**, the benefits of the **Plan** that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the **Plans** that covered the person for a shorter period of time.

How Coordination of Benefits Works

Procedures to be followed by the Secondary Plan to Calculate Benefits
In order to determine which procedure to follow it is necessary to consider:

i. the basis on which the **Primary Plan** and the **Secondary Plan** pay benefits; and
ii. whether the provider who provides or arranges the services and supplies is in the network of either the **Primary Plan** or the **Secondary Plan**.

Benefits may be based on the **Reasonable Charge**, or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the bill charge. In this section, "**Reasonable Charge Plan**" means a plan that bases benefits on a Reasonable Charge.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a "**Network Provider**", bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, "Fee Schedule Plan(s)" means a **Plan** that bases benefits on a negotiated fee schedule. If the covered person uses the services of a **non-network provider**, the **Plan** will be treated as a **Reasonable Charge Plan** even though the **Plan** under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means an HMO or other plan pays the **Network Provider** a fixed amount per covered person. The covered person is liable only for the applicable **deductible**, **coinsurance** or **copayment**. If the covered person uses the services of a **non-network provider**, an HMO or other plan will only pay benefits in the event of emergency care or **urgent care**. In this section, "Capitation Plan" means a **Plan** that pays **Network Providers** based upon capitation.

Primary and Secondary Plans are Fee Schedule Plans
If the provider is a **Network Provider** in both the **Primary Plan** and the **Secondary Plan**, the **Allowable Expense** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The total amount the provider receives from the **Primary Plan**, the **Secondary Plan** and the covered person shall not exceed the fee schedule of the **Primary Plan**. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

Primary Plan is Reasonable Charge Plan and Secondary Plan is Fee Schedule Plan
If the provider is a **Network Provider** in the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

i. the difference between the amount of the billed charges for the **Allowable Charges** and the amount paid by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The covered person shall only be liable for the **deductible**, **coinsurance** or **copayment** under the **Secondary Plan** if the covered person has no liability for **deductible**, **coinsurance** or **copayment** under the **Primary Plan** and the total payments by both the **Primary Plan** and the **Secondary Plan** are less than the providers billed charges. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan
If the provider is a **Network Provider** in the **Primary Plan**, the **Allowable Expense** considered by the **Secondary Plan** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan or Fee Schedule Plan
If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of **urgent care** or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as **urgent care** or emergency care, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Recognized Charge Plan
If the covered person receives services or supplies from a provider who is a **Network Provider** of both the **Primary Plan and the Secondary Plan, the Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Capitation Plan or Fee Schedule Plan or Recognized Charge Plan and Secondary Plan is Capitation Plan
If the covered person receives services or supplies from a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall be liable to pay the capitation to the **Network Provider** and shall not be liable to pay the **deductible**, **coinsurance** or **copayment** imposed by the **Primary Plan**. The covered person shall not be liable to pay any **deductible**, **coinsurance** or **copayment** of either the **Primary Plan** or the **Secondary Plan**.

Primary Plan is an HMO and Secondary Plan is an HMO
If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of urgent or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary and Secondary Plans are Reasonable Charge Plans
The **Secondary Plan** shall pay the lesser of:

i. the difference between the amount of the billed charges and the amount paid by the **Primary Plan;** or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

When the benefits of the **Secondary Plan** are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the **Plan**.

Effects of Automobile Plans for Automobile Related Injuries

This section will be used to determine a **covered person**'s benefits under this **Plan** when expenses are incurred as a result of an automobile related **injury**.

Definitions

"**Automobile Related Injury**" means bodily **Injury** sustained by a **covered person** as a result of an accident:

iii. while occupying, entering, leaving or using an automobile; or
iv. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"**Allowable Expense**" means a **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:

a) the **Policy**;
b) **PIP**; or
c) **OSAIC**.

"**Eligible Expense**" means that portion of expense incurred for treatment of an **injury** which is covered under this **Plan** without application of Cash **Deductibles** and **Copayments**, if any or **Coinsurance**.

"**Out-of-State Automobile Insurance Coverage**" or "**OSAIC**" means any coverage for medical expenses under an automobile insurance policy other than **PIP**. **OSAIC** includes automobile insurance policies issued in another state or jurisdiction.

"**PIP**" means personal **injury** protection coverage provided as part of an automobile insurance policy issued in New Jersey. **PIP** refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The **Policy** provides secondary coverage to **PIP** unless health coverage has been elected as primary coverage by or for the **covered person** under this **Plan**. This election is made by the named insured under a **PIP** policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. The **Policy** may be primary for one **covered person** but not for another if the person has separate automobile policies and has made different selections regarding primary of health coverage.

The **Policy** is secondary to **OSAIC** unless the **OSAIC** contains provisions which make it secondary or excess to the policyholder's plan. In that case this **Plan** will be primary.

If there is a dispute as to which **policy** is primary, this **Plan** will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC

If this **Plan** is primary to **PIP** or **OSAIC** it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this **Plan** will apply if:

a) the **Covered Person** is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if secondary to PIP or OSAIC

If this **Plan** is secondary to **PIP** or **OSAIC** the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after **PIP** or **OSAIC** has provided coverage after applying Cash **Deductibles** and **Copayments**, or
b) the benefits that would have been paid if this **Plan** had been primary.

Medicare

If this **Plan** supplements coverage under **Medicare** it can be primary to automobile insurance only to the extent that **Medicare** is primary to automobile insurance.

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

You are eligible for **Medicare**:

- by reason of age, disability; or
- End Stage Renal Disease.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the **primary payor**, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the **secondary payor**, and pays benefits after **Medicare**.

Which Plan Pays First

When a Covered Person Becomes Eligible for Medicare.
The plan is the **Primary Plan** when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the **Primary Plan** for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the **Secondary Plan** in all other circumstances. Benefits will be payable in accordance with the *Rules for the Order of Benefits Determination* within this Coordination of Benefits section.

If **Medicare** is the **Primary Plan** and if **This Plan** is the **Secondary Plan**, and you are eligible for **Medicar**e but refuse it, drop it, or fail to make proper request for it, **Aetna** will estimate the **Medicare** payment as if you were covered by **Medicare**, and as if **Medicare** was the **Primary Plan** and **Aetna** will pay as if it was the **Secondary Plan**.

How Coordination With Medicare Works

The **plan** pays benefits first when it is the **Primary Plan**. You may then submit your claim to **Medicare** for consideration. When **Medicar**e is the Primary Plan, you must first submit your health care expenses to **Medicare**. You may then submit the expense to **Aetna** for consideration.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

General Provisions

(GR-9N 32-005 02)

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you. **Aetna** will also have the right and opportunity to make an autopsy, in case of death, where it is not prohibited by law.

Legal Action

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

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N 32-005 02)*

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

Misstatements

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of a written statement signed by the person insured is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of the policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding the Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Recovery of Overpayments *(GR-9N-32-015-03-NJ)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right; within the following guidelines:

- To require the return of the overpayment; 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.

With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, **Aetna** will not seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. **Aetna** will not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, **Aetna** will provide written documentation that identifies the error made in the processing or payment of the claim that justifies the reimbursement request. **Aetna** will not base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and **Aetna** has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

In seeking reimbursement for the overpayment from the health care provider, except in cases where the overpayment to the health care provider is a result of fraud, **Aetna** shall not collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal are exhausted; or
(iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

Aetna may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal have been exhausted if **Aetna** submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile your bill.

If **Aetna** has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, **Aetna** may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

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

Reporting of Claims

Written notice of **illness** or of **injury** must be submitted to **Aetna** within 20 days after the date in which the **illness** or **injury** occurred. Any necessary claim forms required for filing a claim will be furnished by **Aetna** upon receipt of written request. Failure to give notice of loss shall not invalidate nor reduce any claim if notice was given as soon as reasonably possible. Written proof of loss must be furnished to **Aetna** within 90 days after the date of such loss. If the person making claim does not receive the requested claim forms before the expiration of 15 days after **Aetna** receives notice of any claim, the person making such claim shall be deemed to have complied with the requirements of the plan as to proof of loss upon submitting within the time fixed within the plan for filing proof of loss, written proof covering the **occurrence**, character and extent of the loss for which claim is made.

Accident and Health expense insurance claims filed by a provider on behalf of you, the provider shall file with us the claim within 60 days of the last date of service or course of treatment. For **Accident** and Health expense insurance claims in which you have assigned your benefits to the provider, the provider shall file the claim within 180 days of the last date of service of a course of treatment. In the event the **provider** does not file the claim within 180 days of the last date of service of a course of treatment, **Aetna** reserves the right to deny or dispute the claim and the **provider** shall be prohibited from seeking payment in whole or in part directly from the member covered person.

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. Failure to furnish such proof within such time shall not reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Payment of Benefits *(GR-9N-32-025-02)*

Health

(1) Upon satisfactory proof of loss, **Aetna** will remit payment for claims submitted by you or your health care provider for **covered expenses** no later than 30 calendar days following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim in submitted by other than electronic means, if:
   a) the health care provider is eligible at the date of service;
   b) the person who received the health care service was covered on the date of service;
   c) the claim is for a service or supply covered under this policy;
   d) the claim is submitted with all the information requested by **Aetna** on the claim form or in other instructions that were distributed in advance to the provider or member in accordance with New Jersey laws; and
   e) A**etna** has no reason to believe that the claim has been submitted fraudulently.

(2) If all or a portion of the claim is not paid within the timeframes provide above because:
   a) The claim submission is incomplete because the required substantiating documentation has not been submitted to **Aetna**;
   b) The diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
   c) **Aetna** disputes the amount claimed; or
   d) There is strong evidence of fraud by the provider and **Aetna** has initiated an investigation into the suspected fraud, **Aetna** shall notify the provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
      i) The claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
      ii) The claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;
      iii) **Aetna** disputes the amount claimed in whole or in part with a statement as to the basis of what dispute; or
      iv) **Aetna** finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with **Aetna**'s fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, **Aetna** shall electronically notify the provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by **Aetna** in accordance with the time limit established in paragraph (1) of this subsection.

(5) **Aetna** shall acknowledge receipt of a claim submitted by electronic means from a health care provider no later than two working days following receipt of the transmission of the claim.

(6) If **Aetna** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(7) Payment of an eligible claim pursuant to paragraphs (1) and (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by **Aetna** of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by **Aetna** of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to paragraph (2) or (3) of this subsection and the covered person and the provider are not notified within the time frames provided for in those paragraphs, the claim shall be deemed to be overdue.

Any overdue payment shall bear simple interest at the rate of 12% per annum. **Aetna** shall pay the interest to the provider at the time the overdue payment is made. The amount of interest paid to a provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the premium.

Acknowledgement of receipt of claims:

(a) **Aetna** shall acknowledge receipt of all claims. The acknowledgement shall include the date **Aetna** received the claim.
   1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which **Aetna** received the claim.
   2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If **Aetna** remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If **Aetna** offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.

(d) If **Aetna** offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

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 other benefit to any of your relatives whom it believes are 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.

All benefits are payable to you, except that, at the request of the employee or covered person or in the event of his/her death, payment of benefits to the extent of expenses incurred on account of hospitalization may be made by **Aetna** to the hospital and except that the group policy may provide that all or any portion of any benefits on account of hospital, nursing, medical or surgical services may, at **Aetna**'s option, be paid directly to the hospital or person rendering such services provided, further, that authorization for any such payments have been obtained from the covered person.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Records of Expenses *(GR-9N-32-030-02 NJ)*

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

Very important are:

- Names of **dentists** who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32-035-01)*

Effect of An 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 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 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 *(GR-9N 32-040-01)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., 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 other 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.

Glossary

(GR-9N-34-005-04 NJ)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-010-01) (GR-9N-34-005-04 NJ)*

Accident *(GR-9N-34-005-04 NJ)*

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

C *(GR-9N 34-015 02)*

Civil Union Partner

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage of **coinsurance** may vary by the type of expense. Please refer to the *Schedule of Benefits* for specific information on the applicable **coinsurance** percentage.

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies whose primary purpose is to alter, improve or enhance appearance.

Covered Expenses

Charges associated with medical, dental, vision or hearing services and supplies shown as covered under this booklet-certificate.

D *(GR-9N 34-020 01)*

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dental Provider
This is:

- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Directory
A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

E *(GR-9N 34-025 02)*

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 **illness** or **injury** involved; or
- Approval required by the FDA 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 or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; 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 or investigational**, or for research purposes.

H *(GR-9N 34-040 02)*

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

However, for purposes of **Hospice Care** coverage, the term **hospital** will include the portion of a **hospital** that provides hospice care.

I *(GR-9N 34-045 02)*

Illness *(GR-9N 34-045 02)*
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by any person.
- An act or event must be definite as to time and place.

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
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.

M

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not primarily for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N *(GR-9N-34-070-04 NJ)*

Negotiated Charge

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network, Participating, Preferred Provider

A **dental provider** who 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 **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or recommended by your **PCD**.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not arise out of (or in the course of) any work related activity you perform for pay or profit, or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

An **illness** 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 **illness** under such law.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not arise from any work related activity you perform for pay or profit or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

O *(GR-9N-34-075-04 NJ)*

Occupational Injury or Occupational Illness

An **injury** or **illness** that arises out of (or in the course of) any activity or work that results in a condition from exposure in a workplace through your employment or self-employment. A secondary **illness** or **injury** that results from the original **occupational illness or occupational injury** will be considered an **occupational illness or occupational injury** under this plan.

Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment *(GR-9N-34-075-04 NJ)*

This is any:

- Medical service or supply; or
- Dental service or supply;

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

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

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of-network provider**; or
- Not furnished or recommended by your **PCD**.

Out-of-Network, Non-Participating, Non-Preferred Provider

A **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

P *(GR-9N-34-080-05 NJ)*

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse, a non-biologically-based illness or biologically-based mental illness condition; and
- A physician is not you or related to you.

Precertification, Precertify, Preauthorization
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or certain **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Dentist (PCD)
This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Dentists** in the **directory**;
- Supervises, coordinates and provides dental services to a person;
- Initiates **referrals** for **specialist dentist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **primary care dentist**.

If you do not choose a **PCD**, **Aetna** will have the right to make a selection for you. You will be notified of the selection.

R

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge.**

As to dental expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 80th percentile of the Prevailing Charge Rate;
  for the Geographic Area where the service is furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

Prevailing Charge Rates: These are the rates reported by Ingenix, a United Health Group subsidiary, in the Prevailing Health Care Charges System (PHCS) database, which is compiled from information that **Aetna** and other insurers submit to Ingenix. Ingenix reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from Ingenix.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Referral

This is a written or electronic authorization made by your **primary care physician** (PCP) or **primary care dentist** (PCD) to direct you to a **network provider**, for **medically necessary** services or supplies covered under the plan.

Referral Care

Covered services given to you by a **specialist dentist** who is a **network provider** after **referral** by your **primary care dentist** and providing that **Aetna** approves coverage for the treatment.

R.N.

A registered nurse.

S *(GR-9N 34-095-02)*

Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist

Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Additional Information Provided by

Sarah Lawrence College

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Sarah Lawrence College - Health Plan

Employer Identification Number:
23-7223216

Plan Number:
509

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999
Telephone Number: (914) 395-2365

Agent For Service of Legal Process:
Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 may 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.

Schedule of Benefits

(GR-29N 01-01 01)

Applies to the Managed Dental Coverage

Employer:	**Sarah Lawrence College**
Group Policy Number:	**GP-875727-NJ**
Issue Date:	February 9, 2011
Effective Date:	November 1, 2010
Schedule:	1A
Cert Base:	1

For: New Jersey - Freedom of Choice DMO - Specialty Dentists

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

(GR-9N-S-20-005-01 NJ)

Plan Coinsurance:
Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

Type B Expenses	80%
Type C Expenses	60%
Orthodontic Treatment	50%

Expense Provisions *(GR-9N S-09-05 01)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts and benefit percentages are contained in the *Schedule of Benefits*.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan coinsurance**" or the "Plan payment percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for the percentage the plan pays for each covered benefit.

General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-9N-Appeals 01-01 02 NJ)*

Policyholder	Sarah Lawrence College
Group Policy No	GP-875727-NJ
Rider	New Jersey Complaint and Appeals Health Rider
Issue Date	February 9, 2011
Effective Date	November 1, 2010

Complaint and Appeals - Health Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations *(GR-9N-Appeals 01-02 02 NJ)*

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will provide written notification of a pre-service determination not later than 5 business days or sooner if the medical exigencies dictate, upon request, of any determination to deny coverage or authorization of services or payment of benefits therefore otherwise covered under the plan and shall include an explanation of the **appeal** process.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days or the time limit established by Medicare, if earlier, after the **post-service claim** is made if the claim is submitted electronically, or 40 days if submitted by a means other than electronic. Aetna may determine that due to matters beyond its control a claim may require special treatment and Aetna will make notification including the reason for delay within 30 days. If this special treatment is needed because Aetna needs additional information to make a claim determination, the notice shall specifically describe the required information. In the event payment is withheld on all or a portion of the claim, because the claim requires special treatment, a claim determination will be made on the withheld portion no later than 30 calendar days or the time limit established by Medicare, if earlier, following receipt of the required documentation for claims submitted by electronic means and no later than 40 days following receipt of the required documentation for claims submitted other than electronically.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for **emergency** or an **urgent care claim** as soon as possible but not later than 24 hours, with respect to an **emergency** or **urgent care claim** service, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. If the request for an extension is not made at least 24 hours prior to the expiration of the approved course of treatment, Aetna will make a determination within the time frame applicable to (1) an **urgent care claim** (if the care is urgent) or (2) a **pre-service** or **post-service claim** (if the care is not urgent or has been completed).

Concurrent Care Claim Reduction or Termination

If Aetna makes notification of a claim determination to reduce or terminate a previously approved course of treatment while the treatment or services are ongoing, you (or a provider on your behalf) may request an expedited **appeal,** and Aetna will handle such a request as a level one **appeal** of an **urgent care claim** (see **Appeals of Adverse Benefit Determinations**). Aetna will not deny coverage based on medical necessity for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by you or the provider.

Complaints *(GR-9N-Appeals 01-05 02 NJ)*

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations *(GR-9N-Appeals 01-06 02 NJ)*

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered. You have the option to provide Aetna will additional information about your **appeal;** however, you are not required to provide additional information in order to have your claim decision reviewed.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to Aetna.

Level One Appeal

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Urgent care claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 5 business days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 5 business days of receipt of the request for an **appeal**.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the adverse determination was based on **medical necessity** or **experimental or investigational** reasons or in situations where the denial is based on characterizing the service as dental or as cosmetic, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim**, **a Pre-Service Claim**, **or a Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**. A level two **appeal** of an **adverse benefit determination** of a **Pre-Service Claim** or a **Post-Service Claim** will be reviewed by the Aetna Appeals Committee.

Urgent Care Claims
Aetna shall issue a decision within 24 hours of receipt of the request for a level two **appeal**.

Pre-Service Claims
Aetna shall issue a decision within 5 business days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two **appeal**.

Exhaustion of Process

Unless serious or significant harm has occurred or will imminently occur to you, you must exhaust the applicable Level one and Level two processes of the **Appeal** Procedure before you:

- contact the New Jersey Department of Banking and Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the New Jersey Department of Banking and Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna; or any matter within the scope of the **Appeals** Procedure, unless serious or significant harm to you has occurred or will imminently occur.

External Review *(GR-9N-Appeals 01-07 02 NJ)*

You or any provider acting on behalf of you, with your consent, who is dissatisfied with the result of the Level One **appeal** and Level Two **appeal** process above, shall have the right to pursue their **appeal** to an independent utilization review organization (IURO) in accordance with the procedures set forth below. The **appeal** review shall not include any decision regarding benefits not covered by your health benefits plan. The right to an external **appeal** under this section shall be contingent upon your exhaustion of both stages of the Level One and Level Two **appeal** processes, except that you and any provider acting on your behalf with your consent shall be relieved of the carrier's internal **appeal** process and may pursue an **appeal** through the Independent Health Care Appeals program if:

- A determination on any **appeal** regarding urgent or **emergency care** is not forthcoming from **Aetna** within 72 hours of receipt by **Aetna** of notice (in the manner required under the plan) of the **appeal**;
- A determination on an initial **appeal**, other than one regarding urgent or **emergency care**, is not forthcoming from **Aetna** within five business days of the date that **Aetna** received notice (in manner required under the plan) of the **appeal**; or
- A determination of a subsequent level of **appeal**, other than one regarding urgent or **emergency care**, is not forthcoming from **Aetna** within 20 business days of the date that **Aetna** received notice (in the manner required under the plan) of the **appeal**.

1. Within 60 calendar days from receipt of the written determination of the Level Two **appeal** panel, you, or a **Provider** acting on behalf of you with your consent, shall file a written request with the New Jersey Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to you by **Aetna** and include both a filing fee and a general release executed by you for all medical records pertinent to the **appeal**. The request shall be mailed to

   Consumer Protection Services
   Department of Banking and Insurance
   20 West State Street, 9th Floor
   Trenton, New Jersey 08625-0329
   Main Phone: (609) 292-5316
   Fax: (609) 292-5865

2. The fee for filing an **appeal** shall be $25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance.

3. Upon receipt of the **appeal**, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the **appeal** to an IURO.

4. Upon receipt of the request for **appeal** from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the **appeal** and accept it for processing if it determines that:

   i. the individual was or is covered by **Aetna**;
   ii. the service which is the subject of the **complaint** or **appeal** reasonably appears to be a covered benefit under the plan;
   iii. you have fully complied with both the Level One and Level Two **Appeal** processes except as provided above;
   iv. you have provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the **appeal** form and a copy of any information provided by **Aetna** regarding its decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from **Aetna** and any other relevant health care provider.
   v. you have remitted the required fee to the New Jersey Department of Banking and Insurance.

5. Upon completion of the preliminary review, the IURO shall immediately notify you and/or provider in writing as to whether the **appeal** has been accepted for processing and if not so accepted, the reasons therefore.

6. Upon acceptance of the **appeal** for processing, the IURO shall conduct a full review to determine whether, you were deprived of **medically necessary** covered benefits. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting **physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by **Aetna**.

7. The full review referenced above shall initially be conducted by a registered, professional nurse or **physician** licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **appeal**. All final recommendations of the IURO shall be approved by the medical director of the IURO.

8. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to **Aetna** setting forth the status of its review and the specific reasons for the delay.

9. If the IURO determines that you were deprived of **medically necessary** covered benefits, the IURO shall recommend to you, **Aetna**, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services you should receive.

10. Once the review is complete, **Aetna** will abide by the decision of the IURO.

For more information about the External Review process, call the toll-free Customer Service telephone number shown on your ID card.

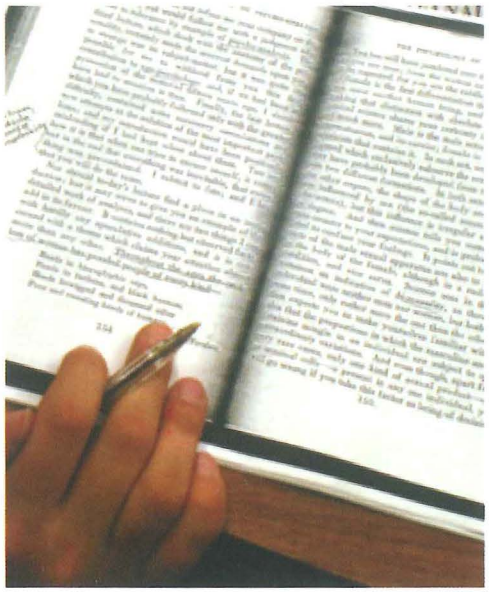
General Information

- Please note that you shall not be held financially liable for payments to providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered services, if Aetna fails to pay for the covered services for any reason.
- Subsequent changes in this coverage shall be evidenced in a separate document issued to you.

(GR-9N-02-005-02 NJ)

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)



What is Phased Retirement?

Phased Retirement lets you work on 50% of a full-time schedule – for up to three years from the start of Phased Retirement – while receiving 65% of your base salary, plus other benefits. If you already work part time, you will continue on your current schedule but will be paid 65% of base salary.

If you elect Phased Retirement, you must retire as of any July 31 within three academic years of the start of your Phased Retirement.

Phased Retirement

To be eligible for Phased Retirement, you must meet the following requirements as of the July 31 when your Phased Retirement starts:

- You must be a tenured faculty member
- You must be age 62 or older, and
- You must have10 or more years of service with the College.

What's Included

If you choose this option, you will teach half time (i.e., a two (2) day schedule all year) for a maximum of three academic years from the start of Phased Retirement, after which you must retire. During Phased Retirement, you will receive:

- 65% of your full-time base salary, plus any usual salary increases (Note: If you currently work part time on 50% schedule and you elect this option, you will continue to work 50% of a full-time schedule with your base salary increasing to 65% of your full-time-equivalent base salary.)
- Coverage under all active employee health insurance benefits (medical, dental, vision) for you, your spouse or domestic partner, and your eligible dependents, in which you are enrolled when Phased Retirement starts,
- Retirement Plan contributions based on 65% of your full-time equivalent base salary, and
- Life insurance coverage based on 100% of your pre-Phased Retirement base salary.

When you actually retire:

- You and your spouse or domestic partner will be eligible for subsidized post-65 retiree medical insurance upon reaching age 65 and becoming eligible for Medicare, and
- You will maintain a continuing connection with Sarah Lawrence through membership in the Professor Emeritus Society for Retired Faculty as described on the following page.