BENEFIT PLAN

Prepared Exclusively For
University of Pennsylvania Postdoctoral
Insurance Plan

Dental Maintenance Organization (DMO)
(Managed Dental Plan)

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

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 P-A)

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

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

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

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

Group Policyholder: University of Pennsylvania Postdoctoral Insurance Plan  
Group Policy Number: GP-861472  
Effective Date: January 1, 2016  
Issue Date: January 19, 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 02-005 02)

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-02-005-01 PA)

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

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 PA)

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

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 (GR-9N.29.005.02)
You are in an eligible class if:

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

Determining When You Become Eligible (GR-9N.29.005.02)
You become eligible for the plan on your eligibility date, which is determined as follows.

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

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

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

Obtaining Coverage for Dependents (GR-9N.29.010.01 PA)
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; 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 PA)
To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.
Coverage for Dependent Children
To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 23, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

* Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 15 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

Active Duty
If your Plan includes coverage for dependent children and your dependent child is a full-time student at an accredited institution of higher education and is a member of:

- the Pennsylvania National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- the Pennsylvania National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch.76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days

and is called to military duty, coverage under this Booklet-Certificate will not terminate for the dependent child while on military duty, or after returning home, subject to the extension qualification requirements listed below.

Coverage under this Booklet-Certificate shall be extended for a period equal to the duration of the dependent's service on active duty or active State duty, or until the dependent is no longer a full-time student. The extension does not apply to Life Insurance. In order to qualify for an extension, the dependent must:

- Submit a form approved by the Department of Military and Veterans Affairs notifying Aetna Life Insurance Company that the dependent has been placed on active duty.
- Submit a form approved by the Department of Military and Veterans Affairs notifying Aetna Life Insurance Company that the dependent is no longer on active duty.
- Submit a form approved by the Department of Military and Veterans Affairs showing that the dependent has re-enrolled as a full-time student for the first term or semester starting 60 or more days after their release from active duty.

As use above, the term "full-time student" means a student enrolled in an approved institution of higher education pursuing an approved program of education equal to or greater than 15 credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

Dependent's Limiting Age
If elected by your employer, coverage shall be provided to an adult dependent child if the adult dependent child:

is under age 30;
is not married;
has no dependents;
is a resident of the Commonwealth of Pennsylvania or is enrolled as a full-time student at an institution of higher learning; and
is not providing coverage under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program, including benefits under Title XVIII of the Social Security Act.
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 PA)

Your Effective Date of Coverage
Your coverage takes effect on the later of:

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

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

Your Dependent’s Effective Date of Coverage
Your dependent’s coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to Aetna within 31 days because they may affect your contributions.
Requirements For Coverage (GR-9N-09-005-01)

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

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

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

(Gr-9N 16-005-01)

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)

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**.
- In addition to the **copayments** shown in the **Schedule of Benefits**, a **copay** applies to each office visit to your network provider for a service or supply in the dental care schedule.
- 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 provider**, your **PCD** may refer you to an **out-of-network provider**. You will receive the **network level of coverage** if your **PCD** gets approval from **Aetna** for this referral.

**Changing Your PCD**

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

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

**Availability of Providers**

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

**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**).

You cannot 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-16-049-01)*

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)*

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage insured or administered by **Aetna** 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

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

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

Tooth Missing but Not Replaced Rule
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.
Alternate Treatment Rule (GR-9N 20-015-01)
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan’s coverage will be limited to the cost of the least expensive service or supply that is:

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

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

Coverage for Dental Work Begun Before You Are Covered by the Plan (GR-9N 20-020-01)
The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

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

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

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

"Ordered" means:

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

Late Entrant Rule (GR-9N 20-025-01)
The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:

- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and Aetna.
This exclusion does not apply to charges incurred:

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

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

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

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

Any instruction for diet, plaque control and oral hygiene.

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

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

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

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

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

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

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

Services and supplies provided by an out-of-network provider.

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-P-A)

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

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

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

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

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

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

Examinations:

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

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

When Coverage Ends (GR-9N-30-005-05 PA)

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-30-015-02)
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 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. In that event, you should provide your Employer a completed and signed Declaration of Termination of Domestic Partnership.

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

Continuation of Coverage (GR-9N-31-010-03)

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

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

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.

**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)

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

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

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

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

COBRA Continuation of Coverage

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.

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<th>Qualifying Event Causing Loss of Health Coverage</th>
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<th>Maximum Continuation Periods</th>
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<td>You and your dependents</td>
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Your covered dependent children no longer qualify as dependents under the plan

<table>
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<tr>
<th>Your dependent children</th>
<th>36 months</th>
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</table>

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

When You Acquire a Dependent During a Continuation Period

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

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

Important Note

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

When Your COBRA Continuation Coverage Ends

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

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

**Conversion from a Group to an Individual Plan**

You may be eligible to apply for an individual health plan without providing proof of good health:

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

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.
Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.
Which Plan Pays First (GR-9N-33-010-01)

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

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

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

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

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.

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

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

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.

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

**How Coordination of Benefits Works**

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

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

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

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

**Right To Receive And Release Needed Information**

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

**Facility of Payment**

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

**Right of Recovery**

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

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-32-005-03 PA)

Type of Coverage

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

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

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

Legal Action

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

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

Confidentiality (GR-9N-32-005-03 PA)

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

Additional Provisions (GR-9N-32-005-03 PA)

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this plan because you are connected with more than one Policyholder.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your Policyholder or Aetna.
- Your Policyholder hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.
Assignments (GR-9N-32.005-03-P-A)

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

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

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

Misstatements (GR-9N-32.005-03-P-A)

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

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

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

Incontestability (GR-9N-32.005-03-P-A)

As to Accident and Health Benefits:

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

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

Recovery of Overpayments (GR-9N-32.015-01-P-A)

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 PA) (GR-9N-32-015-01 PA)*

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](http://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-P.A)
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.
Discount Programs *(GR-9N 32.045-01)*

**Discount Arrangements**

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to Aetna in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

**Incentives** *(GR-9N 32.045-01)*

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 PA)*

**Definitions**

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

Such adverse benefit determination may be based on:

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

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

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

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

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

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

**External Review:** A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you file an appeal, coverage under the plan will continue for the previously approved 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. 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.

**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 depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

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

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

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

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

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

**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 Pennsylvania Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Pennsylvania 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.

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.

**External Review** (GR-9N-32-051-01 PA)

You may receive an adverse benefit determination or final adverse benefit determination. In these situations, you may request an **External Review** if you or your provider disagrees with Aetna's decision.

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

- You have received an adverse benefit determination notice by Aetna, and Aetna did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
- You have received a final adverse benefit determination notice of the denial of the claim by Aetna.
- Your claim was denied because Aetna determined that the care was not necessary or appropriate or was experimental or investigational.
- You qualify for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds $500.

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

You must submit the Request for External Review Form to the U.S. Office of Personnel Management within 123 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

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

A faster review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the adverse benefit determination relates to experimental or investigational treatment, if the physician certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.
You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

**Aetna** will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

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

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

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.

**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 **Actna’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 PA)

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

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

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

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
c) Not mostly for the convenience of the patient, physician, other health care or dental provider; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

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.

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 PA)
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 PA)
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 or a provider who:

- Is a person, corporation, facility or institution licensed or otherwise authorized to provide health care services;
- 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, drug abuse, a non-serious mental illness condition or a serious mental illness condition; and
- A physician is not you or related to you.
Precertification or Precertify
A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

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

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

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

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

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

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](http://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 serious mental illnesses.
• Charges patients for its services.
• An institution or a distinct part of an institution that meets all of the following requirements:
  – It is licensed or approved under state or local law.
  – Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
• Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  – The Joint Commission on Accreditation of Health Care Organizations;
  – The Bureau of Hospitals of the American Osteopathic Association; or
  – The Commission on the Accreditation of Rehabilitative Facilities

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

Skilled nursing facility does not include:

• Institutions which provide only:
  – Minimal care;
  – Custodial care services;
  – Ambulatory; or
  – Part-time care services.
• Institutions which primarily provide for the care and treatment of alcoholism, drug abuse or serious mental illnesses.

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.
BENEFIT PLAN

Prepared Exclusively for
University of Pennsylvania Postdoctoral Insurance Plan

Dental Maintenance Organization (DMO)
(Managed Dental Plan)

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
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Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Colorado ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Colorado. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Colorado, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(Continued from page 2)

GR-9N-22-010-01
Orthodontics
Limited to treatment of cleft lip or cleft palate for a child under age 18

Oral Surgery – Includes local anesthesia where necessary and post-operative care
Cleft lip or cleft palate surgery for a child under age 18

**An amount to be determined which is consistent with other covered services in this section as shown in this Schedule of Benefits.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Connecticut ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Connecticut. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Connecticut, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coordination of Benefits
Getting Started - Important Terms

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

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

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

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

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

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

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

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

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

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

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

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.
When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President  
Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Florida ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other Dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Florida. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Florida, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

**Coverage for Dependent Children**
To be eligible, a dependent child must be:

- Under 19 years of age; or
- Under age 25, as long as he or she solely depends on your support*; and
  - is living in your household, or
  - is a full-time or part-time student.

*Note: Dependent child eligibility ends at the end of the calendar year in which the child reaches the age of 25. Proof of student status is required each year.

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, or whose parent is your child and is covered as a dependent under the plan.

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

Initial Enrollment in the Plan
You will be provided with plan benefit and enrollment information when you first become eligible to enroll. 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. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

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 60 days from birth.

This Schedule Applies to Services Provided by Network Providers

Primary Care Dentist Services

<table>
<thead>
<tr>
<th>Visits and Exams</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral examination (limited to total of 4 visits per year)</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency palliative treatment</td>
<td>$10</td>
</tr>
<tr>
<td>Prophylaxis (cleaning), (limited to 2 treatments per year)</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>$0</td>
</tr>
<tr>
<td>Child</td>
<td>$0</td>
</tr>
<tr>
<td>Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)</td>
<td>$0</td>
</tr>
<tr>
<td>Oral hygiene instruction</td>
<td>$0</td>
</tr>
<tr>
<td>Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)</td>
<td>$5</td>
</tr>
<tr>
<td>Pulp vitality test</td>
<td>$0</td>
</tr>
<tr>
<td>Consultation</td>
<td>$0</td>
</tr>
<tr>
<td>Diagnostic casts</td>
<td>$0</td>
</tr>
</tbody>
</table>

X-Rays and Pathology

<table>
<thead>
<tr>
<th>X-Rays and Pathology</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitewing x-rays (limited to 1 set per year)</td>
<td>$0</td>
</tr>
<tr>
<td>Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years)</td>
<td>$0</td>
</tr>
<tr>
<td>Vertical bitewing X-rays (limited to 1 set every 3 years)</td>
<td>$0</td>
</tr>
<tr>
<td>Periapical x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>Intra-oral, occlusal view, maxillary or mandibular</td>
<td>$0</td>
</tr>
<tr>
<td>Extra-oral upper or lower jaw</td>
<td>$0</td>
</tr>
<tr>
<td>Accession of oral tissue</td>
<td>$0</td>
</tr>
</tbody>
</table>

Space Maintainers - (only when needed to preserve space resulting from premature loss of primary teeth) Includes all adjustments within six months after installation

<table>
<thead>
<tr>
<th>Space Maintainers</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed</td>
<td>$75</td>
</tr>
<tr>
<td>Removable</td>
<td>$70</td>
</tr>
<tr>
<td>Recement space maintainer</td>
<td>$12</td>
</tr>
<tr>
<td>Remove fixed space maintainer (by dentist who did not place appliance)</td>
<td>$12</td>
</tr>
</tbody>
</table>
Endodontics
Pulp cap $0
Pulpotomy $22
Root canal therapy, including necessary x-rays
   Anterior $70
   Bicuspid $109

Restorations and Repairs (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.
Amalgam restoration
   1 surface $0
   2 surfaces $0
   3 surfaces $0
   4 or more surfaces $0
Resin-based composite restoration (anterior)
   1 surface $0
   2 surfaces $0
   3 surfaces $0
   4 or more surfaces or incisal angle $45
Resin-based composite crown, anterior $50
Resin-based composite restoration (posterior)
   1 surface $35
   2 surfaces $45
   3 surfaces $55
   4 or more surfaces $75
Retention pins $10
Stainless steel crowns, prefabricated, primary tooth $40
Stainless steel crowns, prefabricated, permanent tooth $50
Recementing inlays or crowns $10
Recementing bridges $15
Sedative filling $3

Inlays metallic* $195

Crowns
   Porcelain $255
   Porcelain with metal (includes abutments)* $255
   Metallic (full cast) (includes abutments)* $255
   Metallic (3/4 cast)* $255
   Cast post and core* $112
   Prefabricated post and core $74
   Core buildup including pins $80

Pontics
   Metallic (full cast)* $255
   Porcelain with metal* $255

Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.) $125

Dentures and Partialss (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)
   Complete, upper or lower $275
   Partial, upper or lower
      Resin base $275
      Cast metal base $350
   Immediate, upper or lower (does not include charge for reline) $315
   Adjust complete denture, upper or lower $10
Adjust partial denture, upper or lower & $10  
Repair broken acrylic, complete denture, upper or lower & $30  
Replace one tooth on complete denture & $20  
Repair resin denture base, cast frame, broken clasp & $35  
Replace broken tooth, partial & $35  
Add tooth to existing partial denture & $35  
Add clasp to existing partial & $40  
Replace all teeth and acrylic on cast metal framework & $100  
Rebase, complete denture, upper or lower & $100  
Rebase, partial denture, upper or lower & $100  
Reline, complete denture, upper or lower (chairside) & $45  
Reline, partial denture, upper or lower (chairside) & $45  
Reline, complete denture, upper or lower (laboratory) & $102  
Reline, partial denture, upper or lower (laboratory) & $102  
Interim partial denture, upper or lower (stayplate), anterior only & $90  
Tissue conditioning for dentures & $40  

Periodontics  
Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years) & $62  
Scaling and root planing - 1 to 3 teeth per quadrant (limited to once per site every 2 years) & $37  
Periodontal maintenance procedures following surgical therapy (limited to 2 per year) & $45  
Occlusal guard (for bruxism only), limited to 1 every 3 years & $100  

Oral Surgery - Includes local anesthetics and routine post-operative care  
Extraction - exposed root or erupted tooth & $0  
Extraction - coronal remnants - deciduous tooth uncomplicated & $0  
Surgical removal of erupted tooth & $28  
Surgical removal of impacted tooth (soft tissue) & $46  
Incision and drainage of intraoral abscess & $20  
Mobilization of erupted or malpositioned tooth to aid eruption. & $30  
Biopsy of oral tissue & $75  

Specialty Services  

Endodontics - Includes local anesthetics where necessary  
Apicoectomy/periradicular surgery  
  Anterior & $92  
  Bicuspid, first root & $92  
  Molar, first root & $90  
  Each additional root & $55  
Retrograde filling, per root & $40  
Root amputation, per root & $70  
Molar root canal therapy & $280  
Retreatment of previous root canal therapy  
  Anterior & $170  
  Bicuspid & $209  
  Molar & $380  

Oral Surgery - Includes local anesthetics where necessary and post-operative care  
Surgical removal of residual tooth roots & $25  
Frenectomy & $34  
Alveolectomy in conjunction with extractions - per quadrant & $25  
Alveolectomy not in conjunction with extractions - per quadrant & $40
Surgical removal of impacted tooth
  Partially bony $58
  Completely bony $117
  Completely bony with unusual surgical complications $117

Periodontics
Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years $133
Gingivectomy or gingivoplasty - 1-3 teeth, limited to 1 per site, every 3 years $57
Gingival flap procedure - per quadrant $134
Gingival flap procedure - 1-3 teeth one per quadrant $80
Occlusal adjustment (other than with an appliance or restoration)
  Limited $20
  Complete $80
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years $300
Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years $180
Surgical revision procedure, per tooth $120
Pedicle soft tissue graft $230
Free soft tissue graft (including donor site surgery) $245
Subepithelial connective tissue graft $138
Soft tissue allograft $275
Combined connective tissue and double pedicle graft $227
Clinical crown lengthening - hard tissue $180

Orthodontics
Orthodontic screening exam (when no Orthodontic Procedure is performed) $30
Orthodontic diagnostic records $150
Comprehensive orthodontic treatment of adolescent and adult dentition $1,945
Orthodontic retention $275

Orthodontics
Limited to treatment of cleft lip or cleft palate for a child under age 18 **

Oral Surgery – Includes local anesthesia where necessary and post-operative care
Cleft lip or cleft palate surgery for a child under age 18 **

**An amount to be determined which is consistent with other covered services in this section as shown in this Schedule of Benefits.

What The Managed Dental Plan Does Not Cover (GR.9N 28-025 01-FL)

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

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 provided by an out-of-network provider.

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.

*Dental Benefits:* Coverage will be available for up to 90 days for covered services and supplies needed for treatment of any dental condition diagnosed prior to the date coverage ends. These include services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of the 90 day period. Not included are routine services and services and supplies for orthodontic treatment.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President  
Aetna Life Insurance Company  
(A Stock Company)
The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.
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.

You may also cover as your dependent.

A reciprocal beneficiary.

You must file a notarized “Declaration of Reciprocal Beneficiary Relationship” with the Director of Health of the State of Hawaii. The Director will register the Declaration and send you a Certificate of Reciprocal Beneficiary Relationship.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Illinois ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Illinois. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Illinois, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Continuing Coverage for Dependents After Your Death (GR-9N 31-015-01 IL)
If you should die while enrolled in this plan, your dependent’s health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the When Coverage Ends section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan’s definition of “dependent”;
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent’s coverage is being continued for your dependents, a child born after your death will also be covered.
Additional Dependent Coverage Provision
If you should die while enrolled in this plan, your dependent child's coverage will be continued if your dependent child has reached the limiting age under the coverage or is not eligible for coverage under the spousal continuation privilege in this Continuation of Coverage section, upon the earliest to happen of the following:

- Failure to pay premiums when due, including any grace period;
- When coverage would terminate under the terms of the existing policy if your dependent child was still your eligible dependent;
- The date on which your dependent child first becomes, after the date of election, an insured employee under any other group health plan; or
- The expiration of 2 years from the date continuation coverage began.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, Converting to an Individual Health Insurance Policy for more information.

Continuation of Coverage For Your Former Spouse & Retired Employee's Spouse (Spousal Continuation Privilege)
If Health Expense Coverage for your dependent spouse would terminate due to dissolution of marriage, your death or retirement, your former spouse and covered dependents may continue to be covered. For purposes of this section, the term "former spouse" includes a widow or a widower, as well as a divorced spouse. It does not include a retired employee's spouse. Your former spouse or retired employee's spouse has to apply for continuation coverage and pay the initial monthly premium within 30 days of the date your former spouse or retired employee's spouse receives the notice of the right to continue, or the right to continuation of coverage is forfeited and the continuation of benefits terminated.

Premium payments must be continued. Coverage for a former spouse under age 55 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.
- 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 or employee spouse's death unless the coverage would be 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.

Coverage for a former spouse and a retired employee's spouse age 55 or older will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The date coverage would have terminated, except due to the retirement of an employee, if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage, or employee spouse's death or retirement unless the coverage would be 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.
- The date that person reaches the qualifying age or otherwise establishes Medicare eligibility.

Upon the termination of continuation coverage, the former spouse will be entitled to convert the coverage to an individual health insurance policy.
Continuation rights granted to former spouses will include eligible covered dependents covered prior to the dissolution of marriage or the death of the employee, or the retirement of the employee for a former spouse who has attained age 55.

Payment of Benefits *(GR-9N 32-025-01 IL)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. For all health coverages, benefits will be paid within 30 days following receipt of written proof to support the claim.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President  
Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Indiana ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Indiana. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Indiana, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Notice to Policyholders and Certificate Holders

Questions regarding your policy or coverage should be directed to:

Aetna Life Insurance Company
Contact Number: See your Member ID Card.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/doi.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-29-015-01)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Iowa ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Iowa. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Iowa, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Special Enrollment Periods (GR-9N-29-015-01)
If You Adopt a Child
Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan’s definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to Aetna prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent’s life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan’s definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.
Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Maine ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Maine. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Maine, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children
To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 23, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*. If he or she is unable to remain in school on a full-time basis due to a mental or physical illness or an accidental injury, coverage may continue until he or she reaches the age at which coverage for dependent children who are students would otherwise terminate. Aetna will have the right to require that the student provide written proof from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury.

* Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

When Coverage Ends for Employees (GR-9N 30-005 01 ME)
Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
Your employment stops. 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, your coverage may continue until stopped by your employer as described below:

- If you are not at work due to disease or injury, your employment may be continued until stopped by your employer, but not beyond 30 months from the start of the absence.
- If you are not at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

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

**Continuing Coverage**

If you:

- terminate employment due to a temporary lay-off; or
- lose employment due to an injury or disease that you claim to be compensable under workers' compensation;

You may continue any Health Expense Coverage (except Comprehensive Dental Expense Coverage) then in force if:

- you have been employed by your employer for at least 6 months;
- you are not eligible for Medicare;
- you are not covered for like benefits;
- you are not eligible for like benefits under any group plan;
- you are not eligible for continuation of like benefits because of any state or federal law; and
- premium payments are continued.

The coverage may be continued for you or any of your dependents who have been covered as your dependent for at least 3 months or for you and any such dependents. If a dependent has not been eligible for 3 months, the dependent must have been covered at all times while eligible.

You have to make request in writing for this continuation. This must be done within 31 days of the date coverage would otherwise cease. The request must include an agreement to pay up to 102% of the applicable group rate.

Coverage will cease on the first to occur of:

- The date you are eligible for coverage under any other group plan.
- The date you fail to make the contributions needed.
- The date the Workers' Compensation Commission determines that the disease or injury, that entitled the person to continued coverage, is not compensable.
- The end of a one year period which starts on the date coverage would otherwise cease.

Coverage of a dependent will cease earlier when the dependent ceases to be a defined dependent.

If any coverage being continued ceases because it has been continued for one year, the person may apply for a personal policy in accordance with the Conversion Privilege. If it ceases for any other reason, the Conversion Privilege is not available.

**Continuing Coverage for Dependents After Your Death**

If you should die while enrolled in this plan, your dependent’s health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the When Coverage Ends section;
• A request is made for continued coverage within 31 days after your death; and
• Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

• The end of the 12 month period following your death;
• He or she no longer meets the plan’s definition of “dependent”;
• Dependent coverage is discontinued under the group contract;
• He or she becomes eligible for comparable benefits under this or any other group plan; or
• Any required contributions stop; and
• For your spouse, the date he or she remarries.

If your dependent’s coverage is being continued for your dependents, a child born after your death will also be covered.

**Important Note**
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment (GR-GrpAppealsER-03)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Maine Appeals Procedure and External Review
Issue Date: January 19, 2016
Effective Date: This Booklet-Certificate Amendment is effective on January 1, 2016

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

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

Appeals Procedure

Definitions

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

Such adverse benefit determination may be based on:

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

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

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.
Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

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

Retrospective Claim: Any claim that is not a “Pre-Service Claim.”

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

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

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations

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

Urgent Care Claims

Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 48 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 48 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.

Pre-Service Claims

Aetna will notify you of a pre-service claim decision for non-urgent services after the claim is made as soon as possible, but not later than 2 working days after obtaining all necessary information. Aetna will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the service.
Retrospective Claims

Aetna will notify you of a retrospective claim decision after the claim is made as soon as possible, but not later than 30 calendar days after obtaining all necessary information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will notify you of a claim decision within one working day after obtaining all necessary information.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment within one working day after obtaining all necessary information.

As to medical and prescription drug claims only, if you file an appeal, coverage under the plan will continue for the previously approved 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. 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.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for one level or two levels of appeal depending upon the type of coverage provided under the Plan. As to medical and prescription drug claims only, a final adverse benefit determination notice will also provide an option to request an External Review.

You have 180 calendar days with respect to adverse benefit determinations of 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, or call in your appeal to Member Services using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.
As to medical and prescription drug claims only, 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 – Adverse Benefit Determination (Group Health Claims)**

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. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) working days of Aetna's receipt of the appeal. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to Aetna within the next 15 days.

**Urgent Care Claims**
Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

**Pre-Service Claims**
Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal or receipt of any additional information requested.

**Concurrent Care Claim Reduction or Termination**
Aetna shall issue a decision within one working day of the request for an appeal or receipt of any additional information requested.

**Retrospective Claims**
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal or receipt of any additional information requested. Aetna will notify you in writing within 5 working days after making the determination.

If Aetna's final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;
- A statement of the Committee's understanding of the Appeal; and all pertinent facts;
- The specific plan provisions upon which the decision is based;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- A description of the process to obtain a level two Appeal (including the rights; procedures; and time frames that govern such an appeal).
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process;
- Any other information required pursuant to the federal Affordable Care Act.

**Level Two Appeal - Adverse Benefit Determination (Group Health Claims)**

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level two appeal. The appeal must be submitted following the receipt of notice of a level one Appeal.
A level two Appeal of an decision involving an Urgent Care Claim, or a claim involving medical necessity; appropriateness; health care setting; level of care; or effectiveness; shall be provided by the Aetna Appeals Committee. The majority of the Committee will be made up of persons not previously involved in the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. Such person may also appear before the Committee to present information or answer questions. The Committee must include one or more clinical peer health care professionals who were not previously involved in the Appeal, who are not a subordinate of a person involved in the Appeal, and who have no financial or other personal interest in the outcome of the review. The level two Appeal decision must have the concurrence of the majority of such clinical peer health care professionals.

For a level two Appeal concerning all other appeals, the majority of the Committee will be made up of employees or representatives of Aetna who were not previously involved with the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. The person may also appear before the Committee to present information; or answer questions.

If you ask to appear in person before the Committee, the Committee will notify you in writing 15 days in advance of the hearing date. The notice will also advise you if an attorney will be present to argue Aetna's case against you. Aetna will also advise you of your right to obtain legal representation. The hearing will be held during regular business hours. If you cannot attend the hearing, you may participate by conference call; or other available technology; at Aetna's expense. You may also request that Aetna consider a postponement and rescheduling of the hearing. In addition:

- You may request Aetna to provide you with all relevant information that is not confidential or privileged.
- You may be helped or represented at the hearing by the person of your choice.
- You may submit supporting material. This may be done both before and during the hearing.
- You may ask questions of any Aetna representative.

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 a level two Appeal.

Concurrent Care Claim Reduction or Termination
Aetna shall issue a decision within one working day of the request for an appeal or receipt of any additional information requested.

Retrospective Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two Appeal.

If the decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the level one Appeal review;
- A statement of the Committee's understanding of the Appeal and all pertinent facts;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials; and
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau.

Aetna will keep the records of your complaint for 3 years.
NOTICE:

You may contact the Maine Bureau of Insurance at any time during the Appeal Process outlined above. The address is:

Maine Bureau of Insurance
Consumer Health Care Division
34 State House Station
Augusta, Maine 04333
Telephone Number: 1-800-300-5000
Web:  www.state.me.us/pfr/ins/ins_index.htm

Exhaustion of Process

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

As to medical and prescription drug claims only, 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:

As to medical and prescription drug claims only, if Aetna does not adhere to all adverse benefit determination and appeal requirements (including required timeframes for issuing decisions) of the State of Maine and 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 an 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.

### External Review

If Aetna renders a decision resulting in an Adverse Benefit Determination you may contact the Maine Bureau of Insurance to request an external review; if you or your provider disagrees with Aetna’s decision. An external review is a review by an independent external review organization, who has expertise in the problem or question involved. The Maine Bureau of Insurance oversees the external review process. It also contracts with approved independent review organizations to carry out the external review and render a decision.
To request an **External Review**, any of the following requirements must be met:

- You have received notice of the denial of a claim by an Adverse Benefit Determination from Aetna; and
- Your claim was denied because Aetna determined that the care was not **medically necessary** or was **experimental or investigational**; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal **appeal** processes.

The **adverse benefit determination** you receive from **Aetna** will describe:

- the external review process and the procedure to follow if you wish to pursue an external review;
- your right to get assistance from **Aetna** to request the external review;
- your right to attend the external review; submit; and obtain supporting material relating to the adverse decision; ask questions of any **Aetna** representative; and have outside assistance; and
- your right to seek assistance from; or file a complaint with; the Maine Bureau of Insurance (including the Bureau's address and toll-free number).

You or your authorized representative must send the request for external review in writing to the Maine Bureau of Insurance. The request must be made within 12 months of the date you received the final adverse decision letter from Aetna. You also must include: a copy of the final adverse decision letter; and all other pertinent information that supports your request. You will not be required to pay any fees.

**Expedited request for external review:** You will not be required to exhaust the applicable internal Appeals process before requesting an external review if:

- **Aetna** has failed to make a decision within the required time period; or
- You and **Aetna** agree to bypass the internal Appeals procedure; or
- Your life or health is in serious jeopardy; or
- You have died.

The Maine Bureau of Insurance will contact the external review organization that will conduct the review of your claim. The external review organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external review organization will consider how appropriate the service is based on:

- All relevant clinical information relating to your physical and mental condition;
- Any concerns you have voiced about your health status; and
- All relevant clinical standards, including but not limited to, those standards and guidelines used by Aetna.

You will be notified of the decision of the external review organization within 30 calendar days of receipt of your request form and all necessary information from the Maine Bureau of Insurance. If your condition is such that a delay would put in serious jeopardy your life or health or your ability to regain maximum function, a decision will be made no later than 72 hours after receipt of the request.

**Aetna** will abide by the decision of the External Review Organization. Aetna is responsible for paying the Maine Bureau of Insurance for the cost of the external review.

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

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

Mark T. Bertolini  
Chairman, Chief Executive Officer, and President  
Aetna Life Insurance Company  
(A Stock Company)  

Amendment: Appeals - Dental  
Issue Date: January 19, 2016
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Maryland ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Maryland. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Maryland, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

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.

A physician is not you or related to you.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Massachusetts ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Interpreter and Translation Services

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

French

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

Υπηρεσίες Μεταφράσεως

Για να λάβετε πληροφορίες σοσον αφορά τεν υπηρεσίον μας
μεταφράσεως σχετικα με την διαδικασία διοικητική, µπορείτε να
ερχοσσαίες το εκεί µε την Υπηρεσία για τα Μέλη στον αριθµό
(χρονις διοιδα) που βρίσκεσται επάνω στην εξάχρισης σας
ταυτότητας. Οι επαφέλιμωντοι υπαλλήλοι (του τιµωτος της
Αετνα να το οποίο ανασχελίκεται µε τους πελάτες) µπορούν να
χρησιµοποιούν την µεταφραστική υπηρεσία της εταιρείας AT&T.

Italian

Servizi di traduzione e di interpretariato

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

Portuguese

Serviços de Intérprete e de Tradução

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

Russian

Услуги по устному и письменному переводу

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

Spanish

Servicio de Intérprete y Traducción

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

Haitian-Creole

Sèvis intèprèt ak tradikte

Ou kapab pran kontak avèk Sèvis pou moun-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (identifikasyon)
pou ou jwenn ranséyman sou sèvis intèprèt ak tradikte konsèyan pwojè administratif. Pwofesyonnel nan sèvis
kiyàn “Aetna” gen mwayden jwenn sèvis tradiksyon nan “AT&T language line” (sèvis lang AT&T). Yon nimewo
TDD disponnib tou pou moun ki pa tande byen.
Cambodian

نهائيัญักษ์ทุกภาษา

สุ깊อดังังงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนงนง

Chinese

고려 및 변역 서비스

您可以通过拨打在您会员卡上的免费电话号码与客户服务处联系，以便获取有关实施程序的口译及笔译服务的资讯。Aetna的专
用用户服务人员使用AT&T语言专线 (AT&T Language Line) 的翻译
服务。还有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الإتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتنا

للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية

يستطيعون تلقى خدمات الترجمة عن طريق Aetna

خط اللغات لشركة AT&T

وتوفر للأعضاء أيضا رقم جهاز إتصالات الأضواء (TDD).
This Schedule Applies to Covered Expenses Provided by Out-of-Network Providers.

When dental services that are considered covered expenses and shown in the Schedule above are given by out of network Providers, the copay percent is:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Copayment Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Dentist Services</td>
<td></td>
</tr>
<tr>
<td>Type A Services</td>
<td>20%</td>
</tr>
<tr>
<td>Type B Services</td>
<td>50%</td>
</tr>
<tr>
<td>Type C Services</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist Care Dentist Services</td>
<td></td>
</tr>
<tr>
<td>Type B Services</td>
<td>50%</td>
</tr>
<tr>
<td>Type C Services</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Deductible Amount</strong></td>
<td><strong>$500.</strong></td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
</tr>
<tr>
<td>Lifetime Deductible Amount</td>
<td><strong>$1,000</strong></td>
</tr>
<tr>
<td>Orthodontic screening exam (when no Orthodontic Procedure is performed)</td>
<td>$39</td>
</tr>
<tr>
<td>Orthodontic diagnostic records</td>
<td>$195</td>
</tr>
<tr>
<td>Comprehensive orthodontic treatment of adolescent and adult dentition</td>
<td>$2,288</td>
</tr>
<tr>
<td>Orthodontic retention</td>
<td>$358</td>
</tr>
</tbody>
</table>

**When You Receive a Qualified Child Support Order (GR-9N 29-015-01 MA)**

A Qualified Medical Child Support Order (QMCSCO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent’s life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan’s definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, Aetna shall enroll such child upon application by such child’s other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.
Thirty-One Day Continuation (GR-9N 31-015-01 MA)

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to Aetna within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Michigan ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Michigan. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Michigan, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children (GR-9N 29-010-01 MI)

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 23, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

Dependent children who are full-time or part-time students may continue health coverage while taking a leave of absence from school due to illness or injury. Certification of medical necessity for a leave of absence is required from the dependent student’s attending physician. Coverage to continue for the shorter of either: 12 months from the last day of attendance from school, or until the dependent reaches the age at which coverage would otherwise terminate.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Minnesota ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Minnesota. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.

You are only entitled to these benefits, if you are a resident of Minnesota, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Orthodontic Treatment Rule

Orthodontic coverage is only for covered dependent children who are under age 19 on the date active orthodontic treatment begins.

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

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate (This exclusion does not apply to dependent children under age 19.);
- Treatment of micrognathia;
- 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”).

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Aetna Life Insurance Company
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Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: New Mexico ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of New Mexico. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of New Mexico, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children
To be eligible, a dependent child must be:

- Unmarried; and
- Under 25 years of age.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
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Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: New York ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of New York. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of New York, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Payment of Benefits (GR-9N 32:025 01 NY)

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than 45 days after receipt of such proof. Written proof must be provided for all benefits.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company  
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Ohio ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Ohio. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Ohio, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coordination Disputes (GR-9N 33-015 01 OH)
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.

Continuing Coverage for Dependents After Your Death
If you should die while enrolled in this plan, your dependent’s coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan’s definition of “dependent”;
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent’s coverage is being continued for your dependents, a child born after your death will also be covered.
Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Oregon ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Oregon. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Oregon, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents (GR-9N 029-010 02 OR)

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 outlined in the Coverage for Domestic Partner section below; and
- Your dependent children.

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

Coverage for Domestic Partner (GR-9N 029-010 02 OR)

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk; or
- complete and sign a "Declaration of Domestic Partnership" which is acceptable to your Employer.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: Washington ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Washington. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Washington, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent through marriage.
- You elect coverage for yourself and your dependent within 60 days of acquiring a dependent through birth, adoption or placement for adoption.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your policyholder. The form must be completed and returned to Aetna within 31 days of the change for the addition of a spouse, and 60 days for the addition of a dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within these timeframes, you will need to make the changes during the next open enrollment period unless you qualify for another special enrollment period.
Physician
A duly licensed member of a medical profession who:

- Has a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction within which he or she practices;
- Provides medical services which are within the scope of his or her license or certificate, and
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse’s family or your domestic partner.

Continuation of Coverage During a Labor Dispute

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to Aetna. Call the Member Services toll free number on your ID card for information on the premium payment process. Coverage may continue for up to 6 months. At the end of 6 months you will be eligible for Conversion Coverage.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by Aetna for each person’s coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

Coordination of Benefits

Benefits Subject To This Provision: This coordination of benefits (COB) provision applies to this plan when you or your covered dependent has medical, dental, vision, or hearing 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 any health care expense for any **medically necessary** health care service or supply, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the **plans** covering the person. When a **plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. **This plan** limits coordination of health care services or expenses with those services or expenses that are covered under similar types of **plans**, (for example, Medical coverage is coordinated with another Medical **plan**). An expense or service that is not covered by any of the **plans** is not an **allowable expense**. This plan does not coordinate benefits for **prescription drugs**. The following are examples of expenses and services that are not **allowable expenses**:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an **allowable expense**. This does not apply if one of the **plans** provides coverage for a private room.
2. If a person is covered by 2 or more **plans** that compute their benefit payments on the basis of **UCR charges** or relative value schedule reimbursement or other similar reimbursement method, any amount in excess of the highest of the reimbursement amount for a specified 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 negotiated charges is not an **allowable expense**.
4. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan’s deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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.** A calendar year.

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

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. In cases where a court decree awards more than half of the calendar year’s residential time to one parent without the use of “custodial” terminology, the parent to whom the greater resident time is awarded is considered the **custodial parent**.

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

- Group, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

**Plan** does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined in WAC 284-50-370;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a “to and from school” basis;
- Benefits provided in long-term care insurance policies for non medical services;
- Medicare Supplement policies;
A state plan under Medicaid;
A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan’
Benefits provided as part of a direct agreement with a direct patient-provider primary care practice’ and
Automobile insurance policies required by statute to provide medical benefits.

If the plan includes medical, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, medical coverage will be coordinated with other medical plans, and dental coverage will be coordinated with other dental plans. This plan does not coordinate coverage for prescription drugs.

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. A plan is considered the primary plan if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- 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 coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.
- 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:

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

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, covered person, 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, covered person, 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 occurs earlier in each calendar year if:
      - The parents are married or living together whether or not married;
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
      - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
        - The plan of the custodial parent;
        - The plan of the spouse of the custodial parent;
        - The plan of the non-custodial parent; and then
        - The plan of the spouse of the non-custodial parent.

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

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

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

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, covered person, or subscriber longer is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan’s benefits; a change in the entity that pays, provides, or administers the plan’s benefits; or a change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

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 plus any accrued savings.
Effect on Benefits of This Plan
In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense.

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

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

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

When a plan is the secondary plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings are recorded as a benefit reserve for the covered person and must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the issuer of the secondary plan must:

- Determine its obligation under its plan;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that claims determination period.
- Use any amount that has accrued in the covered person’s recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

Multiple Coverage Under Aetna Plans
If a person is covered under this plan and another Aetna plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

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

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

Facility of Payment
Any payment made under another plan may include an amount which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.
Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Claims, Appeals, Grievances, Independent Medical Review

Appeals Procedure
Definitions
Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Written notice of Adverse Benefit Determinations, including the reasons for the determination, will be provided to you and your provider according to the time frames given below. The notice will include information which will assist you in making an appeal if you wish to do so.

In Washington State, an adverse benefit determination is either

- an “adverse determination and non certification” which means a decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility
- a decision that a service or benefit is not covered for other reasons including, but not limited to, member not eligible for coverage at time service is provided, benefit maximums under the plan have been reached, service or supply is not covered under the plan.

Such adverse benefit determination may be based on, among other things:

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

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

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

Concurrent Care Claim Extension: A request to extend a 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” or a “Concurrent Care Claim”.

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

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

You or “the claimant”. For purposes of this amendment “you” also means “you or your attending health care provider or the facility making the claim on your behalf.

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 health care provider 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
If no additional information is required Aetna will make a claim determination as soon as possible but not later than 2 business days after the claim is made. Aetna will provide notification 2 calendar days after the pre-service claim determination is made. Aetna may determine that an extension is needed because Aetna needs additional information to make a claim determination. Aetna will notify you within 15 calendar days from receipt of a pre-service claim if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide Aetna with the required information. Aetna will make the claim determination within 2 business days of receipt of all necessary information and will provide notification to the member and the attending health care provider or ordering provider or facility within 2 calendar days of the determination.

Post-service Claims
If all information necessary to evaluate a claim is provided when the post service claim is received, Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that we need additional information in order to make a claim determination, in which case we may request an extension. 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. 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.

Concurrent Care Claim Extension
Following a request for a concurrent care claim extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, Aetna will make a determination within 14 days following a request for a concurrent care claim extension and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal, but in no event will the timeframe for the notification be longer than one day. If you choose to appeal Aetna’s determination, Aetna will continue to provide the previously approved course of treatment until the appeal is resolved, including Independent Medical Review if requested. If Aetna’s decision is affirmed then you will be responsible for the cost of the services provided after the termination date provided in the notification.
Notification of Adverse Determination and Noncertification

Notifications of claim determinations which include an **adverse determination and noncertification** will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an adverse determination and noncertification are provided to the member and the treating **health care provider** or provider or facility making the claim.

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 Aetna Member Services within 180 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 notification of receipt of your **complaint** within 5 days, and a written response within 14 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your complaint Aetna will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the complaint. Aetna will not take longer than 30 days to respond to your complaint without your written permission. The notice of the decision will tell you what you need to do to request an External Review.

Appeals of Adverse Benefit Determinations

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

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

- Your name;
- Your **policyholder**'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 Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number shown on your ID Card.

Alternatively, you may send your **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the toll-free telephone number listed on such notice.

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

Appeal – Group Health Claims

An **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**. You may request assistance making your appeal by calling the toll free Member Services number listed on your ID card. Aetna will send you notification that your appeal has been received.

**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 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the appeal. You will be notified within the initial 14 day period if additional information is necessary. Aetna will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the appeal period. For appeals of claims decisions based on the determination that the requested treatment, service or supply is **experimental or investigational**, Aetna will issue a decision within 20 working days.
Post-Service Claims
Aetna shall issue a decision within 14 calendar days of receipt of the request for an appeal unless additional information is necessary to complete review of the appeal. You will be notified within the initial 14 day period if additional information is necessary. Aetna will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the appeal period.

Exhaustion of Process
You are encouraged to exhaust the applicable process of the Appeal Procedure before you:

- Contact the Office of the Insurance Commissioner to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Office of the Insurance Commissioner; or
- Establish any:
  - Litigation; or
  - 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.

External Review Group Health Claims
If you do not agree with Aetna's decision of your appeal, or if Aetna takes longer than 30 days from the date of receipt of your appeal to reach a decision without your written consent, you or your provider may request an independent external review. An external review is a review by an External Review Organization, who assigns a reviewer with expertise in the problem or question involved to review your request and reach an independent decision.

The appeal denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 180 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization, according to the requirements of Washington Law, that will conduct the review of your claim and not later than the third business day after the date we receive your request for external review, will forward the required documents, including the material you sent to us to the External Review Organization. You may request a copy of the material we send, and we may request a copy of any additional material you or your treating provider send to the External Review Organization. The External Review Organization will select an independent physician or contract specialist with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your health care provider certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the External Review Organization.
Aetna is responsible for the cost of sending the information that was used to make the initial determination and the claim determination, and any information from you or your provider to the External Review Organization and for the cost of the external review. You are responsible for the cost of compiling and sending the information, other than medical records, that you wish to be reviewed by the External Review Organization to Aetna.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President  

Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.: GP-861472
Rider: West Virginia ET Dental
Issue Date: January 19, 2016
Effective Date: January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of West Virginia. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of West Virginia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children
To be eligible, a dependent child must be:

- Unmarried; and
- Under 25 years of age.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: University of Pennsylvania Postdoctoral Insurance Plan
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Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Wisconsin. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.

You are only entitled to these benefits, if you are a resident of Wisconsin, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Benefits payable under this Booklet-Certificate are primarily based on recognized charges or scheduled benefits which may be less than the actual charge.

For benefit information questions, please contact:
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use Aetna’s toll free customer service number found on your ID card or visit Aetna’s website at www.Aetna.com.

Coverage for Dependent Children
To be eligible, a dependent child must be under 27 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, or whose parent is your child and is covered as a dependent under the plan.
Coverage for a handicapped child may be continued past the age limits shown above. See Handicapped Dependent Children for more information.

**Important Reminder**

Keep in mind that you cannot receive coverage under the plan as:
- Both an employee and a dependent; or
- A dependent of more than one employee.

**Coverage for your Dependent Child Returning from Military Duty**

You may cover your dependent child if he or she returns from active military duty, and he or she:

- is a full-time student attending an accredited institution of higher education,* and
- while a full-time student attending an accredited institution of higher education,* prior to reaching age 27, was called up to active military duty in the National Guard or in a reserve component of the United States armed forces.

If the dependent child over age 27 does not re-enroll in an accredited institution of higher education as a full-time student* within 12 months of the date of his or her return from active military duty, coverage may be terminated. If he or she is called back to active duty more than once within four years following the first call to active duty, the insurer may only use the dependent child’s age at the time of the first call to active duty when determining eligibility.

**Note**

Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 15 credits or is enrolled as a graduate student with a total course load of at least nine credits.

**Special Enrollment Periods GR-9N-29.015-02 WTJ**

**If You Adopt a Child**

Your plan will cover a child who is placed for adoption. ("Placed for adoption" means any of the following: 1) the department, a county department or a child welfare agency licensed under the Wisconsin Code places a child in the insured's home for adoption and enters into an agreement under the Code with the insured; 2) a court under the Wisconsin Code orders a child placed in the insured's home for adoption; 3) a sending agency as defined in the Wisconsin Code places a child in the insured's home for adoption, and the insured takes physical custody of the child at any location within the United States; 4) the person bringing the child into this state has complied with the Wisconsin code, and the insured takes physical custody of the child at any location within the United States; or 5) a court of a foreign jurisdiction appoints the insured as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the insured's home for the purpose of adoption by the insured under the Wisconsin Code.)

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan’s definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to Aetna prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.
When You Receive a Qualified Child Support Order
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent’s life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan’s definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Continuing Coverage for Dependents After Your Death
If you should die while enrolled in this plan, your dependent's health care coverage, if applicable will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 30 days after receiving notice of the right to continue coverage; and
- Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

- The end of the 18 month period following your death;
- He or she no longer meets the plan’s definition of "dependent;"
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent’s coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, Converting to an Individual Health Insurance Policy for more information.

Continuing Coverage Full-time Student on Medical Leave (GR-9N-31-015-03 WI)
You may continue health care benefits for a full-time student dependent child, if coverage ends due to a medically necessary leave of absence.

A full-time student is only entitled to continue coverage if he or she submits to Aetna documentation and certification of the medical necessity of the leave of absence from the full-time student’s attending physician. The date on which the full-time student ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which the coverage continuation begins.
Your full-time student dependent child’s coverage will end when the first of the following occurs:

- Does not intend to return to school full-time.
- Becomes employed full-time.
- Becomes eligible for comparable benefits under this or any other group plan.
- Marries and is eligible for coverage under his or her spouse’s health care coverage.
- Ceases to be defined as a full-time student.
- Full-time student coverage ceases under this Plan.
- One year has elapsed since the full-time student’s coverage continuation began and the full-time student has not returned to school full-time.

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Chairman, Chief Executive Officer and President

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