

BENEFIT PLAN

Prepared Exclusively For
KIPP New Jersey

Passive PPO Dental - Low Option

Aetna Life Insurance Company
Booklet-Certificate

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

What Your Plan
Covers and How
Benefits are Paid

aetnaSM

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.

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

Preface (GR-9N-02-005-02 NJ)

Aetna is pleased to provide you with this *Booklet-Certificate*. Your *Booklet-Certificate* (which includes the *Schedule of Benefits* and any amendments or riders), describes what the plan covers and how benefits are paid for that coverage.

The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* (certificate) under the group policy issued as follows:

Group Policyholder:	KIPP New Jersey
Group Policy Number:	GP-848021
Effective Date:	July 1, 2018
Issue Date:	July 15, 2018
Booklet-Certificate Number:	5

This certificate supersedes all certificates describing similar coverage that **Aetna** previously issued to you. This certificate is subject to the laws of the State of New Jersey.

Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156



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 NJ)

No benefits are covered under this *Booklet-Certificate* in the absence of payment of current premiums by the Group Policyholder subject to the *Grace Period* provision 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.

Except as provided for under the sections *Termination of Coverage (Extension of Benefits)* and *Continuation of Coverage*, 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.

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* if the service or supply is furnished on or after the effective date of the plan modification.

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

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

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.

Only **non-occupational injuries** and **non-occupational illnesses** are covered. Conditions that are related to the complications of pregnancy will be covered under this plan.

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 NJ)

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

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

Who Can Be Covered

Employees

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

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

Determining if You Are in an Eligible Class

You are in an eligible class if:

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

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)

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

- Your legal spouse/**civil union partner**; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; 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)

You may also cover as your dependent a person who is your domestic partner if you and your partner have jointly executed and filed an Affidavit of Domestic Partnership with the local registrar and have been issued a copy of the Affidavit marked "filed".

A domestic partnership shall be established when all of the following requirements are met:

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
 - (a) a joint deed, mortgage agreement or lease;
 - (b) a joint bank account;
 - (c) designation of one of the persons as a primary beneficiary in the other person's will;
 - (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) joint ownership of a motor vehicle;
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older may establish a domestic partnership if they meet the requirements set forth in this section;
- (6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- (7) Both persons file jointly an Affidavit of Domestic Partnership; and
- (8) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died.

Those same-sex relationships entered into outside the State of New Jersey that most closely approximate New Jersey domestic partnerships that is, relationships that provide some, but not all of the rights and obligations of marriage will be treated as domestic partnerships under New Jersey law.

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Under 26 years of age.
- Newborn children from the moment of birth; however if payment of premium is required to provide coverage for the newborn child, **Aetna** may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

An eligible dependent child includes:

- Your biological children;
- Children of **civil union partners**;
- Children of domestic partners;
- 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-29-025-02 NJ)

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.

Dependents' coverage will be effective:

- In the case of marriage, on the date of the marriage;
- In the case of civil union, on the date of the civil union;
- In the case of a newborn, on the date of birth;
- In the case of adoption, on the date of the child's adoption or placement for adoption;
- In the case of court ordered coverage of a spouse/**civil union partner** or child, on the date specified in the court order;
- In the case of loss of COBRA coverage under another plan, on the date the COBRA coverage ends; and
- In the case of loss of coverage for other reasons, the date on which the applicable life event occurs.

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

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.

(GR-9N-27-005-01 NJ)

3. The service or supply must be **medically necessary**. To meet this requirement, the dental services, 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)

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

Understanding Your Aetna Dental Plan

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

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

Important Notes:

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

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

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

Getting Started: Common Terms (GR-9N S 16-010-01)

Many terms throughout this Booklet-Certificate are defined in the *Glossary* Section at the back of this Booklet-Certificate. 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 PPO Dental Plan (GR-9N S 16-025-01)

The plan is a Preferred **Provider** Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more if you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice Is Yours

You have a choice each time you need dental care:

Using Network Providers

- Your out-of-pocket expenses will be lower when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge**. Your **coinsurance** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of-pocket expenses when the plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **deductibles, coinsurance and copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, copayment, coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

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.

Using Out-of-Network Providers

- You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.
- You must satisfy a **deductible** before the plan begins to pay benefits.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).
- If the **dental provider** you select charges more than the **recognized charge**, you must also pay any expenses above the **recognized charge**. That excess amount does not apply toward your **coinsurance** or out-of-pocket **limit**.
- You must file a claim to receive reimbursement from the plan.

Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductibles, copayments, coinsurance** and maximums that apply.

Getting an Advance Claim Review (GR-9N-16-035-01 NJ)

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$350. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See *Benefits When Alternate Procedures Are Available* for more information on alternate dental procedures.)

What is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

What The Plan Covers (GR-9N-S-18-005-01 NJ)

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

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

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

The next sentence applies if:

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

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

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

PPO Dental Expense Coverage Plan (GR-9N 18-006-01)

(GR-9N 18-006-01)

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 planning, (4 or more teeth); per quadrant;
- Scaling and root planning (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year).

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **payment percentage** applied to the other covered dental expenses above will be 100% for **network** expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Plan Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder (GR-9N-18-010-01 NJ)

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

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

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays

Office visit during regular office hours, for oral examination

Routine comprehensive or recall examination (limited to 2 visits every year)

Problem-focused examination (limited to 2 visits every year)

Prophylaxis (cleaning) (limited to 2 treatments per year)

Adult

Child

Topical application of fluoride, (limited to one course of treatment per year and to children under age 16)

Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)

Bitewing X-rays (limited to 1 set per year)

Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)

Vertical bitewing X-rays (limited to 1 set every 3 years)

Periapical x-rays (single films up to 13)

Space Maintainers Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)

Fixed (unilateral or bilateral)

Removable (unilateral or bilateral)

Type B Expenses: Basic Restorative Care

Visits and X-Rays

Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

Emergency palliative treatment, per visit

X-Ray and Pathology

Intra-oral, occlusal view, maxillary or mandibular

Upper or lower jaw, extra-oral

Biopsy and histopathologic examination of oral tissue

Oral Surgery

Extractions

Erupted tooth or exposed root

Coronal remnants

Surgical removal of erupted tooth/root tip

Impacted Teeth

Removal of tooth (soft tissue)

Odontogenic Cysts and Neoplasms

Incision and drainage of abscess

Removal of odontogenic cyst or tumor

Other Surgical Procedures

Alveoplasty, in conjunction with extractions - per quadrant

Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant

Alveoplasty, not in conjunction with extraction - per quadrant

Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant

Sialolithotomy: removal of salivary calculus

Closure of salivary fistula

Excision of hyperplastic tissue

Removal of exostosis

Transplantation of tooth or tooth bud

Closure of oral fistula of maxillary sinus

Sequestrectomy

- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.
(Multiple restorations in 1 surface will be considered as a single restoration.)

Amalgam restorations

Resin-based composite restorations (other than for molars)

Pins

- Pin retention—per tooth, in addition to amalgam or resin restoration

Crowns (when tooth cannot be restored with a filling material)

- Prefabricated stainless steel

- Prefabricated resin crown (excluding temporary crowns)

Recementation

- Inlay

- Crown

- Bridge

Type C Expenses: Major Restorative Care

Oral Surgery

Surgical removal of impacted teeth

- Removal of tooth (partially bony)

- Removal of tooth (completely bony)

Periodontics

Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years

Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years

Soft tissue graft procedures

Clinical crown lengthening, hard tissue

Full mouth debridement, limited to 1 per lifetime

Occlusal adjustment (other than with an appliance or by restoration)

Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)

Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)

Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)

Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years

Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)

Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)

Periodontal maintenance procedures following active therapy (limited to 2 per year)

Localized delivery of antimicrobial agents

Endodontics

Pulp capping

Pulpotomy

Apexification/recalcification

Apicoectomy

Root canal therapy including necessary X-rays

- Anterior

- Bicuspid

- Molar

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 8 years- see *Replacement Rule*).

Inlays/Onlays

Labial Veneers

- Laminate-chairside

- Resin laminate – laboratory

- Porcelain laminate – laboratory

Crowns

- Resin

- Resin with noble metal

- Resin with base metal

- Porcelain/ceramic substrate

- Porcelain with noble metal

- Porcelain with base metal

- Base metal (full cast)

- Noble metal (full cast)

- 3/4 cast metallic or porcelain/ceramic

Post and core

Core build up, including any pins

Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See *Replacement Rule*.)

Bridge Abutments (See Inlays and Crowns)

Pontics

- Base metal (full cast)

- Noble metal (full cast)

- Porcelain with noble metal

- Porcelain with base metal

- Resin with noble metal

- Resin with base metal

Removable Bridge (unilateral)

- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation.

Specialized techniques and characterizations are not eligible.)

- Complete upper denture

- Complete lower denture

- Partial upper or lower, resin base (including any conventional clasps, rests and teeth)

- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)

- Stress breakers

- Interim partial denture (stayplate), anterior only

- Office reline

- Laboratory reline

- Special tissue conditioning, per denture

- Rebase, per denture

- Adjustment to denture more than 6 months after installation

Full and partial denture repairs

- Broken dentures, no teeth involved

- Repair cast framework

- Replacing missing or broken teeth, each tooth

Adding teeth to existing partial denture

Each tooth

Each clasp

Repairs: crowns and bridges

Occlusal guard (for bruxism only), limited to 1 every 3 years

General Anesthesia and Intravenous Sedation (only when **medically necessary** and only when provided in conjunction with a covered surgical procedure)

Reduced Fee Services

Other dental services are available at reduced fees from your **network provider**. These dental services are not **covered expenses** under this Plan. Ask your **network provider** for the appropriate fees for the services you need. You must pay the full reduced fee for these services directly to the **dentist**.

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

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.

Replacement Rule (GR-9N-S-20-010-03 NJ)

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 8 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 partial denture installed during the prior 8 years. The extraction of a third molar does not qualify. Any such appliance must include the replacement of an extracted tooth or teeth.
- The tooth that was removed was not an abutment to a fixed partial denture installed during the prior 8 years. The extraction of a third molar does not qualify. Any such 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-S-20-020-03 NJ)*

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-S-20-025-01 NJ)*

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 PPO Dental Plan Does Not Cover (GR-9N-28-015-01-NJ)(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 (except coverage will be provided for covered newborns from the moment of birth for the **medically necessary** care and treatment of medically diagnosed congenital defects and birth abnormalities), personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

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

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

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth; and
- Cleaning of teeth.

Treatment of malignancies, cysts and neoplasm.

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

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

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

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

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

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

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

Examinations:

- Any dental examinations:
 - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;

- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

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

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

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

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

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical 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, except as described in the *Extension of Benefits* and *A Totally Disabled Employee's Right to Continue Health Benefits* section of the Booklet-Certificate. This will be either the end of the month, end of the month following the month in which you stop active work, or the day before the first premium due date that occurs after you stop active work, whichever occurs first. The premium due date is the 30th day of the calendar month. The policyholder or the policyholder's authorized representative must remit premiums for your continued coverage to **Aetna** by the end of the grace period. However, if you make premium payments or premium payments are made on your behalf, **Aetna** will consider 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.

If you are totally disabled you shall be entitled to continue your health insurance in accordance with the *Extension of Benefits* and *A Totally Disabled Employee's Right To Continue Health Benefits* sections.

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-30-015-03 NJ)

Coverage for your dependents will end if:

- The date you are no longer eligible for dependents' coverage;
- The date you do not make the required contribution toward the cost of dependents' coverage;
- The date your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (other than exhaustion of your overall maximum lifetime benefit, if included);
- When your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent.

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 with 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 your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

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

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

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

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 NJ)

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

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of an intellectual disability 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, as stated in the "When Coverage Ends for Dependents" section, 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-31-020-03 NJ)

Coverage for Health Benefits

If your health benefits end while you are totally disabled due to discontinuance of the health policy, 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 for which you are reasonably fitted by education, training and experience.
- 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-31-020-03 NJ)

(GR-9N-31-020-03 NJ)

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 (GR-9N-31-025-02 NJ)

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.

You and your covered dependents may be eligible to continue group health benefits under the COBRA Continuation of Coverage section and under other continuation sections of the plan at the same time. If an individual is eligible to continue group health benefits under both the plan's COBRA Continuation of Coverage section and certain other continuation provisions of the plan, your rights to elect continuation and the benefits provided may be affected.

Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify the individual for continuation under this section, is covered for group health benefits under the Contract as:

- an active, covered employee;
- the spouse of an active, covered employee; or
- the dependent child of an active, covered employee. Except as stated below, any person who becomes covered under the plan during a continuation provided by this section is not a Qualified Continuee.

Exceptions:

- A child who is born to the covered employee, or who is placed for adoption with the covered employee during the continuation provided by this section is a Qualified Continuee.
- If you are a civil union partner, who is eligible for COBRA continuation of coverage you may elect COBRA continuation of coverage for you and your eligible dependents, including a civil union partner. However, an eligible dependent who is a **civil union partner**, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a “qualified beneficiary” under COBRA rules.

If An Employee's Group Health Benefits Ends

If your group health benefits end due to termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, unless you were terminated due to gross misconduct.

A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:

- is covered under another group plan on or before the date of the COBRA election; or
- is entitled to Medicare on or before the date of the COBRA election.

The continuation:

1. may cover you and any other Qualified Continuee; and
2. is subject to the When Continuation Ends section.

Additional Continuation for Disabled Qualified Continuees

If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date their group health benefits would otherwise end due to the employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, the individual and any Qualified Continuee who is not disabled may elect to extend their 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the employer written proof of Social Security's determination of his or her disability before the earlier of:

- the end of the 18 month continuation period; and
- 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, the individual must notify the employer within 30 days of such determination, and continuation will end, as outlined in the When Continuation Ends section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the employer during this extra 11 month continuation period.

If An Employee Dies While Covered

If an employee dies while covered, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the plan, other than the employee's coverage ending, they may elect to continue such benefits. However, such dependent child must be a Qualified Continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

Concurrent Continuations

If a dependent elects to continue group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

- the dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
- the employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule

Except as stated below, the "special rule" applies to dependents of an employee when the employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a dependent upon the employee's subsequent termination of employment or reduction in work hours will be the longer of the following:

- 18 months from the date of the employee's termination of employment or reduction in work hours; or
- 36 months from the date of the employee's earlier entitlement to Medicare.

Exception: If the employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the employer, in writing, of:

- the legal divorce or legal separation of the Employee from his or her spouse; or
- the loss of dependent eligibility, as defined in the plan, of a covered dependent child.

Such notice must be given to the employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the Qualified Continuee, in writing, of:

- his or her right to continue the plan's group health benefits;
- the monthly premium the individual must pay to continue such benefits; and
- the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:

- the date a Qualified Continuee's group health benefits would otherwise end due to the employee's death or the employee's termination of employment or reduction of work hours; or
- the date a Qualified Continuee notifies the employer, in writing, of the employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered dependent child.

The Employer's Liability

The employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, **Aetna**, if:

- the employer fails to remit a Qualified Continuee's timely premium payment to **Aetna** on time, thereby causing the Qualified Continuee's continued group health benefits to end;
- the employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation

To continue health benefits, the Qualified Continuee must give the employer written notice that they elect to continue coverage. An election by a minor dependent child can be made by the dependent child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed covered under the plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the employer.

If the Qualified Continuee fails to give the employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

- a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
- b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer or **Aetna**.

When Continuation Ends

A Qualified Continuee's continued group health benefits end on the first of the following:

- with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
 - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
 - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- with respect to continuation upon the Employee's death, the employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- with respect to a dependent whose continuation is extended due to the employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- the date the plan ends;
- the end of the period for which the last premium payment is made;
- the date the individual becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of Creditable Coverage;
- the date the individual becomes entitled to Medicare;
- termination of a Qualified Continuee for cause on the same basis that the employer terminates coverage of an active employee for cause.

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

Getting Started - Important
Terms

Which Plan Pays First

How Coordination of Benefits
Works

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan 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 the charge for any health care service, supply or other item of expense for which the person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When **This Plan** is coordinating benefits with a Plan that provides benefits only for dental care, vision care, **prescription drugs** or hearing aids, **Allowable Expense** is limited to like items of expense.

Aetna will not consider the difference between the cost of a private **Hospital** room and that of a semi-private **Hospital** room as an **Allowable Expense** unless the **stay** in a private room is **Medically Necessary**.

When **This Plan** is coordinating benefits with a **Plan** that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

"Claim Determination Period" means a calendar year or portion of a calendar year, during which a person is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense(s)** under such **Plans**.

“Coordination of Benefits (COB)” means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

"**Plan(s)**" means coverage with which **COB** is allowed. **Plan** includes:

- i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- iii. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- iv. Group **hospital** indemnity benefit amounts that exceed \$150 per day;
- v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

"**Plan(s)**" shall not include:

- i. Individual or family insurance contracts or subscriber contracts;
- ii. Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;
- iii. Group or group-type coverage where the cost of the coverage is paid solely by the Member except when coverage is being continued pursuant to Federal or State continuation law;
- iv. Group **hospital** indemnity benefit amounts of \$150.00 per day or less;
- v. School accident-type coverage;
- vi. A State plan under Medicaid.

"**This Plan**" is the part of this Certificate that provides benefits for health care expenses.

"**Primary Plan(s)**" means a **Plan** whose benefits for a person's health care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A **Plan** will be the **Primary Plan** if:

- i. the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this Certificate; or
- ii. all **Plans** which cover the person use order of benefit determination rules consistent with those contained in this Certificate and under those rules, the Plan determines its benefit first.

"**Reasonable Charge**" means an amount this is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a provider within the same geographic area.

"**Secondary Plan(s)**" means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this COB section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this Certificate, has its benefits determined before those of that **Secondary Plan**.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered one **plan**.

Primary and Secondary Plan:

This **Plan** considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

Secondary Plan takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determines the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more than it would have paid if it had been the **Primary Plan**. The method the **Secondary Plan** uses to determine the amount to pay is set forth below in the “Procedures to be followed by the **Secondary Plan** to Calculate Benefits” section.

Which Plan Pays First

Rules for the Order of Benefit Determination:

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree shall be determined before those of the **Plan** that covers the person as a dependent. The coverage as an employee, member, subscriber or retiree is the **Primary Plan**.

The benefits of the **Plan** that covers the person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the **Plan** that covers the person as a laid off or retired employee, or as such a person’s dependent. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the **Plan** that covers the person under a right of continuation pursuant to Federal or State law. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are neither separated nor divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
- ii. If both parents have the same birthday, the benefits of the **Plan** which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
- iii. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- iv. If the other **Plan** contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are separated or divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent with custody of the child shall be determined first.
- ii. The benefits of the **Plan** of the spouse/**civil union partner** of the parent with custody shall be determined second.
- iii. The benefits of the **Plan** of the parent without custody shall be determined last.
- iv. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that **Plan** has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the **Plan** of the other parent shall be considered as secondary. Until the entity providing coverage under the **Plan** has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which **Plan** is the **Primary Plan**, the benefits of the **Plan** that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the **Plans** that covered the person for a shorter period of time.

How Coordination of Benefits Works

Procedures to be followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

- i. the basis on which the **Primary Plan** and the **Secondary Plan** pay benefits; and
- ii. whether the provider who provides or arranges the services and supplies is in the network of either the **Primary Plan** or the **Secondary Plan**.

Benefits may be based on the **Reasonable Charge**, or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the bill charge. In this section, “**Reasonable Charge Plan**” means a plan that bases benefits on a Reasonable Charge.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a “**Network Provider**”, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, “Fee Schedule Plan(s)” means a **Plan** that bases benefits on a negotiated fee schedule. If the covered person uses the services of a **non-network provider**, the **Plan** will be treated as a **Reasonable Charge Plan** even though the **Plan** under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means an HMO or other plan pays the **Network Provider** a fixed amount per covered person. The covered person is liable only for the applicable **deductible**, **coinsurance** or **copayment**. If the covered person uses the services of a **non-network provider**, an HMO or other plan will only pay benefits in the event of emergency care or **urgent care**. In this section, “Capitation Plan” means a **Plan** that pays **Network Providers** based upon capitation.

Primary and Secondary Plans are Fee Schedule Plans

If the provider is a **Network Provider** in both the **Primary Plan** and the **Secondary Plan**, the **Allowable Expense** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

- i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The total amount the provider receives from the **Primary Plan**, the **Secondary Plan** and the covered person shall not exceed the fee schedule of the **Primary Plan**. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

Primary Plan is Reasonable Charge Plan and Secondary Plan is Fee Schedule Plan

If the provider is a **Network Provider** in the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

- i. the difference between the amount of the billed charges for the **Allowable Charges** and the amount paid by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The covered person shall only be liable for the **deductible**, **coinsurance** or **copayment** under the **Secondary Plan** if the covered person has no liability for **deductible**, **coinsurance** or **copayment** under the **Primary Plan** and the total payments by both the **Primary Plan** and the **Secondary Plan** are less than the providers billed charges. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan

If the provider is a **Network Provider** in the **Primary Plan**, the **Allowable Expense** considered by the **Secondary Plan** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

- i. the amount of any **deductible, coinsurance or copayment** required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan or Fee Schedule Plan

If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of **urgent care** or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as **urgent care** or emergency care, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Recognized Charge Plan

If the covered person receives services or supplies from a provider who is a **Network Provider** of both the **Primary Plan** and the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

- i. the amount of any **deductible, coinsurance or copayment** required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Capitation Plan or Fee Schedule Plan or Recognized Charge Plan and Secondary Plan is Capitation Plan

If the covered person receives services or supplies from a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall be liable to pay the capitation to the **Network Provider** and shall not be liable to pay the **deductible, coinsurance or copayment** imposed by the **Primary Plan**. The covered person shall not be liable to pay any **deductible, coinsurance or copayment** of either the **Primary Plan** or the **Secondary Plan**.

Primary Plan is an HMO and Secondary Plan is an HMO

If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of urgent or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary and Secondary Plans are Reasonable Charge Plans

The **Secondary Plan** shall pay the lesser of:

- i. the difference between the amount of the billed charges and the amount paid by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

When the benefits of the **Secondary Plan** are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the **Plan**.

Effects of Automobile Plans for Automobile Related Injuries

This section will be used to determine a **covered person's** benefits under this **Plan** when expenses are incurred as a result of an automobile related **injury**.

Definitions

"**Automobile Related Injury**" means bodily **Injury** sustained by a **covered person** as a result of an accident:

- a) while occupying, entering, leaving or using an automobile; or
- b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"**Allowable Expense**" means a **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:

- a) the **Policy**;
- b) **PIP**; or
- c) **OSAIC**.

"**Eligible Expense**" means that portion of expense incurred for treatment of an **injury** which is covered under this **Plan** without application of Cash **Deductibles** and **Copayments**, if any or **Coinsurance**.

"**Out-of-State Automobile Insurance Coverage**" or "**OSAIC**" means any coverage for medical expenses under an automobile insurance policy other than **PIP**. **OSAIC** includes automobile insurance policies issued in another state or jurisdiction.

"**PIP**" means personal **injury** protection coverage provided as part of an automobile insurance policy issued in New Jersey. **PIP** refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The **Policy** provides secondary coverage to **PIP** unless health coverage has been elected as primary coverage by or for the **covered person** under this **Plan**. This election is made by the named insured under a **PIP** policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. The **Policy** may be primary for one **covered person** but not for another if the person has separate automobile policies and has made different selections regarding primary of health coverage.

The **Policy** is secondary to **OSAIC** unless the **OSAIC** contains provisions which make it secondary or excess to the policyholder's plan. In that case this **Plan** will be primary.

If there is a dispute as to which **policy** is primary, this **Plan** will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC

If this **Plan** is primary to **PIP** or **OSAIC** it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this **Plan** will apply if:

- a) the **Covered Person** is insured under more than one insurance plan; and
- b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if secondary to PIP or OSAIC

If this **Plan** is secondary to **PIP** or **OSAIC** the actual benefits payable will be the lesser of:

- a) the allowable expenses left uncovered after **PIP** or **OSAIC** has provided coverage after applying Cash **Deductibles** and **Copayments**, or
- b) the benefits that would have been paid if this **Plan** had been primary.

Medicare

If this **Plan** supplements coverage under **Medicare** it can be primary to automobile insurance only to the extent that **Medicare** is primary to automobile insurance.

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

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

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

You are eligible for **Medicare**:

- by reason of age, disability; or
- End Stage Renal Disease.

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

When a Covered Person Becomes Eligible for Medicare.

The plan is the **Primary Plan** when your coverage for the **plan's** benefits is based on current employment with your employer. The **plan** will act as the **Primary Plan** 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 Plan** in all other circumstances. Benefits will be payable in accordance with the *Rules for the Order of Benefits Determination* within this Coordination of Benefits section.

If **Medicare** is the **Primary Plan** and if **This Plan** is the **Secondary Plan**, and you are eligible for **Medicare** but refuse it, drop it, or fail to make proper request for it, **Aetna** will estimate the **Medicare** payment as if you were covered by **Medicare**, and as if **Medicare** was the **Primary Plan** and **Aetna** will pay as if it was the **Secondary Plan**.

How Coordination With Medicare Works

The **plan** pays benefits first when it is the **Primary Plan**. You may then submit your claim to **Medicare** for consideration. When **Medicare** is the Primary Plan, you must first submit your health care expenses to **Medicare**. You may then submit the expense to **Aetna** for consideration.

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.

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

Type of Coverage

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

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you. **Aetna** will also have the right and opportunity to make an autopsy, in case of death, where it is not prohibited by law.

Legal Action

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage:

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

Assignments (GR-9N-32-005-05-NJ)

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

When a covered person submits a claim and they assign their right to receive reimbursement for covered **Medically Necessary** services to an out of network provider, **Aetna** is required to pay benefits in line with the assignment of benefits by remitting payment directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as a joint payee, with signature lines for each of the payees.

Any payment made solely to the covered person rather than the health care provider under these circumstance shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

All coverage may be assigned only with the written consent of **Aetna**.

Misstatements

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

Incontestability

As to Accident and Health Benefits:

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

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

Recovery of Overpayments (GR-9N-32-015-01 NJ)

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; within the following guidelines:

- 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.

With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, **Aetna** will not seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. **Aetna** will not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, **Aetna** will provide written documentation that identifies the error made in the processing or payment of the claim that justifies the reimbursement request. **Aetna** will not base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

- (a) in judicial or quasi-judicial proceedings, including arbitration;
- (b) in administrative proceedings;
- (c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
- (d) in which there is clear evidence of fraud by the health care provider and **Aetna** has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

In seeking reimbursement for the overpayment from the health care provider, except in cases where the overpayment to the health care provider is a result of fraud, **Aetna** shall not collect or attempt to collect:

- (i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
- (ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal are exhausted; or
- (iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

Aetna may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal have been exhausted if **Aetna** submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile your bill.

If **Aetna** has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, **Aetna** may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

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 NJ)

Written notice of **illness** or of **injury** must be submitted to **Aetna** within 20 days after the date in which the **illness** or **injury** occurred. Any necessary claim forms required for filing a claim will be furnished by **Aetna** upon receipt of written request. Failure to give notice of loss shall not invalidate nor reduce any claim if notice was given as soon as reasonably possible. Written proof of loss must be furnished to **Aetna** within 90 days after the date of such loss. If the person making claim does not receive the requested claim forms before the expiration of 15 days after **Aetna** receives notice of any claim, the person making such claim shall be deemed to have complied with the requirements of the plan as to proof of loss upon submitting within the time fixed within the plan for filing proof of loss, written proof covering the **occurrence**, character and extent of the loss for which claim is made.

Accident and Health expense insurance claims filed by a provider on behalf of you, the provider shall file with us the claim within 60 days of the last date of service or course of treatment. For **Accident** and Health expense insurance claims in which you have assigned your benefits to the provider, the provider shall file the claim within 180 days of the last date of service of a course of treatment. In the event the **provider** does not file the claim within 180 days of the last date of service of a course of treatment, **Aetna** reserves the right to deny or dispute the claim and the **provider** shall be prohibited from seeking payment in whole or in part directly from the member covered person.

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. Failure to furnish such proof within such time shall not reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

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

Health

- (1) Upon satisfactory proof of loss, **Aetna** will remit payment for claims submitted by you or your health care provider for **covered expenses** no later than 30 calendar days following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim is submitted by other than electronic means, if:
 - a) the health care provider is eligible at the date of service;
 - b) the person who received the health care service was covered on the date of service;
 - c) the claim is for a service or supply covered under this policy;
 - d) the claim is submitted with all the information requested by **Aetna** on the claim form or in other instructions that were distributed in advance to the provider or member in accordance with New Jersey laws; and
 - e) **Aetna** has no reason to believe that the claim has been submitted fraudulently.
- (2) If all or a portion of the claim is not paid within the timeframes provide above because:
 - a) The claim submission is incomplete because the required substantiating documentation has not been submitted to **Aetna**;
 - b) The diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
 - c) **Aetna** disputes the amount claimed; or
 - d) There is strong evidence of fraud by the provider and **Aetna** has initiated an investigation into the suspected fraud, **Aetna** shall notify the provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
 - i) The claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
 - ii) The claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;

- iii) **Aetna** disputes the amount claimed in whole or in part with a statement as to the basis of what dispute;
or
 - iv) **Aetna** finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with **Aetna's** fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.
- (3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, **Aetna** shall electronically notify the provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.
 - (4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by **Aetna** in accordance with the time limit established in paragraph (1) of this subsection.
 - (5) **Aetna** shall acknowledge receipt of a claim submitted by electronic means from a health care provider no later than two working days following receipt of the transmission of the claim.
 - (6) If **Aetna** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.
 - (7) Payment of an eligible claim pursuant to paragraphs (1) and (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by **Aetna** of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by **Aetna** of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to paragraph (2) or (3) of this subsection and the covered person and the provider are not notified within the time frames provided for in those paragraphs, the claim shall be deemed to be overdue.

Any overdue payment shall bear simple interest at the rate of 12% per annum. **Aetna** shall pay the interest to the provider at the time the overdue payment is made. The amount of interest paid to a provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the premium.

Acknowledgement of receipt of claims:

- (a) **Aetna** shall acknowledge receipt of all claims. The acknowledgement shall include the date **Aetna** received the claim.
 - 1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which **Aetna** received the claim.
 - 2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.
- (b) If **Aetna** remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

- (c) If **Aetna** offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.
- (d) If **Aetna** offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

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.

All benefits are payable to you, except that, at the request of the employee or covered person or in the event of his/her death, payment of benefits to the extent of expenses incurred on account of hospitalization may be made by **Aetna** to the hospital and except that the group policy may provide that all or any portion of any benefits on account of hospital, nursing, medical or surgical services may, at **Aetna's** option, be paid directly to the hospital or person rendering such services provided, further, that authorization for any such payments have been obtained from the covered person.

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.

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

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

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

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

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

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

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

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 32-40 03 NJ)

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;

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

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

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. As to medical and **prescription drug** claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the **group policy** or the **booklet-certificate**.

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**.

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.

Emergency Care Claim: Any claim for a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another **hospital** before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Final Internal Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the completion of the internal **appeal** process or an **adverse benefit determination** with respect to which the internal **appeal** process has been exhausted under the deemed exhaustion rules.
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 (which shall include all situations in which the covered person is confined in an inpatient facility) with respect to which the application of the time periods for making non-urgent care determinations could

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.
- An **urgent care claim** could be for any condition if in the opinion of a physician with knowledge of the claimant's medical condition would cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care; or
- in the case of an individual acting on behalf of the plan applying the judgment of a prudent layperson who possess an average knowledge of health and medicine determines urgent care is needed; or
- for a non-life threatening condition that requires care by a provider within 24 hours.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** prior to issuing a **final internal adverse benefit determination**, 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, free of charge. This will be provided to you as soon as possible and sufficiently in advance of the date on which the notice of the **final internal adverse benefit determination** is required to be provided so that you, your authorized representative, and/or **provider** may respond prior to that date.

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**. You, your authorized representative, or a **provider** acting on your behalf must be given written notice of any **adverse benefit determination** within two business days of the **adverse benefit determination**. The written notice must include an explanation of the Appeal Process.

Urgent or Emergency Care Claims

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

If more information is needed to make an **urgent or emergency care claim** decision, **Aetna** will notify the claimant or an authorized representative (which includes health care professionals with knowledge of a claimant's medical condition) within 72 hours of receipt of the claim. The claimant or authorized representative has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant or authorized representative within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the claimant or authorized representative 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 or sooner if the medical exigencies dictate, upon request, of any determination to deny coverage or authorization of services or payment of benefits after the claim is made. The notice will include an explanation of the **appeal** process.

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 or the time limit established by Medicare, if earlier, after the post-service claim is made if the claim is submitted electronically, or 40 days, if submitted by a means other than electronic. **Aetna** may determine that due to matters beyond its control a claim may require special treatment. If so, **Aetna** will notify you in writing including the reason for delay within 30 days. If special treatment is needed because **Aetna** needs additional information to make a decision, the notice shall specifically describe the required information. In the event that payment is withheld on all or a portion of the claim, because the claim required special treatment, a claim determination will be made on the withheld portion no later than 30 calendar days or the time limit established by Medicare, if earlier, following receipt of the required documentation for claims submitted by electronic means and no later than 40 days following receipt of the required documentation for claims submitted other than electronically.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **emergency** or **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided within the time frame applicable to (1) an **urgent care claim** (if the care is urgent) or (2) a **pre-service** or **post-service** claim (if the care is not urgent or has been completed).

Concurrent Care Claim Reduction or Termination

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 internal appeal decision**, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

If **Aetna** makes a claim determination to reduce or terminate a previously approved course of treatment while the treatment or services are ongoing, you (or a **provider** on your behalf) may request an expedited **appeal**, and **Aetna** will handle such a request as a Level One **appeal** or an **urgent care claim** (see **appeals of adverse benefit determinations**). **Aetna** will not deny coverage based on **medical necessity** for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by you or the **provider**.

Rescission of Coverage

As to medical and **prescription drug** claims only, **Aetna** will notify you of a **rescission of coverage** (termination of coverage back to the original effective date) with a 30 day advance written notification to allow you to **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network 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**. A **final internal adverse benefit determination** notice may also provide an option to request an **External Review** (*if available*).

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

- Your name.
- The Employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered. You have the option to provide **Aetna** with additional information about your **appeal**; however, you are not required to provide additional information in order to have your claim decision reviewed.

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 – Group Health Claims involving UR 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**.

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**. An **urgent care claim appeal** may be submitted orally or in writing.

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

Aetna shall issue a decision within 10 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 10 calendar days of receipt of the request for an **appeal**.

Level One Appeal – Group Health Claims involving non-UR Claims

Rescission of Coverage

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

Post-Service Claim

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

Level Two Appeal - Group Health Claims for UR Claims

If **Aetna** upholds an **adverse benefit determination** at the Level One **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons or in situations where the denial is based on characterizing the service as dental or as cosmetic, 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**. A Level Two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the **Aetna** Appeal Committee.

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 15 calendar days of receipt of the request for a Level Two **appeal**.

Level Two Appeal – Group Health Claims for non-UR Claims

Rescission of Coverage

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

Post-Service Claim

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

Please Read:

You may contact the New Jersey Department of Banking and Insurance to file a **complaint/appeal** or request an investigation of a **complaint/appeal** at any time. You are not required to exhaust the Level One and Level Two **appeals** process before contacting the New Jersey Department of Banking and Insurance.

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P. O. Box 329
Trenton, NJ 08625-0329

Before filing a Level One or Two **appeal** with **Aetna**, you or your authorized representative, may also contact the New Jersey Office of Insurance Claims Ombudsman if you are dissatisfied with the decision reached by **Aetna**.

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
Email: ombudsman@dobi.state.nj.us

Exhaustion of Process

Under certain circumstances you may seek simultaneous review through the internal **appeal** procedure and **external review** processes—these include **urgent care claims** and situations where you are receiving an ongoing course of treatment. When you seek a simultaneous expedited **external review**, the **appeal** process will be deemed to have been exhausted.

Important Note:

If **Aetna** waives the requirement to **appeal**, does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, or you have applied for an expedited review at the same time as applying for an expedited internal **appeal**, you are considered to have exhausted the **appeal** requirements and may proceed with **external review** or any of the actions mentioned below. 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**.

You, your authorized representative, or a **provider** acting on your behalf may request a written explanation of the violation from **Aetna** and **Aetna** must provide such explanation of the violation within ten days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal Claim and Appeal Process to be deemed exhausted.

If an external reviewer or a court rejects your request, your authorized representative's request, or **provider's** request for immediate review on the basis that **Aetna** met the standards for the exception set forth in this section, you, your authorized representative, or provider has the right to resubmit and pursue the internal **appeal** of the claim. An **appeal** should be made within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed ten (10) days. **Aetna** must provide notice of the opportunity to resubmit and pursue the internal **appeal**. The time period for submitting the **appeal** begins to run when you, your authorized representative, or **provider** receives notice.

Unless serious or significant harm has occurred or will imminently occur to you, you must exhaust an **appeal** through the Independent Health Care Appeals Program before you establish any litigation, arbitration, or administrative proceeding regarding an alleged breach of the **group policy** terms by **Aetna Life Insurance Company**; or any matter within the scope of the **appeal** procedure.

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

You may receive an **adverse benefit determination** or **final internal adverse benefit determination**.

In either of these situations, you may request an **external review** if you or your **provider** disagrees with **Aetna's** decision in accordance with the procedures set forth below for **final internal adverse benefit determinations** based on **medical necessity**, appropriateness, health care setting, level of care or effectiveness of a covered benefit. An **external review** is a review by an Independent Utilization Review Organization (IURO) assigned by the New Jersey Department of Banking and Insurance made up of **physicians** or other appropriate health care providers. The IURO must have expertise in the problem or question involved.

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 internal adverse benefit determination** notice by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **medically necessary** or was **experimental or investigational**.
- You have exhausted the applicable internal **appeal** processes or you qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final internal adverse benefit determination** that 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* with a general release executed by you for all medical records pertinent to the **appeal** within 123 calendar days of the date you received the **adverse benefit determination** or **final internal adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request. The request shall be mailed to:

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P.O. Box 329
Courier: 20 West State Street
Trenton, New Jersey 08625-0329

The fee for filing an appeal shall be \$25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. The filing fee shall be refunded if the **final internal adverse benefit determination** is reversed by the IURO. Upon a determination of financial hardship, the fee may be reduced to \$2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, New Jersey Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance. Annual filing fees for any one covered person shall not exceed \$75.00.

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

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

- i. The individual was or is covered by **Aetna**.
- ii. The service which is the subject of the **complaint** or **appeal** reasonably appears to be a covered benefit under the plan.
- iii. You have fully complied with both the Level One and Level Two **appeal** processes unless **Aetna** fails to comply with any of the deadlines for completion of the Internal Appeals Process. This will not apply if **Aetna's** violation does not cause and is not likely to cause, prejudice, or harm to the covered person or provider. **Aetna** must demonstrate that the violation was for good cause or due to matters beyond **Aetna's** control and that the violation occurred in the context of an ongoing good faith exchange between **Aetna**, you, your authorized representative, and/or **provider** acting on your behalf and is not reflective of a pattern of non-compliance by **Aetna**.
- iv. You have provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the **appeal** form and a copy of any information provided by **Aetna** regarding its decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from **Aetna** and any other relevant health care provider.
- v. You have remitted the required fee to the New Jersey Department of Banking and Insurance.

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

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

The full review referenced above shall refer all cases for review to an expert **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **appeal**. All final decisions of the IURO shall be approved by the medical director of the IURO who shall be a **physician** licensed to practice in New Jersey.

The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 45 calendar days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to **Aetna** setting forth the status of its review and the specific reasons for the delay.

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

Once the review is complete, **Aetna** will abide by the decision of the IURO except to the extent that other remedies are available to either party under State or Federal law. **Aetna** shall provide benefits (including payment on the claim) pursuant to the IURO's determination without delay even if **Aetna** plans to seek judicial review of the external review decision (unless there is a judicial decision stating otherwise). Within 10 business days of the receipt of the decision of the IURO, **Aetna** must submit a written report to the IURO, you, your authorized representative, or the **provider** who made the **appeal** acting on your behalf with your consent and the Department of Banking and Insurance indicating how **Aetna** will implement the IURO's determination.

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:

- endanger your 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.

If the **appeal** involves care for an urgent or emergency case, an admission, availability of care, continued stay, health care services for which the covered person received emergency services but has not been discharged from a facility or involves a medical condition for which standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the IURO must complete its review within no more than 48 hours following its receipt of the **appeal**.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IURO to New Jersey's Department of Banking and Insurance. **Aetna** is responsible for the cost of sending its information to the IURO.

For more information about the **external review** process, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-9N-34-005-04 NJ)

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)

Civil Union Partner

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to “marriage”, “husband”, “wife”, “family”, “immediate family”, “dependent”, “next of kin”, “widow”, “widower”, “widowed” or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage of **coinsurance** may vary by the type of expense. Please refer to the *Schedule of Benefits* for specific information on the applicable **coinsurance** percentage.

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 whose primary purpose is to alter, improve or enhance appearance.

Covered Expenses

Charges associated with medical, dental, vision or hearing services and supplies shown as covered under this booklet-certificate.

D (GR-9N 34-020 06)

Deductible

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

Dental Provider

This is:

- Any **dentist**;
- Group;
- Organization;

- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

Dental Emergency

Any dental condition that:

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

Dentist

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

Directory

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

E (GR-9N 34-025 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.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
 - drug;
 - device;
 - procedure; or
 - treatment.

that 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.

However, for purposes of **Hospice Care** coverage, the term **hospital** will include the portion of a **hospital** that provides hospice care.

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 any person.
- An act or event must be definite as to time and place.

J (GR-9N 34-050 01)

Jaw Joint Disorder (GR-9N 34-050 01)

This is:

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

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

Medically Necessary or Medical Necessity

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

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

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

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

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

N (GR-9N-34-070-04 NJ)

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; 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**

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not arise out of (or in the course of) any work related activity you perform for pay or profit, or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

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 from any work related activity you perform for pay or profit or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

O (GR-9N-34-075-04 NJ)

Occupational Injury or Occupational Illness

An **injury** or **illness** that arises out of (or in the course of) any activity or work that results in a condition from exposure in a workplace through your employment or self-employment. A secondary **illness** or **injury** that results from the original **occupational illness** or **occupational injury** will be considered an **occupational illness** or **occupational injury** under this plan.

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-34-075-04 NJ)

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-34-075-04 NJ)

Health care service or supply that is:

- Furnished by an **out-of network provider**.

Out-of-Network, Non-Participating, Non-Preferred Provider

A **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Precertification, Precertify, Preauthorization

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or certain **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.

R (GR-9N-34-090-01 NJ)

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

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.

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

- For dental expenses:
 - 80 % of the Prevailing Charge Rate

The **recognized charge** for **providers** in the dental **out-of-network** savings program is the lesser of what the provider bills and the **negotiated charge** for **providers** with whom we have a direct contract but are not **network providers**. Or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

Your **out-of-network** cost sharing applies when you get care from dental out of network savings program **providers**, except for **emergency services**.

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. If Fair Health does not report a rate, we will determine the rate as follows:

- Use rates reported for a comparable service, adjusted to reflect any differences in how much work it takes per form the respective services
- If no rate is reported for a reasonably comparable service, the rate will equal 50% of the charges billed by the provider.

Additional Information:

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

R.N.

A registered nurse.

S (GR-9N-34-095-11)

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 **non biologically-based mental illnesses or biologically-based 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, substance abuse or **non biologically-based mental illnesses or biologically-based 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.

Additional Information Provided by

KIPP New Jersey

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:

KIPP New Jersey Medical & Dental Benefit Plan

Employer Identification Number:

46-2792701

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

KIPP New Jersey
60 Park Place, Suite 802
Newark, NJ 07102
Telephone Number: (908) 202-6806

Agent For Service of Legal Process:

KIPP New Jersey
60 Park Place, Suite 802
Newark, NJ 07102

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

End of Plan Year:

June 30

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the School Business Administrator and Director.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

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

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

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

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

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

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

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

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

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

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

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