

# **Overseas Building Operations USAID**

**Book 1**

**299452**



**Aetna Life & Casualty (Bermuda) Ltd.**

**OPEN CHOICE, AND COMPREHENSIVE DENTAL**

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# Your Group Coverage Plan

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This Plan is underwritten by the Aetna Life & Casualty (Bermuda) Ltd., of Hamilton, Bermuda (called Aetna Bermuda). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will replace and supersede all Booklets issued to you by Aetna Global Benefits under the group contract.

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This is an electronic version of the Booklet on file with your Employer and Aetna Life & Casualty (Bermuda), Ltd. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life & Casualty (Bermuda), Ltd., or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Booklet, please contact your Employer.

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# Health Expense Coverage

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

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

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

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## Basic Health Expense Coverage

This Plan pays the benefits shown below for certain health expenses you incur for the treatment of an injury or a disease. These benefits apply separately to each covered person.

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## Vision Eyewear Expense Coverage

This Plan pays a benefit equal to 100% of the Maximum Allowance of the Covered Vision Supply Expenses you incur.

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### Vision Care Supply Expense Benefits

Covered Medical Expenses include charges for eyeglasses (lenses and frames) and contact lenses when prescribed by a legally qualified ophthalmologist or optometrist to a person.

Covered Medical Expenses for vision care supplies are payable up to the Vision Care Supply Maximum. Covered Medical Expenses will not include charges for more than one pair of eyeglasses (lenses and frames) or one pair of contact lenses during any period of 24 months in a row.

Benefits will be provided for 100% of the cost of Vision Care Supplies up to the Vision Care Supply Maximum \$ 100. If the actual cost of the Vision Care Supply is less than the Maximum, the Benefit will be for that amount.

### Limitations

The following limitations apply.

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No benefits will be payable for a charge which is:

- For a vision care service or supply that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer.
- For a vision care service or supply for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids.
- For anti-reflective coatings.
- For tinting.
- For any eye exam.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- For replacement of lenses or frames that are lost or stolen or broken.
- For duplicate or spare eyeglasses or lenses or frames for them.
- For any service or supply which does not meet professionally accepted standards.
- For a service or supply received while the person is not covered.
- For lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.

### **Benefits After Termination of Coverage**

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

Expenses incurred for eyeglasses and contact lenses within 30 days after a person's coverage under this benefit section terminates will be deemed to be Covered Vision Care Supply Expenses, but only if:

- a complete eye exam was performed in the 30 days right before such coverage ceases; this exam must include refraction;
- the exam resulted in:
  - lenses being prescribed for the first time; or
  - new lenses due to a change in prescription; and
- no other expenses for Vision Care Supplies were incurred in the previous period of 24 months in a row.

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# Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

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## Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred in the United States for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **preferred pharmacy** in the United States to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **preferred pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

A benefit will be paid at the preferred level of coverage for a **prescription drug** dispensed by a **non-preferred pharmacy** for an **emergency condition**.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

### Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf provided you present your member coverage Identification (I.D.) Cards at the **preferred pharmacy** at the time the prescription drug is purchased. In the event your member I.D. Card is not presented at the time the prescription drug is purchased, the benefit amount for each covered **prescription drug** or refill dispensed by the **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges, as determined based on the terms of the **preferred pharmacy's** contract with Aetna.

Any amount so determined will be paid to you.

No benefit will be paid for a **prescription drug** dispensed by a **non-preferred pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

This Plan's medical expense coverage may cover **prescription drugs** dispensed by a **non-preferred pharmacy**. Then, the benefit amount for each covered **prescription drug** or refill is equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug after any applicable deductible or **copay**, as specified in the Summary of Coverage.

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## Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For more than a 365 day supply per **prescription** or refill. This limitation applies to any drugs dispensed by a **mail order pharmacy** and retail pharmacy.
- For the administration or injection of any drug.
- For any injectable drug, except insulin.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

if the **prescriber** has not specified the number of refills; or

if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.

- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For immunization agents.
- For biological sera and blood products.
- For vitamins.
- For nutritional supplements.
- For any fertility drugs.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

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# Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

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## Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

### Hospital Expenses

#### *Inpatient Hospital Expenses*

**Charges** made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

#### *Outpatient Hospital Expenses*

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

### Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. The confinement must start during a "Convalescent Period".

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of days during any one Convalescent Period. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

It ends when the person has not been confined in a **hospital, convalescent facility,** or other place giving nursing care for 90 days in a row.

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### *Limitations To Convalescent Facility Expenses*

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

### **Home Health Care Expenses**

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:
  - medical supplies;
  - drugs and medicines prescribed by a **physician**; and
  - lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

### *Limitations To Home Health Care Expenses*

This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

### **Hospice Care Expenses**

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

### *Facility Expenses*

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  - pain control; and

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- other acute and chronic symptom management.
  - Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.
  - Services and supplies furnished to a person while not confined as a full-time inpatient.

***Other Expenses***

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  - assessment of the person's:
    - social, emotional, and medical needs; and
    - the home and family situation;
    - identification of the community resources which are available to the person; and
    - assisting the person to obtain those resources needed to meet the person's assessed needs.
  - Psychological and dietary counseling.
  - Consultation or case management services by a **physician**.
  - Physical and occupational therapy.
  - Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  - Medical supplies.
  - Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:

physical and occupational therapy;

part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

medical supplies;

drugs and medicines prescribed by a **physician**; and

psychological and dietary counseling.

Not more than the Hospice Outpatient Maximum will be paid for all Hospice Care Expenses incurred while the person is not confined as a full-time inpatient.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.

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- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
  - For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

### **Contraception Expenses**

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
  - consultations;
  - exams;
  - procedures; and
  - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

### **Routine Physical Exam Expenses and Wellness Care Expenses**

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:
  - a review and written record of the patient's complete medical history;
  - a check of all body systems; and
  - a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child to age 18, Covered Medical Expenses will not include charges for:
  - more than 6 exams performed during the first year of the child's life;
  - more than 2 exams performed during the second year of the child's life; and
  - one exam per year thereafter.

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- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
  - For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 24 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam and pap smear.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

### **Vision Care Services Expense Benefits**

Covered Medical Expenses include charges for any service shown below which is furnished by a legally qualified ophthalmologist or optometrist to a person.

#### **Routine Eye Exam Expenses**

Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

Covered Medical Expenses will not include charges for more than one routine eye exam for any period of 24 months in a row.

### **Limitations**

The following limitations apply.

No benefits will be payable for a charge which is:

- For any eye exam to diagnose or treat a disease or injury.
- For drugs or medicines.
- For a vision care service that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer.
- For a vision care service for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.
- For an eye exam which:

is required by an employer as a condition of employment; or

an employer is required to provide under a labor agreement; or

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is required by any law of a government.

- For a service received while the person is not covered.
- For a service or supply which does not meet professionally accepted standards.
- For any exams given while the person is confined in a **hospital** or other facility for medical care.
- For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses

### **Routine Hearing Exam Expenses**

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by: a Physician certified as an otolaryngologist or otologist; or

an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam for any period of 24 months in a row.

Benefits for the Routine Hearing Exam are subject to the applicable deductible or copay and payment percentage shown in the Summary of Coverage.

### **Limitations**

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

### **Other Medical Expenses**

- Charges made by a **physician**.
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

As used here, "skilled nursing care" means these services:

Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

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Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing care" is:

that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or  
any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

Drugs and medicines which by law need a **physician's** prescription and are dispensed by a **non-preferred pharmacy**.

Diagnostic lab work and X-rays.

X-ray, radium, and radioactive isotope therapy.

Anesthetics and oxygen.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

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Artificial limbs and eyes. These are not included: eye exams and eyeglasses; hearing aids; orthopedic shoes, foot orthotics, or other devices to support the feet.

Professional ambulance service including "air ambulance", if necessary, to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given.

Air ambulance is defined as a vehicle medically equipped to transport ill or injured persons that:

is licensed by local, county, or state regulations, and/or

has attendants who are fully trained in emergency care, such as Emergency Medical Technician (EMT) or paramedics.

However, no other expenses in connection with air travel are included.

### **National Medical Excellence Program ® (NME)**

*(applies only in the United States)*

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

#### ***Travel Expenses***

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

#### ***Lodging Expenses***

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

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### ***Travel and Lodging Benefit Maximum***

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

one year after the day the procedure is performed; and

the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

### ***Limitations***

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

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## **Explanation of Some Important Plan Provisions**

### **Inpatient Hospital Deductible**

This is the amount of Inpatient Hospital Expenses you pay for each **hospital** confinement of a person.

The Inpatient Hospital Deductible will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

### **Calendar Year Deductible**

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

### **Family Deductible Limit**

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

### **Lifetime Maximum Benefit**

This is the most that will be payable for any person in his or her lifetime.

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## Limitations

### **Preexisting Conditions**

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Summary of Coverage, whichever applies, to determine a person's effective date of coverage.

For the first 12 months following such date, Covered Medical Expenses incurred for treatment of a preexisting condition only include the first \$ 4,000 of Covered Medical Expenses for which no benefit is payable: under any other part of this Plan; or under any other group plan of your Employer.

### **Special Rules As To A Preexisting Condition**

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person. As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

### **Routine Mammogram and Prostate Cancer Screening**

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred:

- by a female age 40 or over for one routine mammogram; and
- by a male age 40 or over in connection with an annual exam for screening for cancer of the prostate, including:
  - a digital rectal exam; and
  - a prostate specific antigen (PSA) test.

### **Mouth, Jaws, and Teeth**

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

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Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:
  - teeth partly or completely impacted in the bone of the jaw;
  - teeth that will not erupt through the gum;
  - other teeth that cannot be removed without cutting into bone;
  - the roots of a tooth without removing the entire tooth;
  - cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

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Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

muscle training therapy; or

training to correct or control harmful habits.

### **Spinal Disorder Treatment**

There is a calendar year benefit maximum which applies to Covered Medical Expenses incurred for:

- manipulative (adjustive) treatment; or
- other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Calendar Year Maximum will be payable in any one calendar year for all expenses in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

### **Non-Emergency Care In An Emergency Room In The United States**

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

### **Certification For Hospital Admissions In The United States**

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or **mental disorders**. A separate section applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and

- 
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Hospital Expenses incurred for board and room.

As to all other Hospital Expenses:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

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If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

### **Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care In The United States**

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by a **physician** who is a **Preferred Care Provider**;

such Covered Medical Expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

If certification has been requested and denied:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement or (any day of such confinement) is **necessary**:

Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

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Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, hospice care while not confined as an inpatient, or skilled nursing care:

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the necessary service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this plan will be waived for any such day of confinement in a **hospital**.

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## **Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders In The United States**

If, in connection with the **effective treatment of alcoholism or drug abuse** or treatment of **mental disorders**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

### **Treatment of Alcoholism, Drug Abuse, or Mental Disorders**

Certain expenses for the treatment shown below are Covered Medical Expenses.

#### ***Inpatient Treatment***

If a person is a full-time inpatient either:

- in a **hospital**; or

- 
- in a **treatment facility**;

then the coverage is as shown below.

#### ***Hospital***

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

#### ***Treatment Facility***

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

#### ***Calendar Year Maximum Benefit***

A Special Combined Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

#### ***Outpatient Treatment***

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital, treatment facility** or **physician**, benefits will not be payable for more than the Special Combined Outpatient Calendar Year Maximum Visits in any one calendar year.

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# Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

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## Advance Claim Review (Applies Only in the United States)

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be \$ 350 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with Aetna. Forms maybe found at (<http://www.aetna.com/agb>). Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts.

Some services may be given before Advance Claim Review is made. These are oral exams, including prophylaxis and x-rays and treatment of any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment; and
- is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

### *Note:*

As a part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person at its own expense.
- You must give Aetna all diagnostic and evaluative material which it may require. These include x-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

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## Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage which applies to:

- Type A expenses;
- Type B expenses; and
- Type C expenses.

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## Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- **necessary**; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

This Dental Care Schedule includes only services in the list below.

### **Alternate Treatment**

The next sentence applies if:

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

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

Here is a list of Covered Dental Expenses.

### **Type A Expenses**

#### ***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)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to one 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*** *Includes all adjustments within six months after installation.*

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

### **Type B Expenses**

#### ***VISITS AND EXAMS***

- 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***

- Single films (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

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### **ORAL SURGERY**

- Extractions
  - Uncomplicated
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, not in conjunction with extraction - 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**

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Occlusal adjustment (other than with an appliance or by restoration)
- Subgingival curettage or root planing and scaling, per quadrant, limited to 4 separate quadrants every 2 years
- Gingivectomy (including post-surgical visits) per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy, treatment per tooth (fewer than 3 teeth), limited to 1 per site, every 3 years
- Gingival flap procedure, including root planing, per quadrant, limited to 1 per quadrant, every 3 years
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

### **ENDODONTICS**

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root Canal Therapy, including necessary X-rays
  - Anterior
  - Bicuspid

**RESTORATIVE DENTISTRY** *Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)*

- Amalgam Restorations - Primary Teeth
- Amalgam Restorations - Permanent Teeth
- Resin Restorations
- Sedative Fillings
- Pins
  - Pin retention - per tooth, in addition to amalgam or resin restoration

- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge

## **Type C Expenses**

### ***ORAL SURGERY***

- Impacted Teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

### ***PERIODONTICS***

- Osseous surgery (including post-surgical visits), per quadrant, limited to 1 per quadrant, every 3 years

### ***ENDODONTICS***

- Root Canal Therapy, including necessary X-rays
  - Molar

***RESTORATIVE*** *Cast or processed restorations 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.*

- Inlays/Onlays - Metallic or Porcelain/Ceramic
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Inlays/Onlays - Resin
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Labial Veneers
  - Laminate-chairside
  - Resin laminate – laboratory
  - Porcelain laminate – laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
- Post and core

### ***PROSTHODONTICS***

- Bridge Abutments (see Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Base 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 six months after installation. Fees for relines and rebases include adjustments within six 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 six months after installation
  - Full and Partial Denture Repairs
    - Broken dentures, no teeth involved
    - Repair cast framework
    - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
  - Repairs: crowns and bridges
  - Occlusal guard (for bruxism only) limited to 1 every 3 years

***GENERAL ANESTHESIA AND INTRAVENOUS SEDATION*** (only when provided in conjunction with a covered surgical procedure.)

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## Explanation of Some Important Plan Provisions

### **Calendar Year Deductible**

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

### **Family Deductible Limit**

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

### **Calendar Year Maximum Benefit**

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

### **Limitations**

#### **Alternate Treatment Rule**

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

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

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## Replacement Rule

The replacement of; addition to; or modification of:

existing dentures;  
crowns;  
casts or processed restorations;  
removable bridges; or  
fixed bridgework

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

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

The existing denture, crown; cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 8 years before its replacement.

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

## Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; removable bridges; and fixed bridgework is subject to the requirements that such dentures; removable bridges; and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

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## Exclusions and Limitations

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part:
  - under any other part of this Plan; or
  - under any other plan of group benefits provided by your Employer.
- Those for services and supplies to diagnose or treat a disease or **injury** that is not:
  - a non-occupational disease; or
  - a non-occupational **injury**.
- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.
- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for:
  - dentures;
  - crowns;
  - inlays;
  - onlays;
  - bridgework; or
  - other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.

- Those for any of the following services:
  - (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
  - (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  - (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any **jaw joint disorder**; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; except as specifically provided.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.
- Those in connection with a service given to a person age 5 or more if that person becomes a covered person other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:
  - (a) after the end of the twelve month period starting on the date the person became a covered person; or
  - (b) as a result of accidental **injuries** sustained while the person was a Covered Person; or
  - (c) for a Primary Care Service in the Dental Care Schedule that applies shown under the headings Visits and X-rays, Visits and Exams, and X-ray and Pathology.
- Those for a crown; cast; or processed restoration unless:
  - (a) it is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  - (b) the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

### **Benefits After Termination of Coverage**

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

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

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

As to a denture:

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

As to a root canal:

the pulp chamber was opened.

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As to any other item listed above:

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

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## General Exclusions

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### General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or

if required by the FDA, approval 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, investigational, or for research purposes; 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, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.

- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government other than a national. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

sildenafil citrate;  
 phentolamine;  
 apomorphine;  
 alprostadil; or  
 any other drug that

is in a similar or identical class,  
 has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet-Certificate.

- Those for performance, athletic performance, or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet-Certificate.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.

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- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
  - Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
  - Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

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

in the next calendar year.

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

- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.

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

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

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# Effect of Benefits Under Other Plans

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## Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract **B.** from **A.** below:
  - A.** 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  - B.** The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made. Not included is any expense listed in General Exclusions.

To find out whether Aetna will reduce its regular benefits, the order in which the various plans will pay benefits must be figured. This will be done as follows:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.
3. Except in the case of a dependent child whose parents are divorced or separated: the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If the other plan does not have this provision regarding birthdays, then the rule set forth in that plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:
  - a. If there is a court decree which should establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.
  - b. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

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If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

### **Other Plan**

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not, or any other insurance policy or any plan sponsored, underwritten, subsidized, or otherwise provided for, by, or through a government or instrumentality of a nation.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

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# General Information About Your Coverage

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## Termination of Coverage

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

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

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

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond:

- 12 months from the start of the absence, for all other coverage.

If you are eligible as a permanently and totally disabled employee under the terms of the Eligibility section, your employment may be deemed to continue for Life Insurance while you remain eligible under that section.

If you are not at work due to temporary lay-off or leave of absence, your employment is considered terminated.

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

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

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

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

If you cease active work, ask your Employer if any coverage can be continued.

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## **Dependents Coverage Only**

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

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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## **Handicapped Dependent Children**

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

- Health Expense Coverage may not be continued if the child has been issued a personal medical conversion policy.

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

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## **Continuation of Coverage For Your Dependents After Your Death**

If you die while covered under any part of this Plan, any Health Expense Coverage then in force for your dependents will be continued. But your Employer must continue to make premium payments.

Your spouse's coverage will cease, when your spouse remarries. Any dependent's coverage, including your spouse's, will cease when any one of the following happens:

- The end of the 12 month period right after your death.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.
- Dependent coverage ceases as to the Eligible Class of which you were a member right before your death.
- Any required contributions cease.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered.

Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

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## Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below, but, with respect to Medical Expense benefits, only as to expenses incurred in connection with the injury or disease that caused the total disability.

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

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

Basic Vision Care Expense benefits will be available to him or her, while disabled, for up to 3 months. These benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 3 month period.

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

Medical Expense benefits (other than Basic Medical Expense benefits) will be available to him or her while disabled for up to 12 months.

Health Expense benefits (other than Basic benefits) will cease on the first to occur of the following:

- The person's Lifetime Maximum Benefit is paid.
- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

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## Conversion of Medical Expense Coverage

If you or one of your covered dependents return to the United States, the following provision shall apply to the returning family member.

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

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You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

any other hospital or surgical expense insurance policy;

any hospital service or medical expense indemnity corporation subscriber contract;

any other group contract;

any statute, welfare plan or program;

and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been insured under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your Employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

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The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

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## Type of Coverage

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

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

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## Physical Examinations

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

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## Legal Action (Does not apply to Life Insurance)

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

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

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## Additional Provisions

The following additional provisions apply to your coverage.

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

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or Aetna Global Benefits Member Services in Tampa, Florida (U.S.A).

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

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## Assignments

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

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## Recovery of Overpayment

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

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

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

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## Reporting of Claims

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

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

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

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## Payment of Benefits

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

All other 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.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

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## 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 **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

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# Glossary

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

## **Board and Room Charges**

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

## **Brand Name Drug**

A **prescription drug** which is protected by trademark registration

## **Companion**

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

## **Convalescent Facility**

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

professional nursing care by a **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 **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.
- Makes charges.

## **Copay**

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

In no event will the copay be greater than the **prescription** or refill.

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### **Custodial Care**

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

### **Dentist**

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

### **Durable Medical and Surgical Equipment**

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

### **Effective Treatment of Alcoholism Or Drug Abuse**

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

### **Effective Treatment of A Mental Disorder**

This is a program that:

- is prescribed and supervised by a **physician**; and
- is for a disorder that can be favorably changed.

### **Emergency Admission**

One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

placing the person's health in serious jeopardy; or

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serious impairment to bodily function; or  
serious dysfunction of a body part or organ; or  
in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Emergency Care**

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Emergency Condition**

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Generic Drug**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

### **Home Health Care Agency**

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

### **Home Health Care Plan**

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

### **Hospice Care**

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

### **Hospice Care Agency**

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.

- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.
- Provides or arranges for other services which will include:
  - services of a **physician**; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one **physician**; and
  - one **R.N.**; and
  - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

### **Hospice Care Program**

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  - a **physician** attending the person; and
  - appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:
  - palliative and supportive care to **terminally ill** persons; and
  - supportive care to their families.
- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

### **Hospice Facility**

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.

- 
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
  - Provides, 24 hours a day, nursing services under the direction of a **R.N.**
  - Has a full-time administrator.

### **Hospital**

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

### **Jaw Joint Disorder**

This is:

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

### **L.P.N.**

This means a licensed practical nurse.

### **Mail Order Pharmacy**

An establishment where **prescription drugs** are legally dispensed by mail.

### **Mental Disorder**

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

### **NME Patient**

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and

- 
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

### **Necessary**

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

To be appropriate, the service or supply must:

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

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

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

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

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

### **Negotiated Charge**

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

### **Non-Occupational Disease**

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

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

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A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

### **Non-Occupational Injury**

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

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

### **Non-Preferred Care**

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **Preferred Care Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

### **Non-Preferred Pharmacy**

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

### **Non-urgent Admission**

One which is not an **emergency admission** or an **urgent admission**.

### **Other Health Care**

This is a health care service or supply that is neither **Preferred Care** nor **Non-Preferred Care**.

### **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.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

### **Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

### **Physician**

This means a legally qualified physician.

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## Preferred Care

This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency condition** when travel to a **Preferred Care Provider** is not feasible.

## Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

## Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

## Prescriber

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

## Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- Injectable insulin.
- Disposable needles and syringes which are purchased to administer insulin.
- Disposable diabetic supplies.
- An injectable contraceptive drug.

## Psychiatric Physician

This is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

## R.N.

This means a registered nurse.

## Reasonable Charge

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

- the provider's usual charge for furnishing it; and

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

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

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

Aetna may take into account factors, such as:

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

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

### **Semiprivate Rate**

This is the **charge for board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

### **Terminally Ill**

This is a medical prognosis of 6 months or less to live.

### **Treatment Facility (Alcoholism Or Drug Abuse)**

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse.**
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician.**
- Provides, on the premises, 24 hours a day:

Detoxification services needed with its effective treatment program.

Infirmery-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

Supervision by a staff of **physicians.**

Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

If a facility is located in the jurisdiction where the group contract is delivered, only the first 3 tests above will apply.

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## Treatment Facility (Mental Disorder)

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

If a facility is located in the jurisdiction where the group contract is delivered, only the first 2 and last 2 tests above will apply.

## Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.