BENEFIT PLAN

Prepared for
University of Hartford

Freedom of Choice Passive PPO Dental

Aetna Life Insurance Company
Booklet-certificate

What Your Plan Covers and How Benefits are Paid

This Booklet-certificate is part of the Group policy between Aetna Life Insurance Company and the Policyholder
Preferred Provider Organization (PPO) dental insurance plan

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Underwritten by Aetna Life Insurance Company
Welcome

Thank you for choosing Aetna.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your Aetna plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your covered benefits – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the group policy, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for eligible dental services and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group policy between Aetna Life Insurance Company ("Aetna") and the policyholder. Ask the policyholder if you have any questions about the group policy.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they’re part of. When you receive these, they are considered part of your Aetna plan for coverage.

Where to next? Try the Let’s get started! section. Let’s get started! gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Aetna plan.
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Schedule of benefits                                                  Issued with your booklet-certificate
Let’s get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the booklet-certificate and schedule of benefits
- When we say “you” and “your”, we mean you and any covered dependents
- When we say “us”, “we”, and “our”, we mean Aetna
- Some words appear in bold type and we define them in the Glossary section

Sometimes we use technical dental language that is familiar to dental providers.

What your plan does – providing covered benefits
Your plan provides in-network and out-of-network covered benefits. These are eligible dental services for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage
Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the Who the plan covers section.

You can lose coverage for many reasons. To learn more see the When coverage ends section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the Special coverage options after your plan coverage ends section.

How your plan works while you are covered in-network
Your in-network coverage helps you:
- Get and pay for eligible dental services
- Pay less when you use in-network providers

Freedom-of-choice
Your dental plan has two plan options:
- The first option is a Managed dental plan. You must live, work or reside inside the service area to be eligible for that plan. The service area is the geographic location of in-network providers for the Managed dental plan. In-network providers are listed in a separate provider directory for that plan.
- The second option is this PPO dental plan.

You may choose either plan option, 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 to switch from one plan to the other. You can call us to make a change. See the How to contact us for help section. The change will be effective as follows:

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<th>If we receive the request:</th>
<th>The change will become effective on:</th>
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<td>On or before the 15th day of the month</td>
<td>The 1st day of the next month</td>
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Once the change is effective your eligible dental services are based on your current plan not your prior plan. Payments, services and supplies you received under the prior plan will be applied to coverage under the current plan.

Important note:
See the schedule of benefits for any deductibles, coinsurance, and maximum age or visit limits that may apply.

Eligible dental services
Eligible dental services meet these requirements:
- They are listed in the Eligible dental services section in the schedule of benefits.
- They are not carved out in these sections:
  - What are your eligible dental services?
  - What rules and limits apply to dental care?
  - What your plan doesn’t cover – exclusions sections. We refer to this section as “Exclusions”.
- They are not beyond any limits in the What rules and limits apply to dental care? section and the schedule of benefits

Aetna’s network of dental providers
Aetna’s network of dental providers is there to give you the care you need. You can find in-network providers and see important information about them most easily on our online provider directory. Just log onto our self-service website. See the How to contact us for help section.

You can choose any dental provider who is in the dental network.

You generally pay less when you get care from in-network providers, so choose in-network providers as soon as you can. See your schedule of benefits for details.

In-network providers not reasonably available – You can get eligible dental services from an out-of-network provider at the in-network cost share level when an appropriate in-network provider is not reasonably available. You must request approval from us before you get the care. Just contact us.

For more information about the provider directory and in-network providers, see the Who provides the care section.

Paying for eligible dental services– the general requirements
There are general requirements for the plan to pay any part of the expense for an eligible dental service. They are:
- The eligible dental service is medically necessary
- You get the eligible dental service from in-network or out-of-network providers

You will find details on medical necessity requirements in the Medical necessity requirements section.
Paying for eligible dental services—sharing the expense
Generally your plan and you will share the expense of your eligible dental services when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the What the plan pays and what you pay section and see the schedule of benefits.

How your plan works while you are covered out-of-network
The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from providers who are not part of the Aetna network. It’s called out-of-network coverage.

Your out-of-network coverage:
- Means you can get care from dental providers who are not part of the Aetna network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible dental services that you paid directly to a dental provider.
- Means the out-of-network cost share applies and you pay more. See the schedule of benefits.

You will find details on:
- Out-of-network providers and any exceptions in the Who provides the care section
- Cost sharing in the What the plan pays and what you pay section and your schedule of benefits
- Claim information in the When you disagree - claim decisions and appeals procedures section

How to contact us for help
We are here to answer your questions. You can contact us by registering and logging onto our self-service website available 24/7 that requires registration and logon at www.aetna.com.

In our website you can get reliable dental information, tools and resources. Online tools will make it easier for you to:
- Make informed decisions about your dental care
- View claims
- Research care and treatment options
- Access information on health and wellness

You can also contact us by:
- Calling Aetna at 1-877-238-6200
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156
Your ID card
You don’t need to show an ID card. When visiting a dentist, just provide your:

- Name
- Date of birth
- ID card number or social security number

The dental office can use that information to verify your eligibility and benefits. Your ID card number is located on your digital ID card which you can view or print by going to our self-service website. If you don’t have internet access, call us. You can also access your ID card when you’re on the go. To learn more, visit us at www.aetna.com/mobile.
Who the plan covers

You will find information in this section about:
- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible
The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan
As an employee you can enroll yourself and your dependents:
- At the end of any waiting period the policyholder requires
- At any time
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the Special times you and your dependents can join the plan section below)

If you don’t enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)
You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your “dependents”.)
- Your legal spouse (if your spouse is employed by the same employer as you, he or she can be covered as both, an employee and dependent)
- Your dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    o Under 26 years of age
  - Dependent children include:
    o Natural children
    o Stepchildren
    o Adopted children including those placed with you for adoption
    o Foster children
    o Children you are responsible for under a qualified medical support order or court-order
    o Grandchildren in your legal custody

You may continue coverage for a disabled child past the age limit shown above. See the Continuation of coverage for other reasons in the Special coverage options after your plan coverage ends section for more information.
Adding new dependents
You can add the following new dependents any time during the year:

- **A spouse** - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your marriage.
- **A newborn child** – Your newborn child is covered on your dental plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- **An adopted child** – A child that you, or that you and your spouse adopt is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- **A stepchild** – You may put a child of your spouse on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage with your stepchild’s parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes
It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other dental plan

Late entrant rule
The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

- The first 31 days the person is eligible for this coverage
- Any period of open enrollment agreed to by the policyholder and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of injuries sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included)
Special times you and your dependents can join the plan
You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group dental plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- You have added a dependent because of marriage, birth, adoption or foster care. See the Adding new dependents section for more information
- When a court orders that you cover a current spouse or a minor child on your dental plan

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage
Your coverage will be in effect as of the date you become eligible for dental benefits.
Medical necessity requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible dental services and medically necessary. See the Eligible dental services and Exclusions sections plus the schedule of benefits.

This section addresses the medical necessity requirements.

Medically necessary/medical necessity
As we said in the Let's get started! section, medical necessity is a requirement for you to receive a covered benefit under this plan.

The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity".
What are your eligible dental services?

The information in this section is the first step to understanding your plan's eligible dental services. If you have questions about this section, see the How to contact us for help section.

Your plan covers many kinds of dental care services and supplies. But some are not covered at all or are covered only up to a limit.

You can find out about exceptions and exclusions in the
- Dental provider services benefit below
- What rules and limits apply to dental care? section
- Exclusions section

Your dental plan

Your dental plan includes in-network and out-of-network providers. This means that it is a network plan. We explain how this plan works in the Let's get started section.

Schedule of benefits

Eligible dental services include dental services and supplies provided by a dental provider. Your schedule of benefits includes a detailed list of eligible dental services under your dental plan (including any maximums and limits that apply to them).

Dental provider services

You can get eligible dental services:
- At the dental provider's office
- By way of teledentistry

Important note:
Eligible dental services for teledentistry are paid based upon the cost share features that apply to the type of eligible dental service that you get. See your schedule of benefits for details.

The following are not eligible dental services under your plan except as described in the What rules and limits apply to dental care? section of this booklet-certificate, the schedule of benefits, or a rider or amendment issued to you for use with this booklet-certificate:
- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the schedule of benefits
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the schedule of benefits
- Prefabricated porcelain/ceramic crown – permanent tooth
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- 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
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder (TMJ)

**Dental emergency services**

Eligible dental services include dental emergency services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call us.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage.

For follow-up care to treat the dental emergency, you should consider using your in-network provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of eligible dental service and the provider that gives you the care.
What rules and limits apply to dental care?

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

Alternate treatment rule
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service but an eligible dental service would have provided acceptable results, then your plan will pay a benefit for the eligible dental service.

If a charge is made for an eligible dental service but a different eligible dental service would have provided acceptable results and is less expensive, then your plan will pay a benefit based upon the least expensive eligible dental service.

The benefit will be based on the in-network provider’s negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

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 your plan will cover.

Coverage for dental work begun before you are covered by the plan
Your 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
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Reimbursement policies
We reserve the right to apply our reimbursement policies to all services including involuntary services. Those policies may affect the negotiated charge or recognized charge. These policies consider:

- 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
- The educational level, licensure or lecture or length of training of the provider

Aetna reimbursement policies are based on our review of:

- Generally accepted standards of dental practice
- The views of providers and dentists practicing in the relevant clinical areas
Replacement rule

Some **eligible dental services** are subject to your plan’s replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge or other prosthetic item and:
    - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or other prosthetic item installed during the prior 5 years.
    - Your present denture is an immediate temporary one that replaced 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.

- The present item cannot be made serviceable, and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.

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 items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or prosthetic item installed during the prior 5 years.

Any such appliance, prosthetic item or fixed bridge must include the replacement of an extracted tooth or teeth.
An advance claim review

The purpose of an advance claim review is to provide an estimate, in advance, of what we may pay for proposed services. Knowing ahead of time which services are eligible dental services and what your plan may pay helps you and your dentist make informed decisions about the care you are considering. The estimate is not a guarantee of coverage and payment. An advance claim review will not look at whether the service is medically necessary or experimental or investigational.

In estimating the amount of benefits payable, we will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result.

The estimate is voluntary. It is not necessary for dental emergency services or routine care such as cleaning teeth or check-ups or any other service.

When to get an advance claim review

An estimate is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps involved with getting an advance claim review:

1. Ask your dentist to write down a full description of the treatment you need. They must either use an Aetna claim form or an American Dental Association (ADA) approved claim form.
2. Your dentist should send the form to us before treating you.
3. We may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dentist with a statement outlining the estimated benefits payable.
5. You and your dentist can then decide how to proceed.

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.
What your plan doesn’t cover – exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the What are your eligible dental services? section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about the exclusions that apply to your plan.

And just a reminder, you’ll find benefit and coverage limitations in the schedule of benefits.

Exclusions
The following are not eligible dental services under your plan except as described in:

• What are your eligible dental services? section
• What rules and limits apply to dental care? section
• The schedule of benefits
• A rider or amendment issued to you for use with this booklet-certificate

Charges for services or supplies
• Provided by an out-of-network provider in excess of the recognized charge
• Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
• Provided in connection with treatment or care that is not covered under the plan
• Cancelled or missed appointment charges or charges to complete claim forms
• Charges for which you have no legal obligation to pay
• Charges that would not be made if you did not have coverage, including:
  – Care in charitable institutions
  – Care for conditions related to current or previous military service
  – Care while in the custody of a governmental authority

Charges in excess of any benefit limits
Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the schedule of benefits)
• 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 services to protect, clean, whiten, bleach alter the appearance of teeth whether or not for psychological or emotional reasons

Facings on molar crowns and pontics will always be considered cosmetic

Court-ordered services and supplies
• This includes those court ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are an eligible dental service under this plan.
Dental services and supplies
- Those covered under any other plan of group benefits provided by the policyholder

Examinations
Any dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures

Non-medically necessary services
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.

Other primary payer
- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements
- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals
- 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
  - Cleaning of teeth
  - Topical application of fluoride.
- Charges submitted for services by an unlicensed provider or not within the scope of the provider's license.

Services paid under your medical plan
- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member
- Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member
Services received outside of the United States

- Non-dental emergency services received outside of the United States. They are not covered even if they are covered in the United States under this booklet-certificate.

Teledentistry

- Services given by dental providers that are not contracted with Aetna as teledentistry providers
- Services given when you are not present at the same time as the dental provider
- Services including:
  - Telephone calls
  - Teledentistry kiosks
  - Electronic vital signs monitoring or exchanges

Work related illness or injuries

- Coverage available to you under workers’ compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “not work related” regardless of cause.
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network. This section tells you about in-network and out-of-network providers.

In-network providers
We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan.

For you to pay less under this plan you should use in-network providers for eligible dental services.

You don’t have to use in-network providers:
- For dental emergency services – Refer to the What are your eligible dental services? section.
- When they are not available to provide eligible dental services that you need. See the Let’s get started section for more information.

You can find in-network providers and see important information about them by logging onto our self-service website. You can search our online provider directory for names and locations of in-network providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network providers
You also have access to out-of-network providers. This means you can receive eligible dental services from an out-of-network provider. If you use an out-of-network provider to receive eligible dental services, you are subject to a higher out-of-pocket expense and are responsible for:
- Paying your out-of-network deductible
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims
What the plan pays and what you pay

Who pays for your eligible dental services – this plan, both you and this plan or just you? That depends. This section gives the general rule and explains these key terms:

- Your deductible
- Your coinsurance
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an eligible dental service.

The general rule

When you get eligible dental services:

- You pay your deductible

And then

- The schedule of benefits lists how much you pay and your plan pays. The coinsurance percentage may vary by the type of expense.

And then

- You are responsible for any amounts above the calendar year and lifetime maximums.

When we say “expense” in this general rule, we mean the negotiated charge for in-network providers and recognized charge for out-of-network providers. See the Glossary section for what these terms mean.

Important note – when you pay all

You pay the entire expense for an eligible dental service when you get a dental care service or supply that is not medically necessary. See the Medical necessity requirements section.

The dental provider may require you to pay the entire charge. And any amount you pay will not count towards your deductible or towards your Calendar Year or lifetime maximums.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
Where your schedule of benefits fits in
This section explains some of the terms you will find in your schedule of benefits.

How your deductible works
Your deductible is the amount you need to pay for eligible dental services per Calendar Year before your plan begins to pay for eligible dental services. Your schedule of benefits shows the deductible amounts for your plan.

How we count your deductible
When you see in-network providers, we count the negotiated charge toward your in-network deductible. When you see out-of-network providers, we count the recognized charge toward your out-of-network deductible.

How your coinsurance works
Your coinsurance is the amount you pay for eligible dental services after you have paid your deductible. The schedule of benefits shows the coinsurance this plan will pay for specific eligible dental services. You are responsible for paying any remaining coinsurance.

How your maximum works
The maximum is the most your plan will pay for eligible dental services per Calendar Year and lifetime incurred by you or your covered dependent after any applicable deductible and coinsurance. You are responsible for any amounts above the maximum.

Important note:
See the schedule of benefits for any deductibles, coinsurance, maximum and maximum age, visit limits, and other limitations that may apply.
When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your eligible dental services.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your dental provider are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

The table below explains the claim procedures as follows:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should get a claim form from our self-service website or call us</td>
<td>• You must send us notice and proof as soon as reasonably possible</td>
</tr>
</tbody>
</table>
|                         | • The claim form will provide instructions on how to complete and where to send the forms | • If you are unable to complete a claim form, you may send us:  
  - A description of services  
  - Bill of charges  
  - Any dental documentation you received from your dental provider |

Proof of claim

When you have received a service from an eligible dental provider, you will be charged.

The information you receive for that service is your proof of loss.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>A completed claim form and any additional information required by us</td>
<td>You must send us notice and proof as soon as reasonably possible</td>
</tr>
</tbody>
</table>

Benefit payment

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written proof must be provided for all benefits</td>
<td>Benefits will be paid as soon as the necessary proof to support the claim is received</td>
</tr>
<tr>
<td>If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss</td>
<td></td>
</tr>
</tbody>
</table>

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.
Communicating our claim decisions
The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim
A post service claim is a claim that involves dental care services you have already received.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Post-service claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>30 days</td>
</tr>
<tr>
<td>Extensions</td>
<td>15 days</td>
</tr>
<tr>
<td>If we request more information</td>
<td>30 days</td>
</tr>
<tr>
<td>Time you have to send us additional information</td>
<td>45 days</td>
</tr>
</tbody>
</table>

Adverse benefit determinations
We pay many claims at the full rate negotiated charge with in-network providers and the recognized charge with out-of-network providers, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don’t pay at all. Any time we don’t pay even part of the claim, that is called an “adverse benefit determination” or “adverse decision”.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal
A complaint
You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.
An appeal
You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal by calling us.

Appeals of adverse benefit determinations
You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling us. You need to include:
- Your name
- The policyholder’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a dental provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your dental provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals
The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Post-service appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>30 days</td>
</tr>
<tr>
<td>Extensions</td>
<td>15 days</td>
</tr>
<tr>
<td>If we request more information</td>
<td>30 days</td>
</tr>
<tr>
<td>Time you have to send us</td>
<td>45 days</td>
</tr>
<tr>
<td>additional information</td>
<td></td>
</tr>
</tbody>
</table>
Exhaustion of appeals process
You must complete the appeal process with us before you can take these actions:

- Contact the Connecticut Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Connecticut Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

You may contact the Connecticut 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 800-203-3447
cid.ca@ct.gov

You may also contact 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
External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.
You must submit the Request for External Review form:

- To the Connecticut Insurance Department
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will need to mail your application for External Review to:

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

If you are using an overnight delivery service, mail to:

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

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The Connecticut Insurance Commissioner will forward the appeal to Aetna.

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?
We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Recordkeeping
We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses
We do not pay any fees or expenses incurred by you when you submit a complaint or appeal. We will pay for information we send to the ERO plus the cost of the review.
Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:
- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:
- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, policyholder organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works
- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.
<table>
<thead>
<tr>
<th>If you are:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered under the plan as an employee, retired employee or dependent</td>
<td>The plan covering you as an employee or retired employee</td>
<td>The plan covering you as a dependent</td>
</tr>
</tbody>
</table>

**COB rules for dependent children**

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The “birthday rule” applies</th>
<th>The plan of the parent born later in the year (month and day only)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Parents who are married or living together</td>
<td>The plan of the parent whose birthday* (month and day only) falls earlier in the Calendar Year</td>
<td>*Same birthdays--the plan that has covered a parent longer is primary</td>
</tr>
<tr>
<td>● Same birthdays--the plan that has covered a parent longer is primary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The plan of the parent whom the court said is responsible for dental coverage</th>
<th>The plan of the other parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Parents separated or divorced or not living together</td>
<td>But if that parent has no coverage, then their spouse’s plan is primary</td>
<td></td>
</tr>
<tr>
<td>● With court-order</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child of:</th>
<th>Primary and secondary coverage is based on the birthday rule</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child of:</th>
<th>The order of benefit payments is:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Parents separated or divorced or not living together and there is no court-order</td>
<td>● The plan of the custodial parent pays first</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● The plan of the spouse of the custodial parent (if any) pays second</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● The plan of the noncustodial parents pays next</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● The plan of the spouse of the noncustodial parent (if any) pays last</td>
<td></td>
</tr>
</tbody>
</table>

| ● Child covered by: Individual who is not a parent (i.e. stepparent or grandparent) | Treat the person the same as a parent when making the order of benefits determination: |                                                                                 |
|                                                                             | See Child of content above                                                   |                                                                                 |

| Active or inactive employee                                                        | The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee) | A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee) |
COBRA or state continuation | The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage | COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree

Longer or shorter length of coverage | If none of the above rules determine the order of payment, the plan that has covered the person longer is primary

Other rules do not apply | If none of the above rules apply, the plans share expenses equally

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**How are benefits paid?**

| Primary plan | The primary plan pays your claims as if there is no other dental plan involved |
| Secondary plan | The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense |

Benefit reserve | The benefit reserve:
- Is made up of the amount that the secondary plan saved due to COB
- Is used to cover any unpaid allowable expenses
- Balance is erased at the end of each year

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**Other dental coverage updates – contact information**

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

**Right to receive and release needed information**

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

**Right to pay another carrier**

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

**Right of recovery**

If we pay more than we should have under the COB rules, we may recover the excess from:
- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules.
When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Coverage under this plan will end if:

- This plan is no longer available
- You voluntarily stop your coverage
- The group policy ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required premium payment
- We end your coverage
- You become covered under another dental plan offered by your policyholder

Your coverage will end on either the date your employment ends or the day before the first premium contribution due date that occurs after you stop active work.
**When coverage may continue under the plan**

Your coverage under this plan will continue if:

| Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the policyholder and us. | Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us. | Your employment ends because either:  
- Your job has been eliminated  
- You have been placed on severance  
- This plan allows former employees to continue their coverage | Your employment ends because of a paid or unpaid medical leave of absence | Your employment ends because of a leave of absence that is not a medical leave of absence | Your employment ends because of a military leave of absence. |
|---|---|---|---|---|---|
| If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:  
- Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence. | If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:  
- Your coverage will stop on the date that your employment ends. | You may be able to continue coverage. See the **Special coverage options after your plan coverage ends** section. | If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:  
- Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence. | If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:  
- Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence. | If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:  
- Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence. |

**Notification of when your employment ends**

It is the policyholder’s responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.
When will coverage end for any dependents?
Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The group policy ends
- You do not make the required premium contribution toward the cost of dependents’ coverage
- Your coverage ends for any of the reasons listed above

Your dependents’ coverage will end on the earlier of the date the group policy terminates or as defined by the policyholder.

What happens to your dependents if you die?
Coverage for dependents may continue for some time after your death. See the Special coverage options after your plan coverage ends section for more information.

Why would we end your coverage?
We will give you 30 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on loss of coverage.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.
Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

What are your COBRA rights?
COBRA gives some people the right to keep their dental coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to policyholders of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

<table>
<thead>
<tr>
<th>Qualifying event causing loss of coverage</th>
<th>Covered persons eligible for continued coverage</th>
<th>Length of continued coverage (starts from the day you lose current coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your active employment ends for reasons other than gross misconduct</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td>Your working hours are reduced</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your covered dependent children no longer qualify as dependent under the plan</td>
<td>Your dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>
When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>General notice – policyholder or Aetna</td>
<td>Notify you and your dependents of COBRA rights</td>
<td>Within 90 days after active employee coverage begins</td>
</tr>
</tbody>
</table>
| Notice of qualifying event – policyholder  | • Your active employment ends for reasons other than gross misconduct  
• Your working hours are reduced  
• You die  
  • You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy | Within 30 days of the qualifying event or the loss of coverage, whichever occurs later |
| Election notice – policyholder or Aetna      | Notify you and your dependents of COBRA rights when there is a qualifying event                 | Within 14 days after notice of the qualifying event                       |
| Notice of unavailability of COBRA – policyholder or Aetna | Notify you and your dependents if you are not entitled to COBRA coverage.                        | Within 14 days after notice of the qualifying event                       |
| Termination notice – policyholder or Aetna   | Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period | As soon as practical following the decision that continuation coverage will end |
**You/your dependents notification requirements**

<table>
<thead>
<tr>
<th>Notice of qualifying event – qualified beneficiary</th>
<th>Notify the policyholder if:</th>
<th>Within 60 days of the qualifying event or the loss of coverage, whichever occurs later</th>
</tr>
</thead>
</table>
|  | • You divorce or legally separate and are no longer responsible for dependent coverage  
• Your covered dependent children no longer qualify as a dependent under the plan |  |
| Disability notice | Notify the policyholder if:  
• The Social Security Administration determines that you or a covered dependent qualify for disability status | Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends |
| Notice of qualified beneficiary’s status change to non-disabled | Notify the policyholder if:  
• The Social Security Administration decides that the beneficiary is no longer disabled | Within 30 days of the Social Security Administration’s decision |
| Enrollment in COBRA | Notify the policyholder if:  
• You are electing COBRA | 60 days from the qualifying event. You will lose your right to elect, if you do not:  
• Respond within the 60 days  
• And send back your application |

**How can you extend the length of your COBRA coverage?**

The chart below shows qualifying events after the start of COBRA (second qualifying events):

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Person affected (qualifying beneficiary)</th>
<th>Total length of continued coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)</td>
<td>You and your dependents</td>
<td>29 months (18 months plus an additional 11 months)</td>
</tr>
</tbody>
</table>
| • You die  
• You divorce or legally separate and are no longer responsible for dependent coverage  
• Your covered dependent children no longer qualify as dependent under the plan | You and your dependents | Up to 36 months |
How do you enroll in COBRA?
You enroll by sending in an application and paying the premium. Your policyholder has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the premium. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?
Your first premium payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:
- They meet the definition of an eligible dependent
- You notified your policyholder within 31 days of their eligibility
- You pay the additional required premium

When does COBRA coverage end?
COBRA coverage ends if:
- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You and your dependents fail to make the necessary payments on time
- You or a covered dependent become covered under another group dental plan
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?
Your dental coverage may end while you or your covered dependent are 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)
- 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
  - Impressions have been taken from which the item will be prepared

Reinstatement
If your coverage ends because you have not paid your premium, you may not be covered again for a period of 2 years from the date your coverage ends. If you are in an eligible class, you may request reinstatement of coverage for yourself and your eligible dependents at the end of such 2 years period. Your dental coverage will be subject to the rules under the Late entrant rule section and will be effective as described in the Effective date of coverage section.
General provisions – other things you should know

Administrative provisions
How you and we will interpret this booklet-certificate
We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan
We apply policies and procedures we’ve developed to administer this plan.

Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. They are not our employees or agents.

Coverage and services
Your coverage can change
Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we or the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive requirements under the plan or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or provider, can do this.

Financial sanctions exclusions:
If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible dental services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action
You must complete the appeal process before you take any legal action against us for any expense or bill. See the When you disagree - claim decisions and appeals procedures section. You cannot take any action until 60 days after we receive written submission of claim.

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

Physical examinations and evaluations
At our expense, we have the right to have a provider of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.
Things that would be important to keep are:

- Names of **dental providers, dentists** and other **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

**Honest mistakes and intentional deception**

**Honest mistakes**

You or the policyholder may make an honest mistake when facts are shared with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years before we learned of it.

**Intentional deception**

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

**Some other money issues**

**Assignment of benefits**

When you see **in-network providers** they will bill us directly. When you see **out-of-network providers**, we may choose to pay you or to pay the **providers** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group policy**. This may include:

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

To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

**Recovery of overpayments**

We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn’t cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don’t do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

**Premium contribution**

This plan requires the policyholder to make **premium** contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the **When you disagree - claim decisions and appeals procedures** section.
Payment of premiums
The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month (“premium due date”). Each premium payment is to be paid to us on or before the premium due date.

Your dental information
We will protect your dental information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call us. When you accept coverage under this plan, you agree to let your providers share your information with us. We will need information about your physical and mental condition and care.

Effect of prior plan coverage
If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.
Glossary

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

Calendar year
A period of 12 months beginning on January 1st and ending on December 31st.

Calendar year maximum
This is the most this plan will pay for eligible dental services incurred by you during the calendar year.

Coinsurance
Coinsurance is the percentage of the bill that you and this plan have to pay for an eligible dental service. The schedule of benefits shows the percentage that this plan pays.

Copayments
Copayments are flat fees you pay for certain eligible dental services.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible
The amount you pay for eligible dental services per calendar year before your plan starts to pay.

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies.

Dentist
A legally qualified dentist licensed to do the dental work he or she performs.
Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan appears on our self-service website. When searching for in-network providers, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered in-network providers for certain Aetna plans.

Effective date of coverage
The date your coverage begins under this booklet-certificate as noted in our records.

Eligible dental services
The benefits, subject to varying cost shares, covered in this plan. These are:
- Listed and described in the schedule of benefits.
- Not listed as an exception or exclusion in these sections:
  - What are your eligible dental services?
  - What rules and limits apply to dental care?
  - Exclusions.
- Not beyond any maximums and limitations in the What rules and limits apply to dental care? section and the schedule of benefits.
- Medically necessary. See the Medical necessity requirements section and the Glossary for more information.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:
- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the Food and Drug Administration (FDA) has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.
- It is provided or performed in a special setting for research purposes.

Group policy
The group policy consists of several documents taken together. These documents are:
- The group application
- The group policy
- The booklet-certificates
- The schedule of benefits
- Any amendments or riders to the group policy, the booklet-certificate, and the schedule of benefits

Health professional
A person who is licensed, certified or otherwise authorized by law to provide medical or dental care services to the public. For example, providers and dental assistants.

Illness
Poor health resulting from disease of the teeth or gums.
Injury or injuries
Physical damage done to the teeth or gums.

In-network provider
A provider listed in the directory for your plan.

Lifetime maximum
This is the most this plan will pay for eligible dental services incurred by a covered person during their lifetime.

Medically necessary/medical necessity
Dental care services that we determine a provider using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine are:

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

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:

- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Negotiated charge
This is either:

- The amount in-network providers have agreed to accept
- The amount we agree to pay directly to in-network providers or third party vendor (including any administrative fee in the amount paid)

for providing eligible dental services to covered persons in the plan.

Out-of-network provider
A provider who is not an in-network provider and does not appear in the directory for your plan.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Premium
The amount you or the policyholder are required to pay to Aetna to continue coverage.

Provider
A dentist, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.
Recognized charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The recognized charge may be less than the provider’s full charge.

The recognized charge depends upon the geographic area where you receive the eligible dental service. The table below shows the method for calculating the recognized charge for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible dental expenses</td>
<td>90% of the prevailing charge rate</td>
</tr>
<tr>
<td></td>
<td>The provider’s billed amount. This is the amount billed by a provider’s office for eligible dental services.</td>
</tr>
</tbody>
</table>

**Important note:** If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

**Recognized charge** does not apply to:
- Involuntary services

In the Dental out-of-network savings program, your cost may be lower when you get care from a Dental out-of-network savings program provider. Dental out-of-network savings program providers are out-of-network providers and third party vendors that have contracts with us but are not in-network providers.

When you get care from a Dental out-of-network savings program provider, the recognized charge is the contracted charge and your out-of-network cost sharing applies. If the provider bills less than the contracted charge, the recognized charge is what the provider bills.

Special terms used:
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. 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.
- Involuntary services are eligible dental services that are one of the following:
  - Not available from an in-network provider

We will calculate your cost share for involuntary services in the same way as we would if you received the services from an in-network provider.

- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

**Get the most value out of your benefits:**
We have online tools to help you decide the type of care to get and where. Our self-service website offers tools to help you determine the cost of eligible dental services, compare in-network providers and schedule office visits with them. See the How to contact us for help section for the website.
**Teledentistry**
A consultation between you and a **dental provider** who is performing a clinical dental service.

Services can be provided by:
- Two-way audiovisual teleconferencing
- Any other method permitted by state law

**Temporomandibular joint dysfunction/disorder (TMJ)**
This is:
- A **TMJ** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves
Discount programs
We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other rewards
You may be eligible to earn rewards for completing certain activities that improve your health, coverage and experience with us. We may encourage you to access certain dental services or categories of dental providers, participate in programs, including but not limited to financial wellness programs, utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. We may provide incentives based on your participation and outcomes such as:

- Modifications to copayment, deductible or coinsurance amounts
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above
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
Telephone Number: (860) 768-4156

**Agent For Service of Legal Process:**
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Confidentiality Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

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

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

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

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

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

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

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

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

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

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

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

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

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

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