

BENEFIT PLAN

**Prepared Exclusively for
I.B.T. Local No. 145 Health Services &
Insurance Plan**

PPO Dental Plan

**What Your Plan
Covers and How
Benefits are Paid**

ID Cards

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

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

Preface

The dental benefits plan described in this *Booklet* is a benefit plan of the Fund. These benefits are not insured with **Aetna** but will be paid from the Fund's funds. **Aetna** will provide certain administrative services under the **Aetna** dental benefits plan.

Aetna agrees with the Fund to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Fund selects the products and benefit levels under the **Aetna** dental benefits plan.

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

This *Booklet* replaces and supersedes all **Aetna** *Booklets* describing coverage for the dental benefits plan described in this *Booklet* that you may previously have received.

Fund:	I.B.T. Local No. 145 Health Services & Insurance Plan
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Coverage for You and Your Dependents

Health Expense Coverage

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

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

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

Treatment Outcomes of Covered Services

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

When Your Coverage Begins

Who Is Eligible

When Your Coverage Begins

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

Who Is Eligible

Participants

- The I.B.T. Local No. 145 Health and Services & Insurance Plan has been established pursuant to a trust agreement for participant who are represented for collective bargaining purposes by I.B.T. Local Union No. 145 ('Union') and whose employers have agreed to make, on their behalf, contributions necessary to fund the particular benefit level. The Plan is administered in accordance with federal laws by a Board of Trustees, which consists of two Union-designated trustees and two-Employer designated trustees. You may be required to make contribution towards coverage per the Collective Bargaining Agreement.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a new and rehired participant including those returning from lay-off, become eligible for Plan medical coverage on the effective date of this plan and the Fund has made contribution to the plan on the participant behalf.
- Aetna will rely upon the fund to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- A Spouse.
- Unmarried dependent children who are under age 26 and are full-time students at an accredited college or school.
- Unmarried dependent child, who are incapable of self-sustaining employment due to a physical or mental disability which commenced while the child was eligible for benefits under this Plan. A Participant must submit proof of a dependent child's incapacity to the Fund office or Aetna no later than 31 days after the date.
-
- Your domestic partner who meets the rules set by the fund.
- Dependent children of your domestic partner.

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

Coverage for Domestic Partner

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

- He or she is your sole domestic partner and intends to remain so indefinitely.

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

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order; and

Your grandchildren in your court-ordered custody.

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

Military Reinstatement – if your coverage terminates because you enter the military service on an active basis, and if you are employed by a Participant Employer within the 90 day period after your discharge date, your Eligibility Date for coverage under this policy will be the date you become employed with the Participant Employer.

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

When Your Coverage Begins

Your Effective Date of Coverage

Your coverage takes effect on the later of:

The date you are eligible for coverage.

Your Dependent's Effective Date of Coverage

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

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

Requirements For Coverage

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Booklet;
 - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of dental practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or **dental provider** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

Important Note

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

How Your Aetna Dental Plan Works

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

Understanding Your Aetna Dental Plan

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

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

Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents.

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

Store this Booklet in a safe place for future reference.

Getting Started: Common Terms

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

About the PPO Dental Plan

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

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

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

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

The Choice is Yours

You have a choice each time you need dental care:

Using Network Providers

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

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

Using Out-of-Network Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**).

If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a covered expense from an **out-of network provider**.

You must file a claim to receive reimbursement from the plan.

Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductibles, copays, payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

Getting an Advance Claim Review

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

Important Note

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

When to Get an Advance Claim Review

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

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

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

What is a Course of Dental Treatment?

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

In Case of a Dental Emergency

The plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a **network provider** up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given. Additional dental care to treat your **dental emergency** will be covered at the appropriate **coinsurance** level.

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

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

Important Reminder

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

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

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

The next sentence applies if:

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

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

Dental Care Schedule

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

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

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

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the **network** level of benefits even if services and supplies are not provided by a **network provider**. There is a maximum benefit payable. For additional information, please refer to *In Case of a Dental Emergency* section.

PPO Dental Expense Coverage Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage insured or administered by **Aetna** and have at least one of the following conditions:

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

Additional Covered Dental Expenses

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

Payment of Benefits

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

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

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

Important Reminder

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

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

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

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays

Office visit during regular office hours, for oral examination

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

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

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

Adult

Child

Topical application of fluoride, (limited to two courses of treatment per calendar year and to children under age 19)

Sealants, per tooth (limited to one application per calendar year and to children under age 19)

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

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

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

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

Fixed (unilateral or bilateral)

Removable (unilateral or bilateral)

Periapical x-rays (single films up to 13)

Type B Expenses: Basic Restorative Care

Visits and X-Rays

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

Emergency palliative treatment, per visit

X-Ray and Pathology

Intra-oral, occlusal view, maxillary or mandibular

Upper or lower jaw, extra-oral

Biopsy and histopathologic examination of oral tissue

Oral Surgery

Extractions

Erupted tooth or exposed root

Coronal remnants

Surgical removal of erupted tooth/root tip

Impacted Teeth

Removal of tooth (soft tissue)

Odontogenic Cysts and Neoplasms

Incision and drainage of abscess

Removal of odontogenic cyst or tumor

Surgical removal of impacted teeth

Removal of tooth (partially bony)

Removal of tooth (completely bony)

Other Surgical Procedures

Alveoplasty, in conjunction with extractions - per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Excision of hyperplastic tissue
Removal of exostosis
Transplantation of tooth or tooth bud
Closure of oral fistula of maxillary sinus
Sequestrectomy
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

Periodontics

Occlusal adjustment (other than with an appliance or by restoration)
Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
Periodontal maintenance procedures without active therapy (limited to 2 per year)
Localized delivery of antimicrobial agents
Full mouth Debridement (limited to 1 per year)

Endodontics

Pulp capping
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
 Anterior
 Bicuspid
 Molar

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.

(Multiple restorations in 1 surface will be considered as a single restoration.)

Amalgam restorations
Resin-based composite restorations
Pins

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

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

 Prefabricated stainless steel

 Prefabricated resin crown (excluding temporary crowns)

Recementation

 Inlay

 Crown

 Bridge

Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. Replacement of

existing bridges or dentures is limited to 1 every 5 years. (See Replacement Rule.) Replacement of existing crowns/inlays is limited to 1 every 3 years

- Office reline
- Laboratory reline
- Rebase, per denture

Per prior dental document.

Type C Expenses: Major Restorative Care

Periodontics

Soft tissue graft procedures

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

Inlays/Onlays

Labial Veneers

- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns

- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic

Post and core

Core build up, including any pins

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

Bridge Abutments (See Inlays and Crowns)

Pontics

- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal

Resin with base metal
Removable Bridge (unilateral)
One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
Complete upper denture
Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
Laboratory reline
Special tissue conditioning, per denture
Rebase, per denture
Adjustment to denture more than 6 months after installation
Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Adding teeth to existing partial denture
Each tooth
Each clasp
Repairs: crowns and bridges
Clinical crown lengthening, hard tissue

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

Orthodontics

Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization
Removable appliance therapy to control harmful habits
Fixed appliance therapy to control harmful habits

Rules and Limits That Apply to the Dental Plan

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

Orthodontic Treatment Rule

Orthodontic coverage is only for participants and covered dependents who are under age 19 on the date active orthodontic treatment begins.

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

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;

- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

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

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Orthodontic Limitation for Late Enrollees

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

Replacement Rule

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

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

Alternate Treatment Rule

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

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

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

Coverage for Dental Work Begun Before You Are Covered by the Plan

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

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

Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

Late Entrant Rule

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

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

This exclusion does not apply to charges incurred:

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

What The PPO Dental Plan Does Not Cover

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

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

Any instruction for diet, plaque control and oral hygiene.

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

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

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

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

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Additional Items Not Covered By A Health Plan

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

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

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

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

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

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

Examinations:

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

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

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

When Coverage Ends

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

When Coverage Ends for Participants

Your **Aetna** health benefits coverage will end:

- If **Aetna** health benefits plan is discontinued;
- If you voluntarily stop your coverage;
- If you are no longer eligible for coverage;
- If you do not make any required contributions;
- If you become covered under another plan offered by the fund; or
- The fund notifies **Aetna** that your employment is ended.

It is the fund's responsibility to let **Aetna** know when your employment ends.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

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

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

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

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

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

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

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

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

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

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

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

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

Important Note

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

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 90 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

COBRA Continuation of Coverage

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

Continuing Coverage through COBRA

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

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

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify the fund within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the fund within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

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

Determining Your Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

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

When You Acquire a Dependent During a Continuation Period

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

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

Important Note

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

When Your COBRA Continuation Coverage Ends

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

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

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

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

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

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

If a person is covered by one **Plan** that computes its benefit payments on the basis of reasonable or recognized charges and another **Plan** that provides its benefits or services on the basis of **negotiated charges**, the **primary**

plan's payment arrangements shall be the allowable expense for all the **Plans**. However, if the **secondary plan** has a negotiated fee or payment amount different from the **primary plan** and if the provider contract permits, that negotiated fee will be the **allowable expense** used by the **secondary plan** to determine benefits.

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

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

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

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

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

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

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

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

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

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

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

Which Plan Pays First

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major

medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as a participant, 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 participant); then the order of benefits between the two plans is reversed so that the plan covering the person as a participant, member, subscriber or retiree is secondary and the other plan is primary.
 2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

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

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

3. Active Participant or Retired or Laid off Participant. The plan that covers a person as a participant who is neither laid off nor retired or as a dependent of an active participant, is the primary plan. The plan covering that same person as a retired or laid off participant or as a dependent of a retired or laid off participant is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an participant, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as a participant, 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.

How Coordination of Benefits Works

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

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

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

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

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 the Plan.

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

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

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

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

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

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

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

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

When Medicare is Primary

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

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

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

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

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

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

Right to Receive and Release Required Information

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

General Provisions

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact the fund or **Aetna**.
- Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.
- The plan may be changed or discontinued with respect to your coverage.

Financial Sanctions Exclusions

If any benefit provided by this plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Recovery of Overpayments

Health Coverage

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

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

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

Reporting of Claims

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 15 months after the deadline.

Payment of Benefits

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

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

The Plan may pay up to \$1,000 of any other 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.

Records of Expenses

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Effect of Benefits Under Other Plans

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

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

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

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

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

Appeals Procedure

Definitions

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

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;

- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

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

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

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

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

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

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

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

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

Claim Determinations

Urgent Care Claims

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**.

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

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

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

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

Level One Appeal - Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include concurrent care claim reduction or termination)

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

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

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

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

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

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim**, a **Pre-Service Claim**, or a **Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)

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

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 15 calendar days of receipt of the request for 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**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
 - litigation;
 - arbitration; or
 - administrative proceeding;

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

Glossary

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

A

Aetna

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

C

Copay or Copayment

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

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

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

D

Deductible

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

Dental Provider

This is:

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

legally qualified to furnish dental services or supplies.

Dental Emergency

Any dental condition that:

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

Dentist

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

Directory

A listing of all **network providers** serving the class of employees to which you belong. The contract holder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

E

Experimental or Investigational

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

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

H

Hospital

An institution that:

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

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

I

Illness

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

Injury

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

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

J

Jaw Joint Disorder

This is:

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

L

Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

M

Medically Necessary or Medical Necessity

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

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

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

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and

- c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

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

N

Negotiated Charge

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

Network Provider

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

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

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

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

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

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

Non-Occupational Injury

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

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

O

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

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

Occurrence

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

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

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

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

Out-of-Network Provider

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

P

Payment Percentage

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

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Precertification or Precertify

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

Prescriber

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

Prescription

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

Prescription Drug

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

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

R

Recognized Charge

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

In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

A service or supply provided by a **provider** is treated as **covered expenses** under the **other health care** coverage category when:

- You get services or supplies from an **out-of-network provider**. This includes when you get care from **out-of-network providers** during your **stay in a network hospital**.
- You could not reasonably get the services and supplies needed from a **network provider**.

The **other health care** coverage does not apply to services or supplies you receive in an **out-of-network** emergency room.

When the **other health care** coverage applies, you will pay the **other health care** cost share.

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

- For dental expenses:
 - 80% of the prevailing charge rate

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

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on our review of:

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

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

Special terms used

Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area

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

Prevailing Charge Rates

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

Additional Information:

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

R.N.

A registered nurse.

S

Skilled Nursing Facility

An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

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

Specialist

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

Specialist Dentist

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

Specialty Care

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

Additional Information Provided by

I.B.T. Local No. 145 Health Services & Insurance Plan

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:

PPO Dental Plan

Employer Identification Number:

06-0711441

Plan Number:

501

Type of Plan:

Health and Welfare

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

I.B.T. Local No. 145 Health Services & Insurance Plan
2505 Main Street, Suite 233
Stratford, CT 06615
Telephone Number: 203-375-6088

Agent For Service of Legal Process:

I.B.T. Local No. 145 Health Services & Insurance Plan
Attention: Renee M. Bassone
2505 Main Street, Suite 233
Stratford, CT 06615

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

End of Plan Year:

December 31

Source of Contributions:

Paid by the Fund and Participants

Procedure for Amending the Plan:

The Fund may amend the Plan from time to time by a written instrument signed by the Trustees.

The Plan is maintained in accordance with health and welfare provisions of a collective bargaining agreement.

ERISA Rights

As a participant in the group benefit 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 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 participant 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 the fund, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage 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 this Plan 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 this Plan 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 this Plan only if and when this Plan 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.