Your Group Plan

University of Pennsylvania Postdoctoral Insurance Plan

Dental States Rider

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

Connecticut: **Dental Coverage**

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in **Connecticut**. These provisions supercede any provisions in your Booklet-Certificate unless the provisions in your Booklet-Certificate result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Coordination of Benefits - Other Plans Not Including Medicare

Benefits Subject To This Provision: This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has medical and/or dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

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

Allowable Expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room (unless the patient's stay in the private **hospital** room is medically **necessary** in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.

5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

Claim Determination Period means the Calendar Year.

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

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

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

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

If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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

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

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

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

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

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Order Of Benefit Determination.

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

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained through membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. Medical benefits coverage in a group, group type, and individual automobile "no fault" or traditional automobile "fault" type contract is always primary.

D. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

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

(1) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is changed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

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(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

(3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

(4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

(6) **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Plan.

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

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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Right To Receive And Release Needed Information.

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

Facility Of Payment.

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

Right of Recovery.

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

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Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP- 861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

District of Columbia: Dental

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in the District of Columbia. These provisions supercede any provisions in your Summary of Coverage unless the provisions in your Summary of Coverage result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Dependents
You may cover your:

- wife or husband; and
- unmarried children who are under 19 years of age.

The requirement that an unmarried child under age 23 must go to school on a regular basis and depend solely on you for support to be covered as a dependent does not apply to covered persons residing in the District of Columbia.

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

Illinois: **Medical**

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

The provisions set forth describe legislative medical requirements which apply to covered persons residing in **Illinois**. These provisions supercede any provisions in your Booklet-Certificate unless the provisions in your Booklet-Certificate result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left sides of certain blocks of text are required by the Department of Insurance.

Disclosure

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the group policy's fee schedule, reasonable charge or recognized charge (whichever is applicable to this plan and which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the group policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE GROUP POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill covered persons for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the covered person other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free number on your ID Card.

Continuation of Coverage For Your Former Spouse

If Health Expense Coverage for your dependent spouse would terminate due to dissolution of marriage, the former spouse may continue to be covered. Your former spouse has to request continuation within 30 days of the date a notice of the right to continue is sent.

Premium payments must be continued. Coverage will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The end of a 2 year period after the date of dissolution of marriage. This applies only if your former spouse was under age 55 on the date coverage is first continued under this section.
- The date coverage would have terminated if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage unless the coverage would have terminated due to a change in the group contract during such 120 days.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse remarries.
- The end of the period for which contributions have been made.

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

Maine: **DMO Dental Coverage**

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in **Maine**. These provisions supercede any provisions in your Booklet-Certificate unless the provisions in your Booklet-Certificate result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Dental Expense Benefits After Termination
If a person is totally disabled when his or her Dental Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean:

- For a person who was gainfully employed before the disability started:

  That due to injury or disease, the person is not able to engage in any gainful job for which he or she is reasonably suited by:

  training; or

  education; or

  experience.
- For any other person:

  That due to injury or disease, the person is not able to engage in most of the normal activities of a person of like age in good health.

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Dental Care Plan benefits will be available to him or her while disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 12 month period.

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

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Third Party Notice Request Form

I am requesting Aetna to recognize the person named below as my designated third party to receive notice of any intent to cancel my health expense coverage under the group policy for non-payment of premium.

My signature below means that I understand and agree that:

1. I have the option to change this designation at any future time upon my written request.

2. If my coverage has been cancelled, a request for reinstatement of the coverage (for me and my dependents who were covered at the time of cancellation) based on the reason that I suffered from Organic Brain Disease at the time of cancellation and an agreement to pay any required contribution to keep the coverage in force may be made by:

   - me;
   - any of my dependents covered under the group policy at the time of cancellation; or
   - anyone authorized to act on my behalf.

   The request for reinstatement must be made within 90 days of the date coverage is cancelled.

   Proof that I am suffering from this disease must be provided without cost to Aetna.

   "Organic Brain Disease" means a mental or nervous disorder with a demonstrable organic origin causing a significant cognitive impairment including, but not limited to, Pick's Disease, Parkinson's Disease, Huntington's Chorea, and Alzheimer's Disease and related dementias.

Policyholder: _____ Group Policy No.: _____

Name of: _____
(Designated Third Party)

Address: _____
(Street)

_____
(City, State, Zip Code)

_____ _____
Employee's Signature Social Security Number

_____
(Date)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP- 861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

New Jersey **Dental**

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

The provisions set forth describe legislative and dental requirements which apply to covered persons residing in **New Jersey**. The Appeals Procedure provisions supercede any similar provisions in your Booklet-Certificate and Summary of Coverage. All other provisions supercede any provisions in your Booklet-Certificate and Summary of Coverage unless the provisions in your Booklet-Certificate and Summary of Coverage result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Appeals Procedure

The following Appeals Procedure section applies only to Group Dental Coverage.

Definitions

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

Such Adverse Benefit Determination may be based on, among other things:

- The covered person's eligibility for coverage;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

Appeal: A written request to Aetna to reconsider an Adverse Benefit Determination.

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

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

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

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

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

Urgent Care Claim: Any claim for medical care or treatment of a non-life threatening condition that requires care by a provider within 24 hours or in which a delay in treatment could:

- jeopardize the life of the covered person;
- jeopardize the ability of the covered person to regain maximum function;
- cause the covered person 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.

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Claim Determinations – Group Health Coverage

Urgent Care Claims

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

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

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

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

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

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

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

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 10 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an Appeal if Aetna gives notice of an Adverse Benefit Determination. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

You have 180 calendar days with respect to Group Health claims following the receipt of notice of an Adverse Benefit Determination to request your level one Appeal. Your appeal must be in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

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

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

Level One Appeal – Group Health Claims

A level one appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

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

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 5 business days of receipt of the request for an Appeal.

Post-Service Claims
Aetna shall issue a decision within 10 calendar days of receipt of the request for an Appeal.

Level Two Appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent Care Claim shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination. A level two Appeal of an Adverse Benefit Determination of a Pre-Service Claim or a Post-Service claim will be reviewed by the Aetna Appeals Committee.

Urgent Care Claims
Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

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

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

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External Review

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

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

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

New Jersey Department of Banking and Insurance
Consumer Protection Services
20 West State Street, 9th Floor
PO Box 329
Trenton, New Jersey 08625-0360

Main Telephone Number: (609) 292-5316
Fax: (609) 292-5865

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

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

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

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

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

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

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

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

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

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

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

General Information

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

General Claim Information

Any unpaid balance on a claim will be paid within 30 days of receipt by Aetna of the due written proof. However, if the claim is not denied by Aetna for valid and proper reasons and the unpaid balance is not paid within 30 days following receipt of the claim when submitted by electronic means or 40 days following receipt of the claim when submitted by other than electronic means, Aetna will pay the insured interest on accrued benefits at the rate of 10 percent per annum.

11600, 12160-1, 12160-2

Exhaustion of Process

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

- contact the your state's Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with your state's Department of Insurance; or
- establish any:

  litigation;

  arbitration; or

  administrative proceeding;

  regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

11600

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

New Mexico: **Dental**

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in **New Mexico**. These provisions supercede any provisions in your Booklet-Certificate and Summary of Coverage unless the provisions in your Booklet-Certificate and Summary of Coverage result in greater benefits. These provisions do not duplicate the provisions described in the group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Dependents
You may cover your:

- wife or husband; and
- unmarried children who are under 25 years of age.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

5090

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

New York: **Dental Coverage**

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in **New York**. These provisions supercede any provisions in your Booklet-Certificate and Summary of Coverage unless the provisions in your Booklet-Certificate and Summary of Coverage result in greater benefits. These provisions do not duplicate the provisions described in your group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the State of New York.

Disclosure

The accident and health insurance evidenced by this Booklet-Certificate provides DENTAL insurance only.

Handicapped Dependent Children
Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene law), or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

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

Coverage will cease on the first to occur of:

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

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

11048

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Issue Date: April 3, 2007

Effective Date: March 1, 2007

Washington: **Dental**

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

The provisions set forth describe legislative dental requirements which apply to covered persons residing in **Washington**. These provisions supercede any provisions in your Booklet-Certificate and Summary of Coverage unless the provisions in your Booklet-Certificate and Summary of Coverage result in greater benefits. These provisions do not duplicate the provisions described in the group policy.

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

Benefits Subject To This Provision: This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has medical and/or dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense.**

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

Allowable Expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. When This Plan determines it pays its benefits after another Plan or Plans which also cover a person, this Plan pays 100% of the total allowable expense not paid by the other Plans. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of hospital private rooms) is not an allowable expense.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of this Plan's negotiated charges is not an allowable expense.

4. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

Claim Determination Period means the Calendar Year.

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

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

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

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

If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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

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

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

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

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

Order Of Benefit Determination.

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

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

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

(1) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

(3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

(4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

(6) **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Plan.

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

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Benefits Subject to this Provision:

All of the benefits provided under this **Certificate** are subject to **Coordination of Benefits**. If the **Member** has coverage under more than one plan, **HCSC** recommends that the **Member** submit their claim to both plans at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

Right To Receive And Release Needed Information.

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

Facility of Payment.

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

Right of Recovery.

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

Effect of Medicare

The following provisions explain how the benefits under This Plan interacts with benefits available under Medicare.

Medicare, when used in this provision, 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.

A person is "**eligible for Medicare**" if he or she:

- is covered under it by reason of age, disability, or End Stage Renal Disease;
- is not covered under it because of:

  having refused it;
  having dropped it; or
  having failed to make proper request for it.

If a person is eligible for Medicare, This Plan will pay for such benefits as for such person as the Primary Payor or Secondary Payor, as follows:

If your coverage for This Plan's benefits is based on current employment with the Employer, This Plan will act as the Primary Payor for the Medicare beneficiary who is eligible for Medicare:

(a) solely due to age if this 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).
(b) due to end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. But this does not apply if at the start of such eligibility the person was already eligible for Medicare benefits and this Plan's benefits were payable on a Secondary basis.
(c) solely due to any disability other than end stage renal disease; but only if this plan meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

Otherwise, This Plan will cover the benefits as the Secondary payor. This Plan will pay the difference between the benefits of this Plan and the benefits that Medicare pays, up to 100% of "Plan Expenses." "Plan Expenses" means any **necessary** and reasonable health expenses, part or all of which is covered under this Plan.

Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

Exclusions

Those charges for non-emergency care or treatment furnished by a covered person's physician under a Private Contract are excluded. A Private Contract is a contract between a Medicare beneficiary and a **physician** who has decided not to provide services through Medicare.

This exclusion applies to services an "opt out" physician has agreed to perform under a Private Contract signed by the covered person. Physicians who have decided not to provide services through Medicare must file an "opt out" affidavit with all carriers who have jurisdiction over claims the physician would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a Medicare beneficiary.

Right to Receive and Release Needed Information.

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

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Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued a personal medical conversion policy.

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Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

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Ronald A. Williams
Chairman, Chief Executive Officer and President