

Your Group Plan

**CBIA Service Corporation, Inc.
CBIA Health Connections
Connecticut Business & Industry Association**

CT/NY Suite 1 - DMO Dental

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

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

Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the Group Policy number GP-382231-A issued to CBIA Service Corporation, Inc.(called the Association) for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.



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

Cert. Base: 10D
Issue Date: October 12, 2007
Effective Date: October 1, 2007

This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.

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Dental Expense Coverage

Dental Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

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Dental Care Plan

What Are The Benefits?

This coverage pays for many of the charges incurred for the preventive and corrective dental care a covered person receives. Not all charges are eligible. Some charges are eligible only to a limited extent. There is no annual or lifetime maximum.

Aetna has arranged for **Primary Care Dentists** and **Participating Specialist Dentists** to furnish the necessary dental services under this coverage.

These services and supplies must be:

- given by the person's **Primary Care Dentist** at the dental office location; or
- given by a **Participating Specialist Dentist** for a dental condition requiring specialized care if the care is not available from the person's **Primary Care Dentist**, and if the **Primary Care Dentist** has referred the covered person to the **Participating Specialist Dentist**, and provided Aetna approves coverage for the treatment. This care is called **Referral Care**; or
- given by a **Non-Participating Dental Provider** in the case of **Out-of-Area Emergency Dental Care**.

This coverage also provides benefits for services given by **Non-Participating Dental Providers**. A deductible applies to services given by **Non-Participating Dental Providers**. The Dental Care Schedule that applies lists the services that may be given by **Non-Participating Dental Providers** and the amounts that are payable for those services.

Benefits

This coverage pays benefits for **Covered Dental Expenses** for dental services. Aetna pays the benefits to **Primary Care Dentists** and **Participating Specialist Dentists** as mutually agreed with them. Other benefits are payable to you. The amount of benefits payable for services provided by **Non-Participating Dental Providers** is determined by the Dental Care Schedule that applies. No benefits are payable for **Covered Dental Expenses** used to meet a Deductible.

Copayment

A copayment applies to some dental services. You are responsible for making the copayment to the **dentist**. The copayment is determined as follows:

Primary Care Provided by Primary Care Dentists

A copayment applies to Primary Care Services shown on the Dental Care Schedule. The copayment is a percent of the **Primary Care Dentist's** usual fee for that service, reviewed by Aetna for reasonableness. The copayment percent that applies is shown on the Dental Care Schedule.

“Usual fee” means the fee the **Primary Care Dentist** charges to patients in general. Your **Primary Care Dentist** will give you a copy of the usual fee schedule, upon request. It is not a part of this Booklet-Certificate and may be changed from time to time. It is used only for the purpose of calculating a copayment and is not the basis for compensation to the **Primary Care Dentist**. Aetna compensates a **Primary Care Dentist** based on separate, negotiated agreements that may be less than or unrelated to the **Primary Care Dentist's** usual and customary charges. These agreements may vary among **Primary Care Dentists**.

Specialty Services Provided by Participating Specialist Dentists

A copayment applies to Specialty Services shown on the Dental Care Schedule. The copayment is a percent of the **Participating Specialist Dentist's** fee for that service.

The “fee” may be a fee negotiated with the **Participating Specialist Dentists** and approved by Aetna. In that case, the copayment will be based on the actual, negotiated fee.

If Aetna compensates a **Participating Specialist Dentist** on another basis, the “fee” will be the **Participating Specialist Dentist's** usual fee, reviewed by Aetna for reasonableness. “Usual fee” means the fee **Participating Specialist Dentists** charge to patients in general. It is not a part of this Booklet-Certificate and may be changed from time to time. Then it is used only for the purpose of calculating a copayment and is not the basis for compensation to the **Participating Specialist Dentists**. Aetna compensates a **Participating Specialist Dentist** based on separate, negotiated agreements that may be less than or unrelated to the **Participating Specialist Dentists'** usual and customary charges. These agreements may vary among **Participating Specialist Dentists**.

You will be informed of the fee when you visit the **Participating Specialist Dentists**. The copayment percent that applies is shown on the Dental Care Schedule.

Office Visit Copayment

In addition to any copayments shown above, a copayment applies to each office visit to your **Primary Care Dentist** or **Participating Specialist Dentist** for a dental service in the Dental Care Schedule. The Office Visit Copayment amount is shown on the Dental Care Schedule.

Primary Care and Specialty Services Provided by Non-Participating Dental Providers

A copayment applies to the dental services provided by **Non-Participating Dental Providers**. The copayment is equal to the amount of charges made by the **Dental Provider** that exceeds the benefits payable under this coverage. The amount of benefits payable for services provided by **Non-Participating Dental Providers** is determined by the Dental Care Schedule that applies. Any amounts that exceed the benefit payable shown on that Dental Care Schedule are the obligation of the covered person and have not been the subject of negotiation with Aetna.

Deductible for Services Provided by Non-Participating Dental Providers

A deductible applies to services provided by **Non-Participating Dental Providers**. A deductible is the amount of **Covered Dental Expenses** for dental services given by **Non-Participating Dental Providers** that each person must incur in a calendar year before benefits are payable for those services in that year. The deductible amount is shown on the Dental Care Schedule.

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Dental Care Schedule

This Dental Care Schedule applies to covered services provided by **Primary Care Dentists** and **Participating Specialist Dentists**. It includes only services in the list below.

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.

Primary Care Dentist Services Type A Expenses

VISITS AND EXAMS

- Office visit for oral examination (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one treatment per year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to one application every 3 years for permanent molars only), and to covered persons under age 16)
- Pulp vitality test
- Diagnostic casts

X-Rays and pathology

- Bitewing X-rays (limited to 1 set per year)
- Entire series, including bitewings, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*

- Fixed, band type
- Removable acrylic with round wire clasp

Type B Expenses

ENDODONTICS

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
 - Anterior
 - Bicuspid

RESTORATIONS AND REPAIRS

- Amalgam restoration
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces
- Resin restoration (other than for molars)
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures

PERIODONTICS

- Scaling and root planing - per quadrant - (limited to 4 separate quadrants, every 2 years)
- Scaling and root planing - 1 to 3 teeth, per quadrant - (limited to once per site every 2 years)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

ORAL SURGERY *Includes local anesthetics and routine post-operative care*

- Extractions, exposed root or erupted tooth
- Extractions, coronal remnants
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Suture of soft tissue injury

Type C Expenses

RESTORATIONS

- Inlays
 - 1 surface
 - 2 surfaces
 - 3 or more surfaces
- Onlays
 - 2 surfaces
 - 3 surfaces
 - 4 or more surfaces
- Crowns (including build-ups when necessary)
 - Resin
 - Resin with noble metal
 - Resin with base metal
 - Porcelain
 - Porcelain with noble metal
 - Porcelain with base metal
 - Base metal (full cast)
 - Noble metal (full cast)
 - Metallic (3/4 cast)
 - Post and core

- 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
- Dentures and Partials (includes relines, rebases, and adjustments within six months after installation).
 - Full (upper and lower)
 - Partial
 - Stress breakers (per unit)
 - Interim partial denture (stayplate), anterior only
 - Crown and bridge repairs
 - Adding teeth to an existing denture
 - Full and partial denture repairs
 - Relining/rebasing dentures (including adjustments within six months after installation)
 - Occlusal guard (for bruxism only) limited to 1 every 3 years

Participating Specialist Dentist Services Type B Expenses

ENDODONTICS *Includes local anesthetics where necessary*

- Apexification/recalcification
- Apicoectomy (per tooth) - first root
- Apicoectomy (per tooth) - each additional root
- Retrograde Filling
- Root Amputation
- Hemisection

ORAL SURGERY *Includes local anesthetics where necessary and post-operative care*

- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula

PERIODONTICS

- Gingivectomy or gingivoplasty - per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty - 1 to 3 teeth (limited to 1 per site, every 3 years)
- Gingival flap procedure - per quadrant
- Gingival flap procedure - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Occlusal adjustment (other than with an appliance or by restoration)

Type C Expenses

ENDODONTICS *Includes local anesthetics where necessary*

- Molar root canal therapy, including necessary X-rays

INTRAVENOUS SEDATION AND GENERAL ANESTHESIA

ORAL SURGERY *Includes local anesthetics where necessary and post-operative care*

- Surgical removal of impacted teeth
 - Partially bony
 - Completely bony
 - Completely bony with unusual surgical implications

PERIODONTICS

- Osseous surgery (including flap entry and closure), per quadrant, limited to 1 per quadrant, every 3 years
- Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Soft tissue graft procedures

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Out-of-Area Emergency Dental Care

Out-of-Area Emergency Dental Care consists of **necessary** covered dental services given to covered persons by a **Non-Participating Dental Provider** for the palliative (pain relieving; stabilizing) treatment of an **emergency condition**. The emergency care is rendered outside of the 50 mile radius of the covered person's home address. Coverage for **Out-of-Area Emergency Dental Care** is subject to specific limitations described in the **Dental Care Plan**.

When care of an **emergency condition** is received, a benefit will be paid for the **reasonable charges** incurred by a covered person for such care.

The amount paid will not be more than \$ 100; regardless of the number of treatments needed for each separate **emergency condition**.

Payment will be made only if all of the following rules are met:

- The care meets the definition of **Out-of-Area Emergency Dental Care**. Care is given more than 50 miles from the covered person's home address.
- The care given is for the speedy relief of the **emergency condition** until the person can be seen by the **Primary Care Dentist**.
- The person provides an itemized bill to Aetna. It must describe the care given.
- The dental service given is listed on the Dental Care Schedule that applies.

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Exclusions and Limitations

Coverage is not provided for the following charges:

- Those for services or supplies which are covered in whole or in part:
 - under any other part of this Plan; or
 - under any other plan of group benefits provided by or through your Employer.
- Those for services and supplies furnished to diagnose or treat a disease or injury that is not a **non-occupational disease** or **non-occupational injury**.
- Those for services not listed in the Dental Care Schedule, unless otherwise specified.
- Those for replacement of a lost, missing, or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

Facings on molar crowns and pontics will always be considered cosmetic.

- Those for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental, or still under clinical investigation by health professionals.
- Those for:

dentures;

crowns;

inlays;

onlays;

bridgework; or

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

- Those for any of the following services:

an appliance, or modification of one, if an impression for it was made before the person became a covered person;

a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;

root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

- Those for services which Aetna defines as not **necessary** for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending **physician or dentist**.
- Those for services intended for treatment of any **jaw joint disorder**, unless otherwise specified.
- Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; unless otherwise specified.
- Those for general anesthesia and intravenous sedation, unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.
- Those in connection with a service given to a person age 5 or more if that person becomes a covered person other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:

after the end of the twelve month period starting on the date the person became a covered person; or

as a result of accidental injuries sustained while the person was a covered person; or

for a service in the Dental Care Schedule that applies shown under the headings Visits and Exams, and X-rays and Pathology.

- Those for services given by a **Non-Participating Dental Provider** to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
- Those for a crown, cast, or processed restoration 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.

- Those for pontics, crowns, cast, or processed restorations made with high noble metals, unless otherwise specified.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified.

- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

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Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- the service must be listed on the Dental Care Schedule;
- the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a **Participating Dental Provider** and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- the copayment for the approved less costly service; plus
- the difference in cost between the approved less costly service and the more costly covered service.

Replacement Rule

The replacement of; addition to; or modification of:

- existing dentures;
- crowns;
- casts or processed restorations;
- removable denture;
- fixed bridgework; or
- other prosthetic services

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown, cast, or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

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Benefits After Termination of Coverage

Dental services given after the covered person's coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means that prior to the date coverage ends:

As to a denture:

impressions have been taken from which the denture will be prepared.

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

the teeth which will serve as retainers or support; or which are being restored; have been fully prepared to receive the item; and impressions have been taken from which the item will be prepared.

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Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

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

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

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

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

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a **semi-private** room in the **hospital** and the private room (unless the patient's stay in the private **hospital** room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.
5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

Claim Determination Period means the Calendar Year.

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

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

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

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

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

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

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

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

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

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

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- (b) If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
- (c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the noncustodial parent; and then
 - The plan of the spouse of the noncustodial parent.
- (3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled E(1).
- (4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

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

Effect On Benefits Of This Plan.

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
- (1) Determine its obligation to pay or provide benefits under its contract;
 - (2) Determine whether a benefit reserve has been recorded for the covered person; and
 - (3) Determine whether there are any unpaid allowable expenses during that claims determination period.
- B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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Order Of Benefit Determination.

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

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained through membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. Medical benefits coverage in a group, group type, and individual automobile “no fault” or traditional automobile “fault” type contract is always primary.
- D. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- E. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
- (1) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is changed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

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

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

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

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

9362, 11554, 11554-4

Right To Receive And Release Needed Information.

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

Facility Of Payment.

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

Right of Recovery.

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

9361, 11554

Multiple Coverage Under This Plan

If a person is covered under this Plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

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

5030

Effect of A 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 and your eligible dependents 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 dental coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

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

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

7312

Effect of Medicare

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

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

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

having refused it;

having dropped it;

having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

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

5090

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., 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 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.

6051

Appeals Procedure

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

Definitions

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

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

- The covered person's eligibility for coverage;
- The results of any Advance Claim Review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

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

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

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 submitted for completed services.

Urgent Care Claim: Any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

11600

Claim Determinations– Group Health Coverage

Urgent Care Claims

Aetna will give notice of an urgent care claim decision not more than 2 business days after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 24 hours of receipt of the claim. The **claimant** has 48 hours after receipt of such notice to provide Aetna with the information. Aetna will notify the **claimant** within 2 business days of the receipt of the added information.

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

Post-Service Claims

Aetna will give notice of a claim decision not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 day claim decision period is required. Such an extension, of not longer than 15 added calendar days, will be allowed if Aetna notifies the covered person within the first 30 day period. If this extension is needed because Aetna needs added information to make a claim decision, the notice of the extension shall describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the information.

Complaints

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

Notice of Adverse Benefit Determinations

An Adverse Benefit Determination not to certify an admission, service, procedure or extension of stay will be in writing. It will include the: reason(s) for the decision, procedure to make an appeal and procedure to make an external appeal.

Appeals of Adverse Benefit Determinations

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

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

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

Send in your appeal to the address shown on the Notice of Adverse Benefit Determination, or you may call in your appeal using the toll-free number listed on such notice.

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

Level One Appeal – Group Health Claims

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

Urgent Care Claims

Aetna shall issue a decision within 36 hours of receipt of the request for an Appeal.

Post-Service Claims

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

Level Two Appeal

If Aetna upholds an Adverse Benefit Decision at the first level of appeal, and the reason for the adverse decision was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days after receipt of notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent Care Claim shall be provided by a professional Dental Consultant not involved in making the Adverse Benefit Determination. A level two appeal of an Adverse Benefit Determination will be reviewed by a professional Dental Consultant not involved in making the Adverse Determination.

Urgent Care Claims

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

Post-Service Claims

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

11600

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either case, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **dentist**, selected by an external review entity, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received final notice of the denial of a claim by Aetna including notice that you have exhausted the applicable internal Appeal processes.
- You must submit the Request for External Review Form to the Connecticut Insurance Department within 30 calendar days of the date you received the final claim denial letter.
- Your claim was denied because Aetna determined that the care was not **necessary** or was experimental or investigational.

To file an external review request, you must include a completed request form; evidence of being covered under the plan (e.g. photocopy of your ID Card), copy of all claim denial letters and an executed release to obtain necessary medical records, a copy of the certificate of coverage and a filing fee of \$ 25.00.

The request for external review should be mailed to:

Connecticut Insurance Department
PO Box 816
Hartford, Connecticut 06142-0816
Attention: External Appeals
(860) 297-3910

The commissioner will assign the appeal to an external review entity. A preliminary review of the appeal will be conducted within five business days. The external review entity shall notify the commissioner, you and the provider in writing as to whether the appeal is accepted for full review. If not accepted, it shall state the reasons. If accepted, you and the provider have five business days to submit additional information. You will be notified of the decision of the external review entity usually within 30 calendar days. The report of the external review entity will be made available to you, the provider and Aetna. If upon completion of a full review, you receive a favorable decision from the external review entity, the commissioner shall refund any paid filing fee to you.

Aetna will abide by the decision of the external review entity, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the external review entity. Aetna is responsible for the cost of the external review.

11600

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 3 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond 12 months from the date the absence started, provided the required contributions are made.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

If you cease active work, ask your Employer if any coverage can be continued. If the group contract terminates, the law requires your Employer tell you of this at least 15 days in advance.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- The end of the calendar month after the calendar month when such person is no longer a defined dependent.
- When your coverage terminates.

6080

Handicapped Dependent Children

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

6130

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

11048

Dental Expense Benefits After Termination

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

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

6180

Dental Care Plan benefits will be available to him or her, while disabled, as follows:

- If Dental Expense Coverage terminates as to your Eligible Class, for up to 12 months.
- If Dental Expense Coverage terminates for any other reason, for up to 12 months, or, if earlier, the date the person becomes covered under any other group plan for similar benefits.

The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of the 12 month period.

6180

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

6180

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational accidental injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

6450

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

7671

Legal Action

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

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

6470-1

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

6470

Assignments

Coverage may be assigned only with the written consent of Aetna.

6430

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

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

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

9352

Reporting of Claims

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

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

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

6320

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

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

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes 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.

6350, 9265

Records of Expenses

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

Very important are:

Names of **dentists** who furnish services.

Dates expenses are incurred.

Copies of all bills and receipts.

6380

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

9990

Covered Dental Expenses

Those expenses incurred for covered dental services and supplies provided to a covered person, while the person is a covered person. Those expenses are subject to the limitations and exclusions of the **Dental Care Plan**.

Covered Orthodontic Expenses

Those expenses incurred for covered orthodontic services and supplies given to a covered person; while the person is a covered person. These expenses are subject to the limitations and exclusions of the **Dental Care Plan** and the terms of the Dental Care Schedule.

Dental Care Plan

This is the plan of benefits provided under the Dental Care Plan Coverage.

Dental Provider

This is:

- any **dentist**;
- group;
- organization;
- dental facility; or
- other institution or person;

legally qualified to furnish dental services or supplies.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Emergency Condition

This is any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment in order to stabilize the condition; and
- is characterized by symptoms such as severe pain and bleeding.

Jaw Joint Disorder

This is:

- a Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint; or
- a Myofascial Pain Dysfunction (MPD); or
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, mental health or dental professional;
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office or other less costly setting.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

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

Non-Participating Dental Provider

A **Dental Provider** who has not entered into a written agreement with Aetna to provide Dental Care Plan coverage to covered persons.

Orthodontic Treatment

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-Area Emergency Dental Care

Necessary care or treatment given to covered persons by a **Non-Participating Dental Provider** for the palliative (pain relieving; stabilizing) treatment of an **emergency condition** that is rendered outside the 50 mile radius of the covered person's home address. Such care is subject to specific limitations set forth in this **Dental Care Plan**.

Participating Dental Provider

Any **Dental Provider** who has entered into a written agreement with Aetna to provide dental care described under the **Dental Care Plan** to covered persons.

Participating 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, and
- who has entered into a written agreement with Aetna to provide the dental care described under the **Dental Care Plan** to covered persons.

Physician

This means a legally qualified physician.

Primary Care Dentist

A **Participating Dental Provider** currently chosen by you to provide dental care to a covered person.

A Primary Care Dentist chosen by you takes effect as a covered person's Primary Care Dentist on the effective date of that person's coverage.

If you do not choose a Primary Care Dentist, Aetna will have the right to make a selection for you. Aetna will notify you of the selection.

You may change a covered person's Primary Care Dentist by notifying Aetna by telephone or in writing.

The change will be effective as follows:

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

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

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Referral Care

Covered services given to a covered person by a **Participating Specialist Dentist** after referral by the covered person's **Primary Care Dentist** and provided Aetna approves coverage for the treatment.

Confidentiality Notice

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

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

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

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

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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

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

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

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

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

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

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

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

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

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

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

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

Summary of Coverage

Employer: CBIA Service Corporation, Inc.
CBIA Health Connections

Group Policy: GP-382231-A

SOC: 10D

Issue Date: October 12, 2007

Effective Date: October 1, 2007

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This Summary of Coverage may be an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee who works at least 30 hours per week for an Employer Member of the Association, you are a resident of the state of Connecticut or New York, and your Employer has determined that you reside within the Service Area covered under this Plan.

If you elect to have coverage under any other dental plan sponsored by your Employer and such coverage becomes effective, this Booklet-Certificate will no longer apply. A new Booklet-Certificate will be issued to you. Contact your Employer for information as to when coverage under any other dental plan may be effective.

Your Eligibility Date, if you are then in an Eligible Class, is the first day of the calendar month following completion of a period of continuous employment as determined by your Employer.

Dependents

You may cover your:

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

Any other unmarried child under age 23 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any other child you support who lives with you in a parent-child relationship.

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No person may be covered as a dependent of more than one employee. This does not apply to a child whose parents are each covered under this Plan both as an employee and as a dependent.

To figure benefits for a person who is covered as an employee and a dependent, or as a dependent of more than one employee, the terms of this Plan will apply separately.

Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within 31 days of your Eligibility Date.

Your contributions toward the cost of this coverage, if any, will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Effective Date of Coverage

Employees

Your coverage will take effect as follows:

You will be deemed to have completed the enrollment form only if all the required information has been provided and the form has been signed.

Initial Open Enrollment Period

If you are in an Eligible Class during the initial open enrollment period, your coverage will take effect on the date you become eligible, if during the open enrollment period you have completed the enrollment form.

Enrollments Thereafter

If you enter an Eligible Class after the initial open enrollment period, your coverage will take effect:

- on the date you become eligible, if by then you have completed the enrollment form; or
- on the date the written request is made, if you complete the enrollment form during the 31 days following the date you enter an Eligible Class.

If you do not enroll a person (including yourself) for dental coverage within 31 days or at open enrollment, and you enroll thereafter, coverage under this Plan will be limited. See your Booklet-Certificate.

Subsequent Open Enrollment Periods

If you do not enroll in accordance with the above provisions, your coverage will take effect on the first day of the second calendar month following the end of an open enrollment period designated by your Employer and agreed to by Aetna, if you have completed the enrollment form before or during the open enrollment period.

Dependents

Dependent coverage that is contributory will take effect as follows:

Initial Open Enrollment Period

If you are in an Eligible Class during the initial open enrollment period your dependent coverage will take effect on the date you become eligible, if during the open enrollment period you requested dependent coverage and you have completed the enrollment form.

Enrollments thereafter

If you enter an Eligible Class after the initial open enrollment period your dependent coverage will take effect:

- on the date you become eligible, if you have requested dependent coverage and you have completed the enrollment form;
or
- on the date the written request is made, if you complete the enrollment form during the 31 days following the date you enter an Eligible Class.

Subsequent Open Enrollment Periods

If you do not enroll your dependents in accordance with the above provisions, your dependent coverage will become effective on the first day of the second calendar month following the end of an open enrollment period designated by your Employer and agreed to by Aetna, if you have requested dependent coverage and you have completed the enrollment form before or during the open enrollment period.

Health Expense Coverage

Employees and Dependents

Your Booklet-Certificate spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet-Certificate for a complete description of the benefits payable.

Dental Care Schedule

Applies to Covered Services Provided by Primary Care Dentists and Participating Specialists

Primary Care Dentist Services

Type A Services	The Copayment percentage is 0%
Type B Services	The Copayment percentage is 10%
Type C Services	The Copayment percentage is 40%

Participating Specialist Dentist Services

Type B Services	The Copayment percentage is 10%
Type C Services	The Copayment percentage is 40%

Office Visit Copayment Amount	\$ 5
Dental Emergency Maximum	\$ 100.00

Applies to Covered Services Provided by Non-Participating Dental Providers

Copayment

Primary Care and Specialty Services:	The Copayment is the amount of charges that exceeds the benefits payable under this coverage.
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Deductible Amount	\$ 100.00.
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Dental Care Schedule

This Dental Care Schedule applies to covered services provided by Non-Participating Dental Providers. It includes only services in the list below.

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.

Note: The "Amount Payable" shown in the Dental Care Schedule applies only to services given by Non-Participating Dental Providers. The amounts shown are NOT Copayments. They are the maximum charges eligible under the coverage for the service listed.

**Primary Care Dentist Services
Type A Services**

	Amount Payable
<i>VISITS AND EXAMS</i>	
• Office visit for oral examination (limited to 4 visits per year)	\$ 12.00
• Emergency palliative treatment	100.00
• Prophylaxis (cleaning) (limited to 2 treatments per year)	
Adult	26.00
Child	14.00
• Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)	16.00
• Oral hygiene instruction	12.00
• Sealants; per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)	10.00
• Pulp vitality test	8.00
<i>X-RAYS AND PATHOLOGY</i>	
• Bitewing X-rays (limited to 1 set per year)	8.00
• Entire series; including bitewings; or panoramic film (limited to 1 set every 3 years)	14.00
• Vertical bitewing X-rays (limited to 1 set every 3 years)	12.00
• Periapical X-rays	6.00
• Intra-oral; occlusal view; maxillary or mandibular	8.00
• Extra-oral upper or lower jaw	12.00
• Biopsy and histopathologic examination of oral tissue	27.00
<i>SPACE MAINTAINERS - Includes all adjustments within six months after installation.</i>	
• Fixed; band type	40.00
• Removable acrylic with round wire clasp	32.00

Type B Services

	Amount Payable
<i>ENDODONTICS</i>	
• Pulp cap	\$ 3.00
• Pulpotomy	27.00
• Surgical exposure for rubber dam isolation	26.00
• Root canal therapy; including necessary X-rays	
Anterior	80.00
Bicuspid	96.00
<i>RESTORATIONS AND REPAIRS</i>	
• Amalgam restoration	
1 surface	12.00
2 surfaces	16.00
3 or more surfaces	24.00
• Resin restoration (other than for molars)	
1 surface	12.00
2 surfaces	16.00
3 or more surfaces or incisal angle	26.00
• Retention pins	14.00
• Sedative fillings	12.00
• Stainless steel crowns	26.00
• Prefabricated resin crowns (excluding temporary crowns)	60.00
• Recementing inlays; crowns; bridges; space maintainers	16.00
• Tissue conditioning for dentures	26.00

PERIODONTICS

- Emergency treatment (abscess; acute periodontitis; etc.) 26.00
- Subgingival curettage (limited to 4 separate quadrants; every 2 years) 40.00
- Scaling and root planning (limited to 4 separate quadrants every 2 years) 40.00
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year) 40.00

ORAL SURGERY - Includes local anesthetics and routine post-operative care.

- Extractions; uncomplicated 27.00
- Surgical removal of erupted tooth 32.00
- Surgical removal of impacted tooth (soft tissue) 40.00
- Excision of hyperplastic tissue 32.00
- Excision of pericoronal gingiva 40.00
- Incision and drainage of abscess 20.00
- Crown exposure to aid eruption 26.00
- Removal of foreign body from soft tissue 20.00
- Suture of soft tissue injury 20.00

Type C Services

RESTORATIONS

- **Inlays**
 - 1 surface \$ 60.00
 - 2 or more surfaces 80.00
- **Onlays**
 - 2 surfaces 80.00
 - 3 or more surfaces 80.00
- **Crowns** (including build-ups when necessary)
 - Resin 120.00
 - Resin with noble metal 120.00
 - Resin with base metal 120.00
 - Porcelain 120.00
 - Porcelain with noble metal 120.00
 - Porcelain with base metal 120.00
 - Base metal (full cast) 120.00
 - Noble metal (full cast) 120.00
 - Metallic (3/4 cast) 120.00
 - Post and core 27.00
- **Pontics**
 - Base metal (full cast) 20.00
 - Noble metal (full cast) 20.00
 - Porcelain with noble metal 20.00
 - Porcelain with base metal 20.00
 - Resin with noble metal 20.00
 - Resin with base metal 20.00
- **Dentures and Partials** - (includes relines; rebases and adjustments *within six months after installation*)
 - Full (Upper or Lower) 120.00
 - Partial 120.00
 - Stress breakers (per unit) 40.00
 - Interim partial denture; (stayplates); anterior only 40.00
 - Crown and bridge repairs 27.00
 - Adding teeth to an existing denture 40.00
 - Full and partial denture repairs 27.00
 - Relining/rebasing dentures (includes adjustments with six months after installation) 40.00
 - Occlusal guard (for bruxism only); (limited to 1 every 3 years) 40.00

Specialty Services Type B Services

	Amount Payable
ENDODONTICS - Includes local anesthetics where necessary.	
• Apexification/recalcification - per visit	\$ 32.00
• Apicoectomy	
First root	60.00
Each additional root	40.00
Retrograde Filling	14.00
Root Amputation	27.00
Hemisection	27.00
 ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.	
• Removal of residual root	27.00
• Removal of odontogenic cyst	40.00
• Closure of oral fistula	48.00
• Removal of foreign body from bone	20.00
• Sequestrectomy	20.00
• Frenectomy	40.00
• Transplantation of tooth or tooth bud	48.00
• Alveoplasty in conjunction with extractions - per quadrant	27.00
• Alveoplasty not in conjunction with extractions - per quadrant	40.00
• Removal of exostosis	60.00
• Sialolithotomy; removal of salivary calculus	36.00
• Closure of salivary fistula	36.00
 PERIODONTICS	
• Gingivectomy or gingivoplasty - per quadrant (limited to 1 quadrant; every 3 years)	40.00
• Gingivectomy or gingivoplasty - per tooth (limited to 1 per site; every 3 years)	20.00
• Gingival flap procedure - per quadrant	60.00
• Occlusal adjustment (other than with an appliance or by restoration)	
Limited	20.00
Entire Mouth	40.00

Type C Services

	Amount Payable
ENDODONTICS - Includes local anesthetics where necessary.	
• Complex Molar Root Canal Therapy	\$ 120.00
 INTRAVENOUS SEDATION AND GENERAL ANESTHESIA	
- per 15-minute segment.	20.00
 ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.	
• Surgical removal of impacted tooth	
Partially bony	53.00
Completely bony	60.00
Completely bony with unusual surgical complications	64.00
 PERIODONTICS	
• Osseous surgery (including flap entry and closure) - per quadrant (limited to 1 per quadrant; every 3 years)	80.00

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

Disclosure

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

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE**

Additional Information Provided by Aetna Life Insurance Company

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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.