# BENEFIT PLAN

**Prepared Exclusively For**
**Board of Franklin County Commissioners**
**Aka- Franklin County Cooperative Dental Plan**

**Dental Maintenance Organization - DMO**
**(Managed Dental Plan)**

## What Your Plan Covers and How Benefits are Paid

**Aetna Life Insurance Company**
**Booklet-Certificate**

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

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

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

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

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

# Preface *(GR-9N-02-005-01 OH)*

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

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

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

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

**NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.**

| | |
|---|---|
| **Group Policyholder:** | Board of Franklin County Commissioners aka- Franklin County Cooperative Dental Plan |
| **Group Policy Number:** | GP-659146 |
| **Effective Date:** | April 1, 2016 |
| **Issue Date:** | April 9, 2016 |
| **Booklet-Certificate Number:** | 1 |

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

## Important Information Regarding Availability of Coverage *(GR-9N-02-020-01 OH)*

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

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

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

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

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

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

# Coverage for You and Your Dependents *(GR-9N-02-020-01 OH)*

# Health Expense Coverage *(GR-9N-02-020-01 OH)*

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

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

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

## Treatment Outcomes of Covered Services *(GR-9N-02-020-01 OH)*

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

# When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

## Who Can Be Covered

### Employees

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

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

### Determining if You Are in an Eligible Class

You are in an eligible class if:

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

**Probationary Period** *(GR-9N-S-29-005-02-OH)*

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

**Determining When You Become Eligible**

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

**On the Effective Date of the Plan**

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

**After the Effective Date of the Plan**

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 30 days of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

### Obtaining Coverage for Dependents *(GR-9N 29-010 02 OH)*

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

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer; except that a domestic partner is not eligible for Life Insurance coverage; and
- Your dependent children; and
- Dependent children of your domestic partner.

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

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

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver's license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

## Coverage for Dependent Children *(GR-9N-S-29-005-02-OH)*

To be eligible, a dependent child must be:

- Unmarried; and
- Under 26 years of age

An eligible dependent child includes:

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

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

**Important Reminder**

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

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

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

## Initial Enrollment in the Plan

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

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

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

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

## Annual Enrollment

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

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

# When Your Coverage Begins *(GR-9N-29-025-01 OH)*

## Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date your enrollment information is received.

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

## Your Dependent's Effective Date of Coverage

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

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

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

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

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

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

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

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

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

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

**Important Note**

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

# How Your Aetna Dental Plan Works

*(GR-9N 16-005-01)*

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

## Understanding Your Aetna Dental Plan

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

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

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

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

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

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

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

## About the Managed Dental Plan *(GR-9N 16-015-01)*

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

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

**Out-of-network services and supplies** are not covered, except in the event of a **dental emergency**.

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

Accessing **Network Providers**

- The plan pays a higher level of benefits when your **PCD** provides your care or refers you to a **specialist dentist**.
- You must pay a **copay** for certain types of services and supplies.
- You have no further out-of-pocket expenses after you pay all applicable **copays**, as shown in the *Schedule of Benefits*.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network providers** less any cost sharing required by you. You will be responsible for **coinsurance** and **copayments**, if any.

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

### Changing Your PCD

You may change your **PCD** at any time on **Aetna**'s website, www.**Aetna.**com, or by writing to **Aetna** or calling the Member Services toll-free number on your identification card. The change will be effective as follows:

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

### Availability of Providers

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

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

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

## The Referral Process

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

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

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

### How Referrals Work

Here are some important points to remember:

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

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

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

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

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

### When You Do Not Need a PCD Referral

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

- **Emergency care.** Please refer to the "*In the case of a Dental Emergency*" section.
- Direct Access Services. Orthodontic services and supplies do not require a **referral**.

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

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

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

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

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

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

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

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

If you seek care from an **out-of-network provider** for a non-emergency dental condition (that is, one that does not meet the definition above), no benefit will be payable.

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

## Managed Dental Plan

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

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

- The services and supplies must be **medically necessary**.
- The service and supplies must be listed in the dental care schedule.
- You must be covered by the plan when you incur the expense.

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

The next sentence applies if:

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

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

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

**Important Reminder**
The **copays**, that apply to each type of dental care are shown in the *Schedule of Benefits*.

## Managed Dental Expense Coverage Plan *(GR-9N-19-006-01)*

*(GR-9N-19-006-01)*
The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

## Additional Covered Dental Expenses

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

## Payment of Benefits
The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **copayment** will be waived for the other covered dental expenses above and will not be subject to any frequency limits except as shown above.

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

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

## Orthodontic Treatment Rule

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

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

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

## Orthodontic Limitation for Late Enrollees

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

## Replacement Rule *(GR-9N 20-010-01)*

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

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

## Tooth Missing but Not Replaced Rule

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

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

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

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

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

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

## Coverage for Dental Work Begun Before You Are Covered by the Plan *(GR-9N 20-020-01)*

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

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

## Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

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

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

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

This exclusion does not apply to charges incurred:

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

# What The Managed Dental Plan Does Not Cover *(GR-9N-28-025-01-OH)*

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

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

Any instruction for diet, plaque control and oral hygiene.

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

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

General anesthesia and intravenous sedation.

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

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

Prescribed drugs; pre-medication; or analgesia.

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

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

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth; and
- Cleaning of teeth.

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

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

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

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

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

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

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

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.

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

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

# When Coverage Ends *(GR-9N-30-015-04)*

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

## When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or

- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

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

### When Coverage Ends for Dependents *(GR-9N 30-010 01 OH)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

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

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

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

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

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

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

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

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

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;

- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

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

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

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

## Handicapped Dependent Children *(GR-9N 31-015 01 OH)*

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

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

### Continuing Coverage for Reservist Called to Active Duty

Any eligible person may continue health care benefits under the group policy for a period of 18 months after the date on which a reservist's coverage under the group policy would otherwise end because he or she was called to active duty.

The term "eligible person" means you, if you are a reservist called to active duty, and your covered spouse and dependent children. The term "reservist" means a member of a reserve component of the armed forces of the United States including the Ohio National Guard.

If you are a reservist and are called to active duty, your employer shall notify each eligible person of this continuation right and explain how to enroll for this continued coverage and the amount of the required contribution. The eligible person must elect continuation and pay the required contribution to the employer by the earlier of:

- 31 days after the date coverage would otherwise terminate;
- 31 days after the date your employer notifies the eligible person of the right to continuation.

Coverage may be extended up to a 36 month period if any one of the following occurs during the 18 month continuation:

- The death of the reservist;
- The divorce or separation of a reservist from the reservist's spouse;
- The child no longer qualifies as a dependent child under the terms of the group policy.

The 36 month period is deemed to begin on the date of any occurrence above.

Coverage under this continuation as to an eligible person will end on the earlier to occur of the following:

- The 18 month, or if applicable, the extended 36 month period, expires.
- Required contributions are not made when due.
- The eligible person enrolls in another group health policy that does not contain a preexisting conditions limitation or exclusion.
- The group policy is terminated, unless replaced by similar coverage.

# Extension of Benefits *(GR-9N 31-020 01)*

## Coverage for Health Benefits

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

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

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

### Extended Health Coverage *(GR-9N 31-020 01)*

*(GR-9N 31-020 01)*
*Dental Benefits (other than Basic Dental benefits)*: Coverage will be available while you are totally disabled, for up to 12 months. Coverage will be available only if covered services and supplies have been rendered and received, including delivered and installed, prior to the end of that 12 month period.

### When Extended Health Coverage Ends

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

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

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

# COBRA Continuation of Coverage *(GR-9N 31-025-06 OH)*

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

## Continuing Coverage through COBRA

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

You or your dependents will need to:

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

## Who Qualifies for COBRA

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

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

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

## Disability May Increase Maximum Continuation to 29 Months

**If You or Your Covered Dependents Are Disabled.**

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.

- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

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

## Determining Your Premium Payments for Continuation Coverage

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

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

## When You Acquire a Dependent During a Continuation Period

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

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

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

## When Your COBRA Continuation Coverage Ends

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

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

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

*(GR-9N 33-005-01-OH)*

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

## When Coordination of Benefits Applies

### General

A. This coordination of benefits ("COB") provision applies to **This Plan** when an employee or the employee's covered dependent has health care coverage under more than one plan. "**Plan**" and "**This Plan**" are defined below.
B. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of **This Plan** are determined before or after those of another plan. The benefits of **This Plan**:
   - Shall not be reduced when, under the order of benefit determination rules, **This Plan** determines its benefits before another plan; but
   - May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

## Getting Started - Important Terms

A. "**Plan**" means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
   - Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other then school accident-type coverage.
   - Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
   - "**Plan**" does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies.
   - Each contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.
B. "**This Plan**" is the part of this group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" the order of benefit determination rules state whether **This Plan** is a Primary Plan or Secondary Plan as to another plan covering the person. When **This Plan** is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When **This Plan** is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, **This Plan** may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.
D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered by this plan. However, **This Plan** is not required to pay for an item, service, or benefit which is not a part of this **Plan's** contract. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

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

A. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:
   1) The other plan has rules coordinating its benefits with those of This Plan; and
   2) Both those rules and this plan's rules, in subsection below, require that this plan's benefits be determined before those of the other plan.
B. This Plan determines its order of benefits using the first of the following rules which applies:
   1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is;
      - Secondary to the plan covering the person as a dependent and
      - Primary to the plan covering the person as other than a dependent (e.g. a retired employee).
   2) Benefits for a dependent child whose parents are not separated or divorced shall be determined as follows:
      - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      - If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (A) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   3) Benefits for a dependent child whose parents are divorced or separated shall be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:
      - If the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent shall be the Secondary Plan.
      - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (A) nor (B) applies, the order of benefits shall be determined in the following order:

1) The plan of the parent with custody of the child;
2) The plan of the spouse of the parent with the custody of the child;
3) The plan of the parent not having custody of the child; and
4) The plan of the spouse of the parent not having custody of the child.
5) The benefits of a plan which covers a person as an employee who is neither laid off not retired (or as that employee's dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.

6) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.
7) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

# How Coordination of Benefits Works

A. This section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) below.
B. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
   - The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and
   - The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

If the allowable expense under This Plan is lower than the primary plan's, Aetna will use the primary plan's allowable expense. That may be lower than the actual bill.

## Right To Receive And Release Needed Information *(GR-9N 33-015-01-OH)*

Certain facts are needed to apply these COB rules. **Aetna** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Aetna** need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give **Aetna** any facts it needs to pay the claim.

## Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, **Aetna** may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. **Aetna** will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Another plan; or
- The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

# When You Have Medicare Coverage

*(GR-9N-33-020-01)*

**Which Plan Pays First**

**How Coordination with Medicare Works**

**What is Not Covered**

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

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

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

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

## Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

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

The plan is the secondary payor in all other circumstances.

## How Coordination With Medicare Works

### When the Plan is Primary

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

### When Medicare is Primary

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

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

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

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

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

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

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

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

# General Provisions *(GR-9N-32-005-02)*

## Type of Coverage

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

## Physical Examinations

**Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

## Legal Action

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

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

## Confidentiality

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

## Additional Provisions

The following additional provisions apply to your coverage.

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

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

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

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

# Misstatements *(GR-9N-32-005-03)*

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

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

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

# Incontestability

As to Accident and Health Benefits:

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

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

# Recovery of Overpayments *(GR-9N-32-015-01-OH)*

## Health Coverage

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

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

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

# Reporting of Claims *(GR-9N-32-020-01-OH) (GR-9N-32-015-01-OH)*

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

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

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

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

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

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

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

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

**Aetna** may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

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

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

Very important are:

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

# Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

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

## Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen dental coverage under an HMO Plan offered by your employer, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

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

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

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

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

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

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

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

# Incentives *(GR-9N-32-045-01-OH)*

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, coinsurance, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

# Appeals Procedure *(GR-9N-32-050-01-OH)*

## Definitions

**Adverse Benefit Determination (Decision)** means:

A decision by **Aetna**:

- To deny, reduce, terminate or fail to provide or make payment in whole or in part, for a service, supply or benefit. Such **adverse benefit determination** may be include all of the following:
  - Your eligibility for coverage.
  - A determination that the health care services does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments.
  - A determination of your eligibility for individual health insurance coverage, including coverage offered through a non-employer group, to participate in a plan or health insurance coverage.
  - The results of any Utilization Review activities.
  - A determination that a health care service is not a covered benefit.
  - The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to you, including coverage offered through a non-employer group.
- As to medical and prescription drug claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

**Authorized Representative:** An individual who represents you in an internal appeal or external review process of an **adverse benefit determination** who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an **adverse benefit determination**;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional, but only when you are unable to provide consent.

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

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

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

**Covered Benefits** or **Benefits:** Those health care services to which a covered person is entitled under the terms of a health benefit plan.

**Covered Person:** Policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's **authorized representative** with regard to an internal appeal or external review.

**Emergency Services:**

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

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

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

**Health Benefit Plan:** A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

**Health Care Services:** Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

**Health Plan Issuer:** An entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the **superintendent** of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the **superintendent**.

**Independent Review Organization:** An entity that is accredited to conduct independent external reviews of **adverse benefit determinations**.

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

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

**Rescission** or **to rescind:** A cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

**Stabilize:** The provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part.

- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

**Superintendent:** The Superintendent of Insurance.

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

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

## Full and Fair Review of Claim Determinations and Appeals

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

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

## Claim Determinations

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

### Urgent Care Claims

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

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

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

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

### Pre-Service Claims

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

### Post-Service Claims

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

information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

### Concurrent Care Claim Extension

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

### Concurrent Care Claim Reduction or Termination

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

If you file an **appeal**, coverage under the plan will continue for the previously approved ongoing course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

## Complaints

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

### Notice of an Adverse Determination

When **Aetna** notifies you of an **adverse benefit determination** in writing, you will also be notified of your right to an **external review**. As part of the written notice, the Plan will include the following:

- Sufficient information to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;
- A description of the reason or reasons for the **adverse benefit determination**, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;
- A description of the available internal **appeals** and **external review** processes, including information regarding how to initiate an **appeal** and an **external review**; and
- Disclosure of the availability of assistance from the **superintendent** with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the **superintendent**'s Office of Consumer Services.

## Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** if the services are eligible for external review.

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

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

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

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna** if you decide to choose an authorized representative**.** You may also supply additional information that you would like us to consider regarding your appeal. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

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

## Level One Appeal

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

**Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 36 hours of receipt of the request for an **appeal**.

**Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

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

## Level Two Health Appeal

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

**Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 36 hours of receipt of the request for a Level Two **Appeal**.

**Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)**
**Aetna** shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

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

## Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Ohio Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Ohio Department of Insurance; or
- Establish any:
  Litigation;
  Arbitration; or
  Administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Exceptions to the exhaustion of the Level One and Level Two processes of the **Appeals** procedure may occur in the following instances:

a) **Aetna** agrees to waive the Exhaustion requirement;
b) You did not receive a written decision of **Aetna's** internal **appeal** within the required timeframe;
c) **Aetna** fails to meet all requirements of the internal appeals process unless the failure:
   - was *de minimis*;
   - does not cause or is not likely to cause prejudice or harm to you;
   - was for good cause and beyond the control of the Plan; or
   - is not reflective of a pattern or practice of non-compliance.
d) an expedited **external review** is sought simultaneously with an expedited internal review.

An internal **appeal** process shall be considered exhausted if you have requested an internal **appeal** and have not received a written decision from **Aetna** at each level of **appeal** within the timeframes listed above and **Aetna** fails to adhere to all requirements of the internal **appeals** process.

You may not request an **external review** of an **adverse benefit determination** involving a retrospective utilization review decision until **Aetna's** internal **appeal** process has been exhausted unless the **Aetna** agrees to waive the exhaustion requirement

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

**Important Note:**

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

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

# Opportunity for External Review *(GR-9N-32-051-01-OH)*

An **external review** may be conducted by an **Independent Review Organization (IRO)** or by the Ohio Department of Insurance. You do not pay for the **external review**. There is no minimum cost of health care services denied in order to qualify for an **external review**. However, you must generally exhaust the health Plan issuer's internal **appeal** process before seeking an **external review**. Exceptions to this requirement will be included in the notice of the **adverse benefit determination**.

## External Review by an IRO

You are entitled to an **external review** by an IRO in the following instances:

- The **adverse benefit determination** involves a medical judgment or is based on any medical information
- The **adverse benefit determination** indicates the requested service is **experimental or investigational**, the requested health care service is not explicitly excluded in your health benefit Plan, and the treating physician certifies at least one of the following:
    - Standard **health care services** have not been effective in improving the your condition.
    - Standard **health care services** are not medically appropriate for you.
    - No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- Your treating physician certifies that the **adverse benefit determination** involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal **appeal**.

- Your treating physician certifies that the **final adverse benefit determination** involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of a standard **external review**.

- The **final adverse benefit determination** concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but has not yet been discharged from a facility.

- An expedited internal **appeal** is already in progress for an **adverse benefit determination** of **experimental or investigational** treatment and your treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited **external review** is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to you.)

## External Review by the Ohio Department of Insurance

You are entitled to an **external review** by the Department in the either of the following instances:

- The **adverse benefit determination** is based on a contractual issue that does not involve a medical judgment or medical information.
- The **adverse benefit determination** for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND the Plan's decision has already been upheld through an **external review** by an IRO.

## Request for External Review

Regardless of whether the **external review** case is to be reviewed by an IRO or the Department of Insurance, you or an **authorized representative**, must request an **external review** through **Aetna** within 180 days of the date of the notice of final **adverse benefit determination** issued by their Plan.

All requests must be in writing, except for a request for an expedited **external review**. Expedited **external review**s may be requested electronically or orally; however written confirmation of the request must be submitted to **Aetna** no later than five (5) days after the initial request. You will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete **Aetna** will initiate the **external review** and notify you in writing, or immediately in the case of an expedited review, that the request is complete and eligible for **external review**. The notice will include the name

and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform you that, within 10 business days after receipt of the notice, you may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. **Aetna** will also forward all documents and information used to make the **adverse benefit determination** to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete **Aetna** will inform you in writing and specify what information is needed to make the request complete. **Aetna** determines that the **adverse benefit determination** is not eligible for **external review**, **Aetna** must notify you in writing and provide you with the reason for the denial and inform you that the denial may be **appeal**ed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for **external review** regardless of the decision by **Aetna** and require that the request be referred for **external review**. The Department's decision will be made in accordance with the terms of the health benefit Plan and all applicable provisions of the law.

## IRO Assignment

When the Plan initiates an **external review** by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Aetna, you, the health care provider or the health care facility will not be selected to conduct the review.

## IRO Review and Decision

The IRO must consider all documents and information considered by **Aetna** in making the **adverse benefit determination**, any information submitted by you and other information such as; your medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the health Plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the plan of a request for a standard review or within 72 hours of receipt by the Plan of a request for an expedited review. This notice will be sent to you, **Aetna** and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for **external review**.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the **external review**.
- The dates over which the **external review** was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an **adverse benefit determination** that involves a health care treatment or service that is stated to be **experimental or investigational** also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

**Binding Nature of External Review Decision**

An **external review** decision is binding on **Aetna** except to the extent that **Aetna** has other remedies available under state law. The decision is also binding on you except to the extent that you have other remedies available under applicable state or federal law.

You may not file a subsequent request for an **external review** involving the same **adverse benefit determination** that was previously reviewed unless new medical or scientific evidence is submitted to the Plan.

**If You Have Questions About Your Rights or Need Assistance**

You may contact the Plan:

**Aetna**
National External Review Unit
11675 Great Oaks Way
Alpharetta, GA 30022
Toll Free # (877) 848-5855
Fax #: (860) 975-1526

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

# Glossary

*(GR-9N 34-005 01)*

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

## A *(GR-9N-34-005-05)*

### Aetna

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

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

### Coinsurance

**Coinsurance** is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

### Copay or Copayment

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

### Cosmetic

Services or supplies that alter, improve or enhance appearance.

### Covered Expenses

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

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

### Deductible

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

### Dental Provider

This is:

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

legally qualified to furnish dental services or supplies.

## Dental Emergency
Any dental condition that:

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

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

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

# E *(GR-9N 34-25 09)*

## Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

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

## Hospital
An institution that:

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

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

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

## Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

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

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

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

## Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

# M *(GR-9N-34-065-03 OH)*

## Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

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

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

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

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

# N *(GR-9N 34-070 02)*

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

## Network Provider
A **dental provider** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

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

## Network Service(s) or Supply(ies)
Health care service or supply that is:

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

## Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

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

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

## Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

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

# O *(GR-9N-34-075-01 OH)*

## Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

## Orthodontic Treatment *(GR-9N-34-075-01 OH)*
This is any:

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

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

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

whether or not for the purpose of relieving pain.

## Out-of-Network Service(s) and Supply(ies) *(GR-9N-34-075-01 OH)*
Health care service or supply that is:

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

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

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

## Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

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

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

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

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

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

## Primary Care Dentist (PCD) *(GR-9N-34-030-02 OH)*
This is the **network provider** who:

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

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

# R *(GR-9N-34-090-01 OH)*

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

Your plan's **recognized charge** applies to all **out-of-network covered expenses**. In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

- For dental expenses:
- 80th percentile of the Prevailing Charge Rate

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

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;

- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

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

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

Special terms used
Geographic Area and Prevailing Charge Rates are defined as follows:

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

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

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

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

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

## R.N.
A registered nurse.

# S *(GR-9N 34-95-10)*

## Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a L.P.N. directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.

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

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

**Skilled nursing facility** does not include:

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

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

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

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

## Confidentiality Notice

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

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

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

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

## Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

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

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

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

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

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

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

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

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

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

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

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