

BENEFIT PLAN

Prepared Exclusively For
University of Hartford

Freedom of Choice DMO (Managed Dental
Plan)

Aetna Life Insurance Company
Booklet-Certificate

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

What Your Plan
Covers and How
Benefits are Paid



ID Cards

If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetna.com. You can also access your benefits information when you're on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.

Remember, DMO®/DNO members need to choose a primary care dentist in Aetna's network. Otherwise, you could end up paying more. You can use our provider search tool online or call us at 1-877-238-6200 to make your selection.

CA /AZ DMO® participants, if you have not selected a PCD, one may have been selected for you. View your digital ID card to determine if one was selected on your behalf.

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

Preface (GR-9N-02-005-01 CT)

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	University of Hartford
Group Policy Number:	GP-724328
Effective Date:	January 1, 2020
Issue Date:	November 11, 2019
Booklet-Certificate Number:	1



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage (GR-9N-02-020-01 CT)

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* 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.

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.

Please refer to the sections, “*Termination of Coverage (Extension of Benefits)*” and “*Continuation of Coverage*” for more details about these provisions.

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* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents (GR-9N-02-020-01 CT)

Health Expense Coverage (GR-9N-02-020-01 CT)

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.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

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

Treatment Outcomes of Covered Services (GR-9N-02-020-01 CT)

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

(GR-9N 29-005-01-CT)

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.
- You are a retired employee of an employer participating in this plan, and you:
 - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
 - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
 - If when you terminate active employee status your age plus years of service (which must be a minimum of 10 years) are equal to 75.

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 eligibility coverage date is the first day of the month coinciding with or next following 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-CT)

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

- Your legal spouse; 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 Dependent Children (GR-9N-29-010ng-08 CT) (GR-9N-29-010-08 CT)

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- 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 the plan as:

- Both an employee and a dependent child; 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-29-025-01 CT)

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.

Retired Employees (GR-9N-29-025-01 CT)

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

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

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.
3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or 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:
 - (a) In accordance with generally accepted standards of 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** or **dental provider** or other health care provider;
 - (d) 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-S-16-005-01 CT)

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.

This Booklet-Certificate describes a dental program with two options:

- The first option is a managed dental plan.
- The second option is an alternate dental plan.

You may choose either plan, *but you cannot be covered for both at the same time.*

The choice you make for your coverage also applies to your covered dependents. You may request a switch from one plan to the other. Just call the telephone number 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, your benefits are subject to all the terms and conditions of the plan under which you are covered. The terms and conditions of the plan under which you were covered immediately before the change in coverage no longer apply. 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.

Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents.

Your health plan pays benefits only for care that is described in this Booklet-Certificate as covered expenses that are **medically necessary**.

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 16-010-01)

Many terms throughout this Booklet-Certificate are defined in the *Glossary* Section at the back of this document. 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 Managed Dental Plan (GR-9N 16-015-01 CT)

Under the Managed Dental Plan, you access care through the **primary care dentists (PCD)** you select when you enroll. Each covered family member may select a different **PCD**. Your **PCD** provides basic and routine dental services and supplies, and will refer you to other **dental providers** in the network.

You may select a **PCD** from the **Aetna network provider directory** or by logging on to **Aetna's** website at www.Aetna.com. You can search **Aetna's** online **directory**, provider search, for names and locations of **network providers**.

You may also seek care from an **out-of-network provider** for **covered expenses**. You will receive a lower level of benefits for covered **out-of-network services and supplies**.

Important Reminder

You must have a **referral** from your **PCD** in order to receive coverage for any services a **specialist dentist** provides. Please refer to the *Referral Process* section.

The Choice Is Yours

Each time you need non-emergency care, you have a choice:

Accessing Network Providers

- The plan pays a higher level of benefits when your **PCD** provides your care or refers you to a **specialist dentist**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).
- The coinsurance for primary dental services is a percent of the **PCD's** usual fee* for that service, reviewed by **Aetna** for reasonableness.
- The **coinsurance** for specialty dental services is a percent of the **specialist dentist's** fee for that service or supply. The "fee" may be a fee negotiated with the specialist dentist and approved by **Aetna**. In that case, the **coinsurance** will be based on the actual, negotiated fee. If **Aetna** compensates a specialist dentist on another basis, the "fee" will be the **specialist dentist's** usual fee*, reviewed by **Aetna** for reasonableness.

*"Usual fee" means the fee the PCD or specialist dentist charges patients in general. Your PCD will give you a copy of the usual fee schedule, upon request. You will be informed of the fee when you visit a specialist dentist. It is not part of this booklet-certificate and may be changed from time to time. It is used only for the purpose of calculating your **coinsurance** and is not the basis of compensation to the **network provider**. **Aetna** compensates network providers based on separate, negotiated agreements that may be less than or unrelated to the network provider's usual and customary charges. These agreements may vary among dentists.

If you need a service that is not available from a **network provider**, your **PCD** may refer you to an **out-of-network provider**. You will receive the **network** level of coverage if your **PCD** gets approval from **Aetna** for this referral.

Changing Your PCD

You may change your **PCD** at any time on **Aetna's** website, www.Aetna.com, or by writing to **Aetna** or calling the Member Services toll-free number on your identification 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.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **PCD** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between **Aetna** and your selected **PCD** is terminated, **Aetna** will notify you of the termination and request you to select another **PCD**.

Accessing Out-of-Network Providers

You can directly access **dentists** of your choice without a referral from your **PCD**. Your **covered expenses** will be covered as out-of-network expenses if you do not obtain services and supplies from your **PCD** or with a **referral** from your **PCD**, *even if you choose a **provider** in the network*. The plan covers **out-of-network services and supplies**, but your out-of-pocket expenses may be higher.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses. You are responsible for the portion of the **dentist's** charge that is above the scheduled limit shown for a service in the dental care schedule.

If the **dentist** you select charges more than the **recognized charge**, you must also pay any expenses above the **recognized charge**. That excess amount does not apply toward your **coinsurance limit**.

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

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductibles**, **copayments**, **coinsurance** and maximum benefit limits. There is separate deductible and maximum that applies to **orthodontic treatment**.

Using Your Dental Plan (GR-9N 16-020-01)

The Referral Process

There may be times when you need services and supplies that only a dental **specialist** can provide. In these cases, your **PCD** will make a **referral** to a **specialist dentist**. A **PCD referral** is not required for any orthodontic services.

Having a **referral** from your **PCD** keeps your out-of-pocket expenses lower for services of a **specialist dentist** and any necessary follow-up treatment. The **referral** is important because it is how your **PCD** arranges for you to receive care and follow-up treatment.

Important Reminder

You must have a **referral** from your **PCD** in order to receive the network level of coverage for any services received from a **specialist dentist**.

How Referrals Work

Here are some important points to remember:

When your **PCD** determines that your treatment should be provided by a **specialist dentist**, you'll receive a written or electronic **referral**. The **referral** will be good for 90 days, as long as you remain covered under the plan.

Go over the **referral** with your **PCD**. Make sure you understand what types of services have been recommended and why.

When you visit the **specialist dentist**, bring the **referral** (or check in advance to verify that they have received the electronic **referral**). Without it, you'll receive out-of-network benefits – even if you receive your treatment from a **network provider**.

You can not request a **referral** from your **PCD** *after* you have received services from a **specialist dentist**.

If a service you need isn't available from a **network provider**, your **PCD** may refer you to an **out-of-network provider**. Your **PCD** must get **precertification** from **Aetna** and issue a special out-of-network referral for services from **out-of-network providers** to be covered at the network level of coverage.

When You Do Not Need a PCD Referral

You do *not* need a **PCD referral** for:

- **Emergency care.** Please refer to the "*In the case of a Dental Emergency*" section.
- **Out-of-network Benefits.** The plan gives you the option to visit any **dental provider** without a **referral** from your **PCD** and receive coverage at the out-of-network benefit level. Remember that you will receive this lower benefit level even if the **provider** is a **network provider**. You may save money by visiting **network providers** because they have agreed to **negotiated charges** for their services, and these fees may be lower than those charged by **out-of-network providers**.
- Direct Access Services. Orthodontic services and supplies do not require a **referral**.

In Case of a Dental Emergency (GR-9N 16-040 01 CT)

If you need dental care for the palliative treatment (pain relieving, stabilizing) of a **dental emergency**, you are covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:

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

Follow the guidelines below when you believe you have a **dental emergency**.

If you have a **dental emergency**, call your **PCD**. If you cannot reach your **PCD** or are away from home, you may get treatment from any **dentist**. You may also call Member Services for help in finding a **dentist**. The care must be for the temporary relief of the **dental emergency** until you can be seen by your **PCD**. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given.

The plan pays a benefit up to the dental emergency maximum.

All follow-up care should be provided by your **PCD**.

If you seek care from an **out-of-network provider** for a non-emergency dental condition (that is, one that does not meet the definition above), benefits will be paid at the lower **out-of-network** level.

What The Plan Covers (GR-9N-19-005-01)

Managed Dental Plan

Managed Dental Plan is merely a name of the benefits in this section. The plan does not pay a benefit for all dental 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 service and supplies must be in the listed in the dental care schedule.
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a **dental provider** only for the services and supplies that are listed in the dental care schedule that applies.

The next sentence applies if:

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

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

Dental Care Schedule for the Managed Dental Plan

The Dental Care Schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses** that are focused on keeping your teeth healthy: diagnostic, preventive and restorative services and supplies.

Coverage is also provided for a **dental emergency**. For additional information, please refer to *In Case of a Dental Emergency*.

Important Reminder

The **copays**, **deductible**, and **coinsurance** that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive care from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the network level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the out-of-network level of benefits shown in the *Schedule of Benefits*.

Network Benefits *(GR-9N 19-010 01)*

This Dental Care Schedule applies to covered services and supplies provided by **Primary Care Dentists** and other **network providers** upon referral from your PCD. The plan covers only the services and supplies in the list below.

Primary Dental Services

Type A Expenses

Visits and Exams

- Office visit for oral exam (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
 - Adult
 - Child
- Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 18)
- Oral hygiene instruction
- Sealants, per tooth (limited to 1 application every 3 years for permanent molars only)
- Pulp vitality test
- Diagnostic casts

X-Rays and Pathology

- Bitewing X-rays (limited to 2 sets per year)
- Entire series, including bitewings, or panoramic films (limited to 1 sets 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

Restoration and Repair

- 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

- Scaling and root planning - per quadrant (limited to 4 separate quadrants, every year)
- Scaling and root planning - 1 to 3 teeth, per quadrant (limited to once per site, every year)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

Oral Surgery (Includes local anesthetics and routine post-operative care)

- Extractions, erupted tooth or exposed root
- Extractions, coronal remnants
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissues)
- 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 6 months after installation).

- Full (upper and lower)
- Partial
- Stress breakers (per unit)
- Interim partial denture (stayplate), anterior 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 Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 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

Specialty Dental Services

Type B Expenses

Endodontics (Includes local anesthetics where necessary)

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

Oral Surgery (Includes local anesthetics where necessary and post-operative care)

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

Periodontics

- Gingivectomy or gingivoplasty - per quadrant
- Gingivectomy or gingivoplasty - 1 to 3 teeth
- Gingival flap procedure - per quadrant
- Soft tissue procedures
- Occlusal adjustment (other than with an appliance or by restoration)

Type C Expenses

Endodontics (Includes local anesthetics where necessary)

- Molar root canal therapy, including necessary X-rays

Intravenous Sedations and General Anesthesia

Oral Surgery (Includes local anesthetics where necessary and post-operative care)

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

Periodontics

- Osseous surgery (including flap entry and closure), per quadrant
- Osseous surgery (including flap entry and closure), 1 to 3 teeth per quadrant
- Clinical crown lengthening - hard tissue

Orthodontics

- Orthodontic screening exam
- Orthodontic diagnostic records
- Comprehensive orthodontic treatment of adult or adolescent dentition
- Orthodontic retention

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

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

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")

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 20-010-01)*

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 or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or 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 20-020-01)*

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 20-025-01)

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 Managed Dental Plan Does Not Cover (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, 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.

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

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-30-015-04)

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 health 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. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem 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 of active work before the start of the lay-off or leave of absence.

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. Upon cancellation or discontinuance of coverage under the Policy, the employer shall furnish each employee notice of such cancellation or discontinuance not less than 15 days preceding the effective date of the cancellation or discontinuance.

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

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-30-015-07 CT)

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees;
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the policy month when your dependent no longer meet the plan's definition of a dependent. A "policy month" is defined in the group policy on file with your Policyholder.

Important Note:

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 the *Continuation of Coverage* section for more information.

Continuation of Coverage (GR-9N-31-015-05 CT)

Continuing Health Care Benefits (GR-9N-31-015-06 CT)

Continuing Coverage for Dependent Students on Medical Leave of Absence (GR-9N-31-015-01-CT)

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness or injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children (GR-9N-31-015-01-CT)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of a mental 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 90 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 for any reason 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-31-020-01-CT)

Extension of Benefits

Extension of Benefit While You Are Receiving Inpatient Care

When there is a succeeding carrier:

If you are receiving inpatient care in a **hospital** or **skilled nursing facility** on the date coverage under this Booklet-Certificate terminates such care is covered in accordance with the Booklet-Certificate only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay;
2. determination by the Plan Medical Director in consultation with the attending **physician**, that care in the **hospital** or **skilled nursing facility** is no longer **medically necessary**;
3. the date the contractual benefit limit has been reached;
4. the date you become covered for similar coverage from another health benefits plan; or
5. 12 months of coverage under this extension of benefits provision.

The extension of benefits shall not extend the time periods during which you may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of premium for such coverage. However, in the event you are confined in a **hospital** on the date the plan terminates, payment of your premium for the period of the extension of benefit is not required.

When there is no succeeding carrier, under Connecticut State Law:

When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are confined to a health care facility, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

The extension will apply until the date the covered individual is not confined to a health care facility or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

Extension of benefits will be available provided that evidence of the facility confinement is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

Extension of Benefits Upon Total Disability Under Connecticut State Law:

The extension of benefits shall not extend the time periods during which you may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of premium for such coverage. However, in the event you are totally disabled on the date the plan terminates, payment of your premium for the period of the extension of benefit is not required.

When there is no succeeding carrier:

When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are **totally disabled**, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

The extension will apply until the date the covered individual is no longer totally disabled, or the date that is 12 calendar months following the date the policy was discontinued, whichever is earlier.

Extension of benefits will be available provided that evidence of any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

When there is a succeeding carrier, and you are not confined:

If you are **totally disabled** and not confined in a health care facility on the date of discontinuance of the Group Policy when the group health insurance plan is replaced by a succeeding group health insurance plan the succeeding carrier shall be responsible for all coverage for the totally disabled individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the disabling condition. During the transitional period, benefits under the succeeding carrier's plan for treatment of the disabling condition will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

The extension will apply until the earlier of the date that you: are no longer **totally disabled**; have exhausted the benefits available for treatment of that condition; or after a period of 12 months in which benefits under such coverage are provided to you.

COBRA Continuation of Coverage (GR-9N-31-025-01 CT)

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.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

If the termination (other than gross misconduct), leave of absence or reduction in hours results from your eligibility to receive Social Security income, this continuation for you and any covered dependents may continue until midnight of the day preceding your eligibility for Medicare.

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

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

(GR-9N-33-005-02)

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 and may reduce the benefits it pays 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 a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First (GR-9N-33-010-01)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the **custodial parent**;
 - The plan of the **noncustodial parent**; and then
 - The plan of the spouse of the **noncustodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. 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 is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works (GR-9N-33-015-01 CT)

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of This Plan and another plan both agree that This Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Multiple Coverage Under This Plan

If a person is covered under This Plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under this Plan will be set up as a separate "Plan".
- The order in which various plans will pay benefits will apply to the "Plans" set up above and to all other plans.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under the Plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

(GR-9N-33-020-02 CT)

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**.

If you are enrolled in **Medicare**, coverage under this Booklet-Certificate will pay for such benefits as follows.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan's** benefits is based on current employment with your employer. The **plan** will act as the primary payor 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 payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense**.

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.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions (GR-9N-32-005-02-CT)

Type of Coverage

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

Physical Examinations (GR-9N-32-005-03-CT)

Aetna will have the right and opportunity to have a **physician** or **dentist** of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations, and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

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

Confidentiality (GR-9N 32-005-05-NE)

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 this 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 Member Services at the number on the back of the ID card.

Entire Contract - Changes

This Booklet-Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Additional Provisions (GR-9N 32-005-05-NE)

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

- This document describes the main features of this plan. Additional provisions are described elsewhere in the *group* contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your Policyholder or **Aetna**.
- Your Policyholder hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments (GR-9N-32-005-03-CT)

An assignment is the transfer of your rights under the group policy to a person you name.

All coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.

Misstatements (GR-9N-32-005-03-CT)

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 the statement 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 this 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 (GR-9N-32-005-03-CT)

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 this Policy after it has been in force for 2 years from its effective date.
- No statement made by you 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-32-015-01 CT)

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:

- 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.

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

Reporting of Claims

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

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

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

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

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

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

Aetna 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.

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.

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

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.

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

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

Effect of Prior Coverage - Transferred Business (GR-9N-32-040-02 CT)

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.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence*.

Appeals Procedure^(GR-9N-32-050-01 CT)

Definitions

Adverse Benefit Determination (Decision): 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.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Clinical Peer: A physician or other health care professional who holds an unrestricted license in a state within the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and concerning mental health and substance abuse conditions, holds a national board certification in psychiatry or psychology and has training or clinical experience in the treatment of substance use disorders or mental disorders. In the case of children or adolescents, holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and has training or clinical experience in the treatment of child or adolescent mental health disorders or substance use disorders.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

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

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

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

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (IRO) assigned by the State Insurance Commissioner and made up of **physicians** or other appropriate health care **providers**. The IRO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Grievance. A written **complaint**, or, if the **complaint** involves an urgent care request, an oral **complaint**, submitted by or on behalf of a **Member**, regarding the availability, delivery, or quality of health care services, including a **complaint** regarding an adverse determination made due to utilization review, claims payment, handling or reimbursement for health care services; or any matter pertaining to the contractual relationship between the **Member** and **Aetna**.

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:

- Seriously jeopardize your life or health;
- 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.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 72 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 to occur:

- 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 notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

Aetna would notify the **provider** at least three business days prior to the scheduled date of admission, service, procedure or extension of stay, that the pre-authorization has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage.

If you file an **appeal**, coverage under the plan will continue, without liability, for the previously approved course of treatment until a final **appeal** decision is rendered.

Grievances/Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Member Services within 180 days. The complaint 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 20 calendar days of the receipt of the **complaint**, unless more 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.

You may contact the Department of Insurance for assistance regarding any grievance or appeal at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid,ca@ct.gov.

Or, the Office of Healthcare Advocate at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov.

Appeals of Adverse Benefit Determinations

A review of an **Appeal** of an **adverse benefit determination** shall be provided by **clinical peers**. They not have been involved in making the **adverse benefit determination**.

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** may be submitted orally or in writing and must include:

- Your name.
- The employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

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

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal - Group Health Claims

A review of an **Appeal** of an **adverse benefit determination** shall be provided by clinical peers. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 72 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 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 60 calendar days of receipt of the request for an **appeal**.

External Review^(GR-9N-32-051-01 CT)

You may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- The claim involves medical judgment;
- The care is not **necessary** or appropriate; or
- A service, supply or treatment is **experimental or investigational** in nature.
- The adverse benefit determination relates to eligibility, or a rescission, defined as a cancellation or discontinuance of coverage which has a retroactive effect (unrelated to failure to pay required contribution).

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.

If the Adverse Benefit Determination relates to an Experimental or Investigational Procedure treatment, the Physician must certify in writing, that the following criteria is met:

1. The Member has a terminal medical condition, life threatening condition, or a seriously debilitating condition, and
 2. The Member has a condition that qualifies under one or more of the following: standard health care services or treatments have not been effective in improving the Member's condition; or standard health care services or treatments are not medically appropriate for the Member; or there is no available standard health care service or treatment covered under the Member's health care plan, that is more beneficial than the requested or recommended health care service or treatment; and
 3. The health care service or treatment recommended and which has been denied, is likely to be more beneficial to the Member than any available standard health care service or treatment.
- You qualify for an expedited review as explained below.
 - As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds \$500.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the Connecticut Insurance Department within 120 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

Mailing Instructions:

Please mail your application for external review to:

Connecticut Insurance Department
Attention: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only: please mail your application for external review to:

Connecticut Insurance Department
Attention: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

The Connecticut Insurance Department will forward the appeal to Aetna, and Aetna will conduct a preliminary review to determine if the appeal is eligible. If it is determined not to be eligible, the Member may then appeal to the Commissioner.

The Connecticut Insurance Department will assign the IRO that will conduct the review of your claim. The IRO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the IRO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

An expedited review is possible if your **physician** certifies (on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive an expedited review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility, or mental health or substance abuse disorders.

Expedited reviews are decided within 72 hours after the **IRO** receives the request, except in the case of experimental or investigational reviews, which have a 5 day timeframe, and in the case of an expedited review involving a substance abuse disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting, the review will be decided as expeditiously as the member's medical condition requires, but not later than 24 hours after the IRO receives the request to conduct this review.

The decision is binding on **Aetna**, except to the extent that **Aetna** has other remedies under state or federal law.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the IRO and for the cost of the external review except for dental, vision and hearing claims.

You may contact the Department of Insurance for assistance regarding any External Review or Expedited External Review, at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid, ca@ct.gov.

Or the Office of Healthcare Advocate at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-9N 34-005 01)

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-34-005-05 CT)

Aetna

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

C (GR-9N 34-015 02)

Coinsurance

Coinsurance is both the percentage of **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 “plan **coinsurance**” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

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 that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

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

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**, provider search. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

E (GR-9N 34-25 09)

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 U. S. Food and Drug Administration (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, procedure 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.

I (GR-9N 34-045 02)

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set 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 the 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 alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L (GR-9N 34-055 01)

Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

M (GR-9N-34-065-03 CT)

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
 - an **illness**;
 - an **injury**;
 - a disease; or
 - its symptoms.

The provision of the service, supply or **prescription drug** must be:

- 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 mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same 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. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N (GR-9N 34-070 02)

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 Provider

A **dental provider** who has contracted to furnish services or supplies for this plan; 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 arranged 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 for pay or profit; or
- Result in any way from an **illness** that does.

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

O (GR-9N-34-075-01 CT)

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

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-34-075-01 CT)

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) (GR-9N-34-075-01 CT)

Health care service or supply that is:

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

Out-of-Network Provider

A **dental provider** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P (GR-9N-34-80-09)

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 a **mental or nervous condition**; and
- A **physician** is not you or related to you.

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **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.
- Disposable hypodermic needles and syringes for the purpose of administering injectable drugs for a covered medical condition provided that such injectable prescription drugs are covered under the Policy.
- Injectable insulin; disposable needles; and syringes; when prescribed and purchased at the same time as insulin; and disposable diabetic supplies.

Primary Care Dentist (PCD) (GR-9N-34-030-02 CT)

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 (GR-9N-34-090-02 CT)

Recognized Charge (GR-9N 34-090 16)

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the provider's full charge.

In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For dental expenses:
 - 80% of the prevailing charge rate

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and **dentists** practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used

Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area

The Geographic Area is made up of the first three digits of the U.S. Postal Service zip code. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic Area such as an entire state.

Prevailing Charge Rates

The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, **Aetna** has the right to substitute an alternative database that **Aetna** believes is comparable.

Additional Information:

Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on **Aetna’s** member website to help decide whether to get care in network or out-of-network. **Aetna’s** secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna’s** member website to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Cost Estimator” tools.

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 34-95-10)**Service Area**

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

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
 - Professional nursing care by an **R.N.**, or by a L.P.N. directed by a full-time **R.N.**; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental or nervous conditions**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of **Hospitals** of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
 - Minimal care;
 - **Custodial care** services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, drug abuse or **mental or nervous conditions**.

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**.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Booklet-Certificate Amendment - *Appeals Procedure and External Review*

Policyholder: University of Hartford

Group Policy No.: GP-724328

Effective Date: This Booklet-Certificate Amendment is effective on the later of:
January 1, 2020; or
The date you become covered under the Group Policy.

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

The following Appeals Procedure, and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision):

- (a) A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.
- (b) A denial of eligibility for coverage.
- (c) Rescission (retroactive termination) of coverage.

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

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

Clinical Peer: A **physician** or other health care professional who holds an unrestricted license in a state within the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and concerning mental health and substance abuse conditions, holds a national board certification in psychiatry or psychology and has training or clinical experience in the treatment of substance use disorders or mental disorders. In the case of children or adolescents, holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and has training or clinical experience in the treatment of child or adolescent mental health disorders or substance use disorders.

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

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

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

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Grievance: A written **complaint** or, if the **complaint** involves an urgent care request, an oral **complaint**, submitted by or on behalf of a **Member**, regarding the availability, delivery or quality of health care services, including a **complaint** regarding an adverse determination made due to utilization review; claims payment, handling or reimbursement for health care services; or any matter pertaining to the contractual relationship between the **Member** and **Aetna**.

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:

- seriously jeopardize your life or health;
- 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;
- For a substance use disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting; and
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations – Group Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, your authorized representative, and to your **provider**.

Urgent Care Claims (May include concurrent care claim reduction or termination)

Aetna will notify you of an **urgent care claim** decision as soon as possible, but not later than 24 hours for mental health and substance abuse claims, and no later than 36 hours after the claim is made for all other claims.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim for mental health or substance abuse claims and within 36 hours of all other claims. 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 to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims

Aetna will make notification of a claim determination within 15 calendar days of receipt of all information needed to make a decision. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **emergency** or **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

Aetna would notify the **provider** at least three business days prior to the scheduled date of admission, service, procedure or extension of stay, that the pre-authorization has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage.

If you file an **appeal**, coverage under the plan will continue, without liability, for the previously approved course of treatment until a final **appeal** decision is rendered.

Claim Determinations

Aetna will provide written notification to you, and your authorized representative, of a claim decision within 60 calendar days after the claim is made for paper claims, and within 20 days if the claim is filed in electronic format. **Aetna** may determine that additional information is needed to provide a determination, if this occurs with a paper claim, **Aetna** will contact you and your authorized representative within 30 days after receipt of the claim, and within 10 days for an electronic claim.

Grievances Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Member Services within 180 calendar days of the incident. The **grievance** 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 20 calendar days of the receipt of the **grievance**, unless more 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.

You may contact the Department of Insurance for assistance regarding any complaint, **grievance** or appeal at the following address:

**State of Connecticut Insurance Department
Consumer Affairs Department
P.O.Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid,ca@ct.gov.**

Or, the Office of Healthcare Advocate at:

**State of Connecticut
Office of the Healthcare Advocate
P.O.Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov.**

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level or two levels of **appeal** depending upon the type of coverage provided under the Plan. A **final adverse benefit determination** notice may also provide an option to request an **External Review** (*if available*).

When the covered person receives an **adverse benefit determination** that was based on **medical necessity**, **Aetna** must notify the covered person's **physician** or other health care professional of the opportunity to confer, at the **physician** or other health care professional's request, with a **clinical peer** of **Aetna**. This conference will not be considered a **grievance** of the **adverse benefit determination** as long the **covered person** or the covered person's authorized representative has not submitted an **appeal** to **Aetna**.

We will assign your appeal to a clinical peer, someone who was not involved in making the original decision.

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- Your employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

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

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Connecticut Department of Insurance.

Level One Appeal – Group Health Claims

Level One Appeal – Group Health Claims

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by clinical peers. They shall not have been 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**. With respect to mental health or substance abuse disorders, the decision will be made within 24 hours.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Voluntary Level Two Appeal - Group Health Claims

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, 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 a decision of a Level One **Appeal**.

Review of a voluntary 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 **clinical peers**. They shall not have been 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 a Level Two **Appeal**. This level of appeal will not apply to mental health and substance abuse disorder claims.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **external review** or any of the actions mentioned above.

A **member** may contact the Department of Insurance for assistance regarding any Complaint/Grievance, or Appeal at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid.ca@ct.gov

Or, the Office of Healthcare Advocate, at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- the care is not **necessary**; or
- a service, supply or treatment is **experimental or investigational** in nature.]
- the **adverse benefit determination** relates to eligibility, or a rescission, defined as a cancellation or discontinuance of coverage which has a retroactive effect (unrelated to failure to pay required contribution).

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision of the level one appeal, or the level two appeal if this has been requested.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and grievance and **appeal** requirements, including timeframes for review and notification requirements of state law.
- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or was **experimental or investigational**.

If the Adverse Benefit Determination relates to an **Experimental or Investigational Procedure** treatment, the Physician must certify in writing, that the following criteria is met:

1. The Member has a terminal medical condition, life threatening condition, or a seriously debilitating condition, and
2. The Member has a condition that qualifies under one or more of the following: standard health care services or treatments have not been effective in improving the Member's condition; or standard health care services or treatments are not medically appropriate for the Member; or there is no available standard health care service or treatment covered under the Member's health care plan, that is more beneficial than the requested or recommended health care service or treatment; and
3. The health care service or treatment recommended and which has been denied, is likely to be more beneficial to the Member than any available standard health care service or treatment.
 - You qualify for an expedited review as explained below.
 - As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds \$500.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the [Connecticut Insurance Department](#) within 120 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

Mailing Instructions

Please mail your application for external review to:

Connecticut Insurance Department
Attention: External Review
P.O.Box 816
Hartford, CT 06142-0816

For overnight delivery only: please mail your application for external review to:

Connecticut Insurance Department
Attention: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

The Connecticut Insurance Commissioner will forward the appeal to **Aetna**, and **Aetna** will conduct a preliminary review to determine if the **appeal** is eligible. If it is determined not to be eligible, the member may appeal to the Commissioner.

Aetna will contact the IRO that will conduct the review of your claim. The IRO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the IRO usually within 45 calendar days of **Aetna's** receipt of your request form and all necessary information.

An expedited review is possible if your **physician** certifies (on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive an expedited review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility, or mental health and substance use disorders.

If you are seeking services related a substance abuse disorder, or a co-occurring mental disorder, your appeal of a final adverse determination will be considered as a fast external review.

You may contact the Connecticut Department of Insurance for help regarding any external review at the addresses or phone numbers listed in the appeals section.

Expedited reviews are decided within 72 hours after the **IRO** receives the request, except in the case of experimental or investigational reviews, which have a 5 day timeframe, and in the case of an expedited review involving a substance abuse disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting, the review will be decided as expeditiously as the member's medical condition requires, but not later than 24 hours after the IRO receives the request to conduct this review.

The decision is binding on **Aetna**, except to the extent that **Aetna** has other remedies under state or federal law.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the IRO and for the cost of the external review except for dental, vision and hearing claims.

You may contact the Department of Insurance for assistance regarding any External Review or Expedited External Review at the following address:

**State of Connecticut Insurance Department
Consumer Affairs Department
P.O.Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid,ca@ct.gov.**

Or, the Office of Healthcare Advocate at:

**State of Connecticut
Office of the Healthcare Advocate
P.O.Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov.**

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 1
Issue Date: November 11, 2019

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

University of Hartford

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:

University of Hartford Welfare Plan

Employer Identification Number:

06-0731360

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117-1599
Telephone Number: (860) 768-4156

Agent For Service of Legal Process:

University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117-1599

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

End of Plan Year:

December 31

Source of Contributions:

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.

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 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 FMLA 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.