Your Group Plan

Emory University

DMO - Georgia
ID Cards

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

Remember, DMO® members need to choose a primary care dentist in Aetna’s network. Otherwise, you could end up paying more. You can use our provider search tool online or call us at 1-877-238-6200 to make your selection.

CA /AZ DMO® participants, if you have not selected a PCD, one may have been selected for you. View your digital ID card to determine if one was selected on your behalf.
This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Health Inc. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.
AETNA HEALTH INC.  
(GEORGIA)  
CERTIFICATE OF COVERAGE  
DENTAL CARE PLAN

This Certificate of Coverage ("Certificate") is part of the Group Agreement ("Group Agreement") between Aetna Health Inc., hereinafter referred to as HMO, and the Contract Holder. The Group Agreement determines the terms and conditions of coverage. Provisions of this Certificate include the Dental Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

HMO agrees with the Contract Holder to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this Certificate. Members covered under this Certificate are subject to all the conditions and provisions of the Group Agreement.

This Certificate describes covered dental care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a Member. This means that coverage is provided only for dental care services furnished while this coverage is in force. Except as shown in the Continuation section of this Certificate, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this Certificate. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this Certificate.

This Certificate is not in lieu of insurance for Workers’ Compensation. This Certificate is governed by applicable federal law and the laws of Georgia.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER’S AND THE MEMBER’S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN DENTAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER’S ABILITY TO RECEIVE DENTAL CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.
NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

NOTICE: The laws of the State of Georgia prohibit insurers from unfairly discrimination against any person based upon his or her status as a victim of family violence.

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B. The Primary Care Dentist.

The PCD coordinates a Member's dental care, as appropriate, either by providing treatment or by issuing Referrals to direct the Member to a Participating Dental Provider. Except in an Out of Area Emergency, only those services which are provided by or referred by a Member's PCD will be covered. Covered Benefits are described in the Covered Benefits section of this Certificate. It is a Member's responsibility to consult with the PCD in all matters regarding the Member's dental care.

If the Member's PCD performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member's responsibility.

C. Availability of Providers.

HMO cannot guarantee the availability or continued participation of a particular Provider. Either HMO or any Participating Dental Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients. If the PCD initially selected cannot accept additional patients, the Member will be notified and given an opportunity to make another PCD selection. The Member must then cooperate with HMO to select another PCD.

D. Changing a PCD.

A Member may change the PCD at any time by notifying HMO by telephone or in writing. The change will become effective as follows:

1. If HMO receives the request before the 15th day of the month, the change will be effective on the first day of the next month.

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

E. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by Dental Providers to determine whether such services and supplies are Covered Benefits under this Certificate. If HMO determines that the recommended services and supplies are not Covered Benefits, the Member will be notified. If a Member wishes to appeal such determination, the Member may then contact HMO to seek a review of the determination.
ELIGIBILITY AND ENROLLMENT

A. Eligibility.

1. To be eligible to enroll as a Subscriber, an individual must:
   a. meet all applicable eligibility requirements agreed upon by the Contract Holder and HMO; and
   b. live or work in the Service Area.
   c. An employee who, upon termination of active service with the Contract Holder, meets the retiree eligibility requirements as defined by the Contract Holder and agreed to by HMO.

2. To be eligible to enroll as a Covered Dependent, the Contract Holder must provide dependent coverage for Subscribers, and the dependent must be:
   a. the legal spouse of a Subscriber under this Certificate, or
   b. a dependent child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, dependents of dependents) who meets the eligibility requirements described on the Dental Schedule of Benefits.

3. A Member who resides outside the Service Area is required to choose a PCD and return to the Service Area for Covered Benefits. Members shall be covered for an Emergency Condition only when obtained outside the Service Area.

B. Enrollment.

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in HMO regardless of health status, age, or requirements for dental services within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

   An eligible individual and any eligible dependents may enroll within 31 days of the eligibility date.

2. Open Enrollment Period.

   Eligible individuals or dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent Open Enrollment Period upon submission of complete enrollment information and Premium payment to HMO.

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

   A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in HMO within the initial 31 day period. If coverage does not require the payment of an additional Premium for a Covered Dependent, the Subscriber must still enroll the child within 31 days after the date of birth for the purpose of coordinating care and payment of claims.

   The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this Certificate.
b. Adopted Children.

A legally adopted child or a child for whom a Subscriber is a court appointed legal guardian, and who meets the definition of a Covered Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a Subscriber’s coverage becomes effective, and the Subscriber must make a written request for coverage within 31 days of the date the child is adopted or placed with the Subscriber for adoption for the purpose of coordinating care and payment of claims.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a Subscriber and who resides outside the Service Area, if there is a qualified medical child support order requiring the Subscriber to provide dependent dental coverage for a non-resident child, and is issued on or after the date the Subscriber’s coverage becomes effective. The child must meet the definition of a Covered Dependent, and the Subscriber must make a written request for coverage within 31 days of the court order.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the Subscriber for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility. In order to continue coverage for a handicapped child, the Subscriber must provide evidence of the child’s incapacity and dependency to HMO within 31 days of the date the child’s coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to HMO as requested, but not more frequently than annually beginning after the two year period following the child’s attainment of the age specified on the Dental Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent’s incapacity ends.

5. Notification of Change in Status.

It shall be a Member’s responsibility to notify HMO of any changes which affect the Member’s coverage under this Certificate. Such status changes include, but are not limited to, change of address, change of Covered Dependent status, and enrollment in Medicare or any other group dental plan of any Member. Additionally, if requested, a Subscriber must provide to HMO, within 31 days of the date of the request, evidence satisfactory to HMO that a dependent meets the eligibility requirements described in this Certificate.

An eligible individual and any eligible dependents may be enrolled if the eligible individual’s spouse was covered under another dental benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the Open Enrollment Period. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. HMO’s completed change form must be submitted to the Contract Holder within 31 days of the event causing the change in status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent is covered under another group dental plan or other dental insurance coverage when initially eligible for coverage under HMO;

b. the eligible individual or eligible dependent declines coverage in writing under HMO;

c. the eligible individual or eligible dependent loses coverage under the other group dental plan or other dental insurance coverage for one of the following reasons:

   i. the other group dental coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
ii. the other coverage is a group dental plan or other dental insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes a loss of coverage as a result of the entry of a valid decree of divorce, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the HMO Certificate of Coverage; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

The Effective Date of Coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or preexisting condition provision described in this Certificate.

6. Late Enrollment.

Eligible individuals and their dependents may also be enrolled at any other time upon submission of complete enrollment information and payment of Premium to HMO. Coverage shall not become effective until confirmed, in writing, by HMO and will be limited for twelve months. See exclusion fifteen for details.

C. Effective Date of Coverage.

Coverage shall take effect at 12:01 a.m. on the Member’s effective date. Coverage shall continue in effect from month to month subject to payment of Premiums made by the Contract Holder and subject to the Contract Holder Termination section of the Group Agreement.

If a Subscriber is not Actively at Work on the date coverage would otherwise become effective, coverage for the eligible individual and any eligible dependents will not become effective until the date the eligible individual is Actively at Work for one full day.
COVERED BENEFITS

A Member shall be entitled to the Covered Benefits as specified below, in accordance with the terms and conditions of this Certificate. If a Member has questions regarding coverage under this Certificate, the Member may call the Member Services 800 telephone number listed on the Member’s identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE DENTAL SCHEDULE OF BENEFITS.

HMO has arranged for PCD’s and Participating Specialist Dentists to furnish the necessary dental services under this coverage.

These services and supplies must be:

1. Given by the Member’s PCD at the dental office location; or

2. Given by a Participating Specialist Dentist for a dental condition requiring specialized care if the care is not available from the Member’s PCD; and if the PCD has referred the Member to the Par Specialist Dentist; and provided HMO approves coverage for the treatment. This care is called “Referral Care”; or


OUT-OF-AREA-EMERGENCY DENTAL CARE

“Out-Of-Area Emergency Dental Care” consists of Dental care that is given to covered persons by a Non-Par Dental Provider for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the covered person’s home address. Coverage for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this Dental Care Plan.

When care for an Emergency Condition is received; a benefit will be paid for the Reasonable Charges incurred by a covered person for such care. The amount paid will not be more than $100; regardless of the number of treatments needed for each separate Emergency Condition.

When care for an Emergency Condition is received; the maximum amount payable by the Dental Care Plan is the amount shown on the Dental Care Schedule that applies.

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

• The care meets the definition of Out-Of-Area Emergency Dental Care. Care is given more than 50 miles from the covered person’s home address.
• The care is for the temporary relief of the Emergency Condition until the covered person can be seen by the PCD.
• The person provides an itemized bill to Aetna. It must describe the care given.
• The dental service given is listed on the Dental Care Schedule that applies.

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

The following are not Covered Benefits except as described in the Covered Benefits section of this Certificate:

1. Services or supplies which are covered in whole or in part:
   a. Under any other part of this Dental Care Plan; or
   b. Under any other plan of group benefits provided by or through your Employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   a. A non-occupational disease; or
   b. A non-occupational injury.

3. Services not listed in the Dental Schedule of Benefits that applies, unless otherwise specified in the Certificate.

4. Replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

5. Plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which are primarily intended to improve, alter, or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. **Experimental or Investigational Procedures** or ineffectual surgical procedures or research studies as determined by HMO, unless approved by HMO prior to the treatment being rendered.

7. Those for:
   a. dentures;
   b. crowns;
   c. inlays;
   d. onlays;
   e. bridgework;
   f. other appliances or services used for the purpose of splinting;
   g. to alter vertical dimension to restore occlusion, or
   h. correcting attrition, abrasion, or erosion.

8. 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 Member;
   b. A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a Member;
   c. Root canal therapy, if the pulp chamber for it was opened before the person became a Member.

9. Those for services that HMO defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending Physician or Dentist.

10. Those for services intended for treatment of any Jaw Joint Disorder, unless otherwise specified in the Certificate.

11. Those for Space Maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Certificate.

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

14. 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.

15. Those in connection with a service given to a person age 5 or more if that person becomes a Member other than: (i) during the first 31 days the Member is eligible for this coverage, or (ii) as prescribed for any period of open enrollment agreed to by the Contract Holder and HMO. This does not apply to charges incurred:
a. After the end of the twelve month period starting on the date the person became a Member; or

b. As a result of accidental injuries sustained while the person was a Member; or

c. For a Primary Care Service in the Dental Schedule of Benefits that applies shown under the headings Visits and Exams, and X-rays, and Pathology.

16. Those for services given by a Non-Par Dental Provider.

17. 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.

18. Those for pontics, crowns, cast or processed restorations made with high noble metals, unless otherwise specified in the Certificate.

19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Certificate.

20. Those for services needed solely in connection with non-covered services.

21. Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

22. Court ordered services, or those required by court order as a condition of parole or probation.

23. Military service related diseases, disabilities or injuries for which the Member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the Member.

24. Missed appointment charges, including any charge incurred for a missed appointment with a Participating Dental Provider.

25. Non-medically necessary services, including but not limited to, those services and supplies:

   a. which are not medically necessary, as determined by HMO, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
   b. that do not require the technical skills of a medical or dental professional;
   c. furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member’s family, or any Provider;
   d. 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.

26. Outpatient prescription or non-prescription drugs and medicines.

27. Payment for benefits for which Medicare or a third party payer is the primary payer.

28. Services for which a Member is not legally obligated to pay in the absence of this coverage.

29. Services performed by a relative of a Member for which, in the absence of any dental benefits coverage, no charge would be made.

30. Services which are not a Covered Benefit under this Certificate, even when a prior Referral has been issued by a PCD.

31. Special dental reports, including those not directly related to treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
32. Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-
participating Hospital owned or operated by any federal, state or other governmental entity, except to the extent
required by applicable laws.

33. Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the
course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if
proof is furnished to HMO that the Member is covered under a workers' compensation law or similar law, but
is not covered for a particular disease or injury under such law, that disease or injury will be considered
“non-occupational” regardless of cause.

34. Unauthorized services, including any service obtained by or on behalf of a Member without prior Referral
issued by the Member's PCD or certified by HMO. This exclusion does not apply in a medical emergency, or
when it is a direct access benefit.

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

B. Limitations.

Dental Care Plan coverage is subject to the following rules:

Replacement Rule: The replacement of; addition to; or modification of:

1. existing dentures;
2. crowns;
3. casts or processed restorations;
4. removable bridges; or
5. 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. Dental Care Plan coverage must have been in force for the Member 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 5 years before its replacement.

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

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures; 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 Member;
and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a Member's dental condition; HMO may
decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

1. The service must be listed on the Dental Schedule of Benefits;
2. The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
3. The service selected must meet broadly accepted national standards of dental practice.
If treatment is being given by a **Participating Dental Provider** and the **Member** asks for a more costly covered service than that for which coverage is approved; the specific **Copayment** for such service will consist of:

1. The **Copayment** for the approved less costly service; plus

2. The difference in cost between the approved less costly service and the more costly covered service.

**Orthodontic Treatment:**

Coverage for Orthodontic Treatment is limited to those services and supplies listed on the Dental Schedule of Benefits that applies.

**HMO** has arranged for **Participating Specialist Dentists** to furnish the Orthodontic Procedures. A **Copayment** applies to the Orthodontic Procedures done on a **Member**.

Comprehensive orthodontic treatment is limited to a lifetime maximum of:

- 24 months of active, usual and customary orthodontic treatment on permanent dentition, plus an extra 24 months of post-treatment retention.

Coverage for services and supplies are not provided for any the following:

1. replacement of broken appliances;
2. re-treatment of orthodontic cases;
3. changes in treatment necessitated by an accident;
4. maxillofacial surgery;
5. myofunctional therapy;
6. treatment of cleft palate;
7. treatment of micrognathia;
8. treatment of macroglossia;
9. treatment of primary dentition;
10. treatment of transitional dentition; or
11. lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”).

Coverage is not provided for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a **Member** for the benefits of the **Certificate**.

Coverage is not provided for an Orthodontic Procedure for which an active appliance has been installed within the two years starting with the date the person became a **Member** for the benefit. This applies only to a person who does not become such a **Member** by the 31st day after the first day the person is eligible to become such a **Member**.
TERMINATION OF COVERAGE

A Member’s coverage under this Certificate will terminate upon the earliest of any of the conditions listed below.

A. Termination of Subscriber Coverage.

A Subscriber’s coverage will terminate on the date of any of the following occurrences:

1. employment terminates;
2. the Group Agreement terminates;
3. the Subscriber is no longer eligible as outlined on the Dental Schedule of Benefits; or
4. the Subscriber becomes covered under an alternative dental benefit plan or under any other plan which is offered by, through, or in connection with, the Contract Holder in lieu of coverage under this Certificate.

B. Termination of Dependent Coverage.

A Covered Dependent's coverage will terminate on the date of any of the following occurrences:

1. a Covered Dependent is no longer eligible, as outlined on the Dental Schedule of Benefits;
2. the Group Agreement terminates; or
3. the Subscriber’s coverage terminates.

C. Termination For Cause.

HMO may terminate coverage for cause:

1. subject to the Grievance Procedure described in this Certificate, upon 31 days advance written notice, if the Member is unable to establish or maintain, after repeated attempts, a satisfactory physician-patient relationship with a Participating Provider. Notice shall be given by certified mail and return receipt requested. At the effective date of such termination, prepayments received by HMO on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the Contract Holder.

2. upon 31 days advance written notice, if the Member has failed to make any required Copayment or any other payment which the Member is obligated to pay. Upon the effective date of such termination, prepayments received by HMO on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to Contract Holder.

3. immediately, upon discovering a material misrepresentation by the Member in applying for or obtaining coverage or benefits under this Certificate or discovering that the Member has committed fraud against HMO in applying for or procuring coverage. This may include, but is not limited to, furnishing incorrect or misleading information to HMO, or allowing or assisting a person other than the Member named on the identification card to obtain HMO benefits. HMO may, at its discretion, rescind a Member's coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the Member the reasonable and recognized charges for Covered Benefits, plus HMO’s cost of recovering those charges, including reasonable attorneys’ fees. In the absence of fraud or material misrepresentation, all statements made by any Member or any person applying for coverage under this Certificate will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to the Member prior to termination.

HMO shall have no further liability or responsibility under this Certificate except for coverage for Covered Benefits provided prior to the date of termination of coverage.
The fact that Members are not notified by the Contract Holder of the termination of their coverage due to the termination of the Group Agreement shall not deem the continuation of a Members' coverage beyond the date coverage terminates.

A Member may request that HMO conduct a grievance hearing, as described in the Grievance Procedure section of this Certificate, within 15 working days after receiving notice that HMO has or will terminate the Member's coverage as described in the Termination For Cause subsection of this Certificate. HMO will continue the Member's coverage in force until a final decision on the grievance is rendered, provided the Premium is paid throughout the period prior to the issuance of that final decision. HMO may rescind coverage, to the date coverage would have terminated had the Member not requested a grievance hearing, if the final decision is in favor of HMO. If coverage is rescinded, HMO will refund any Premiums paid for that period after the termination date, minus the cost of Covered Benefits provided to a Member during this period.

Coverage will not be terminated on the basis of a Member's health status or health care needs, nor if a Member has exercised the Member's rights under the Certificate's Grievance Procedure to register a complaint against HMO. The grievance process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this Certificate.

CONTINUATION

A. COBRA Continuation Coverage.

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits Members or Covered Dependents to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:

   The Contract Holder must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this Certificate would otherwise cease.

3. Loss of coverage due to:
   a. divorce or legal separation, or
   b. Subscriber's death, or
   c. Subscriber's entitlement to Medicare benefits, or
   d. cessation of Covered Dependent child status under the Eligibility and Enrollment section of this Certificate:

   The Member may elect to continue coverage for 36 months after eligibility for coverage under this Certificate would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:
   a. the last day of the 18-month period.
   b. the last day of the 36-month period.
c. the first day on which timely payment of Premium is not made subject to the Premiums section of the Group Agreement.
d. the first day on which the Contract Holder ceases to maintain any group health plan.
e. the first day on which a Member is actually covered by any other group health plan. In the event the Member has a preexisting condition, and the Member would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the Member’s preexisting condition becomes covered under the new plan, whichever occurs first.
f. the date the Member is entitled to Medicare.

5. Extensions of Coverage Periods:

a. The 18-month coverage period may be extended if an event which would otherwise qualify the Member for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than be longer than 36 months from the event which qualified the Member for continuation coverage initially.

b. In the event that a Member is determined, within the meaning of the Social Security Act, to be disabled and notifies the Contract Holder before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to Members who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the Members reduction in hours or termination. The Member may be charged a higher rate for the extended period.

6. Responsibility to provide Member with notice of Continuation Rights:

The Contract Holder is responsible for providing the necessary notification to Members, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay Premiums to HMO:

Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the Subscriber or Member pays the applicable Premium charges due within forty-five (45) days of submitting the application to the Contract Holder and Contract Holder in turn remitting same to HMO.

8. Premiums due HMO for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the Group Agreement and shall be calculated in accordance with applicable federal law and regulations but shall not exceed 102% of the applicable Premium charged to the Subscriber’s group for coverage.

B. Extension of Benefits Upon Total Disability.

Any Member who is Totally Disabled on the date coverage under this Certificate terminates is covered in accordance with the Certificate.

This extension of benefits shall only:

1. provide Covered Benefits that are necessary to treat dental conditions causing or directly related to the disability as determined by HMO; and

2. remain in effect until the earlier of the date that:
   a. the Member is no longer Totally Disabled; or
   b. the Member has exhausted the Covered Benefits available for treatment of that condition; or
   c. after a period of twelve (12) months in which benefits under such coverage are provided to the Member.
3. A subject of family violence has the right to convert if the perpetrator of family violence is the Subscriber and any of the following occurs:

   a. divorce or separation from the **Subscriber**;
   b. loss of custody of the subject of family violence by the **Subscriber**; or
   c. the **Subscriber**’s coverage has terminated voluntarily or involuntarily.

   The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.
**GRIEVANCE PROCEDURE**

The following procedures govern complaints, grievances, and grievance appeals made or submitted by **Members**.

A. **Definitions**

1. An “inquiry” is a **Member’s** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.

2. A “grievance” is a complaint that may or may not require specific corrective action, and is made in writing to **HMO**.

B. **Grievance Review**

1. A written notice shall be sent by **HMO** to the **Member**:
   a. acknowledging each grievance; and
   b. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance; and
   c. informing the **Member** of the **Member’s** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance process; and
   d. informing the **Member** as to when a response should be forthcoming.

2. The Grievance Committee deciding the grievance shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Committee shall review and decide the grievance within 30 days of receipt unless additional information necessary to resolve the grievance is not received during such time, or by the mutual written agreement of **HMO** and the **Member**.

3. A written notice stating the result of the review by the Grievance Committee shall be forwarded by **HMO** to the **Member** within ten (10) working days of the date of the decision. Such notice shall include:
   a. a description of the Committee’s understanding of the **Member’s** grievance as presented to the Grievance Committee (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and
   b. the Committee’s decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO’s** position (i.e., the **Member** did not contact the **PCD**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and
   c. citations to the evidence or documentation used as the basis for the decision (i.e., reference to the **Certificate**, medical records, etc.); and
   d. a statement indicating:
      i. that the decision will be final unless the **Member** appeals in writing to the Grievance Appeal Committee within thirty (30) days of the date of the notice of the decision of the Grievance Committee; and
      ii. a description of the process of how to appeal to the Grievance Appeal Committee; and
   e. that the decision of the Grievance Committee shall be final and binding unless appealed by the **Member** to **HMO** within thirty (30) days of the date of the notice of the decision of the Grievance Committee.

C. **Appeal Hearing**

1. Upon receipt of a written appeal by the Grievance Appeal Committee, **HMO** shall provide the **Member** filing the appeal with the procedures governing appeals before the Grievance Appeal Committee. The **Member** shall be notified of the **Member’s** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

2. The Grievance Appeal Committee shall be established by the Board of Directors of the **HMO** and shall be comprised of three members, one of whom shall be a non-employee **Subscriber** of the **HMO**. The Grievance Appeal Committee shall not include any person previously involved with the grievance. An **HMO** Dental Director may serve as a member of the Committee if the Dental Director was not previously involved with the grievance.
3. The Grievance Appeal Committee shall hold appeal hearings in HMO offices on a certain day each month to consider all appeals filed seven business days or more in advance of the hearing day. In the event a Member is unable to attend the hearing on the scheduled hearing day, the Member may request that their appeal be heard on the next scheduled hearing day. If no scheduled hearing day is suitable for the Member, the hearing will be scheduled for the following month.

4. The Member shall have the right to attend the appeal hearing, question the representative of HMO designated to appear at the hearing and any other witnesses, and present their case. The Member shall also have the right to be assisted or represented by a person of the Member’s choice, and submit written material in support of their grievance. The Member may bring a Physician or other expert(s) to testify on the Member’s behalf. HMO shall also have the right to present witnesses. Counsel for the Member may present the Member’s case and question witnesses; if the Member is so represented, HMO may be similarly represented by counsel. The Grievance Appeal Committee shall have the right to question the HMO representative, the Member and any other witnesses.

5. The appeal hearing shall be informal. The Grievance Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Grievance Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Grievance Appeal Committee shall ask both the Member and the HMO representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Grievance Appeal Committee. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Grievance Appeal Committee shall be confidential and shall not be transcribed.

8. The Grievance Appeal Committee shall render a written decision within 30 working days of the conclusion of the appeal hearing. The decision shall contain:

   a. a statement of the Grievance Appeal Committee’s understanding of the nature of the grievance and the material facts related thereto; and
   b. the Grievance Appeal Committee’s decision and rationale; and
   c. a summary of the evidence, including necessary document supporting the decision; and
   d. a statement of the Member’s right to appeal to the Department of Insurance, with the phone number and complete address of the Department of Insurance.

D. Emergency Care

1. In the event a complaint requires specific action, and the Member or HMO believes serious dental consequences will arise in the near future, within up to 15 days from HMO’s denial to pay for the provision of allegedly necessary covered health services, the Member shall receive expedited review of their complaint.

2. In the event the issue is of an emergency nature, an HMO Dental Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the Member by telephone.

3. An adverse decision by a Dental Director in an emergency dental situation shall be immediately reviewed by an HMO Regional Dental Director or his designee. The decision of the Regional Dental Director shall be provided to the Member by telephone and confirmed in writing.

E. Exhaustion of Process

The foregoing procedures and process are mandatory and must be exhausted prior to the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the Group Agreement or Certificate by HMO, or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.
F. **Record Retention**

HMO shall retain the records of all grievances for a period of at least 7 years.

G. **Fees and Costs**

Nothing herein shall be construed to required HMO to pay counsel fees or any other fees or costs incurred by a Member in pursuing a grievance or appeal.

H. **Appeal to Independent Review Agency**

1. A Member or someone who was a Member at the time of request for treatment may appeal a review decision to an independent review agency when:
   a. They have received notice of an adverse outcome of a HMO grievance procedure or HMO did not comply with the State requirements with respect to conducting the grievance process.
   b. HMO has determined that a proposed treatment is Experimental and all of the following are met:
      • Member has a terminal condition that in the determination of the treating Physician has a substantial probability of causing death within two years of the date of independent review request or that the Member’s ability to regain or maintain function would be impaired by withholding treatment.
      • Either after exhausting the standard treatments or a finding that such treatments would be of little or no benefit, the Member’s treating Physician certifies that the Member has a condition for which there is no standard treatment more beneficial than the proposed experimental treatment.
      • The treating Physician has certified in writing treatment likely to be more beneficial than the standard treatment.
      • The treating Physician has certified in writing treatment likely to be more beneficial than the standard treatment.
      • The treatment would otherwise be covered if it had not been determined experimental for a condition.

2. Proposed treatments require an expenditure of $500.00 before being eligible for independent review.

3. A parent or guardian may request independent review on behalf of a minor. Otherwise independent review actions may only be requested by the Member or someone authorized to act on the Member’s behalf.

4. HMO is responsible for the full cost of the independent review.

5. Both the Member and HMO have responsibility for supplying information including releases for medical information as necessary for the review organization to make a decision.

6. Notice of this right, as well as instructions for initiating this independent review, shall be provided, in writing, to a Member following an adverse outcome of the Grievance Procedure contained herein.
COORDINATION OF BENEFITS

Some Members have dental coverage in addition to the coverage provided under this Certificate. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this Certificate.

When coverage under this Certificate and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. 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:
   1. secondary to the plan covering the person as a dependent; and
   2. primary to the plan covering the person as other than a dependent.

C. 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 both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:
   1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.
   2. If there is a court decree which makes one parent financially responsible for the dental care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent.
   3. If there is not such a court decree as described in 1 or 2 above, then:
      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.
      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.

E. If A, B, C and D 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 as a:
   1. laid-off or retired employee; or
   2. the dependent of such person;
   shall be determined after the benefits of any other plan which covers such person as:
   1. an employee who is not laid-off or retired; or
   2. 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.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision regarding right of continuation pursuant to federal or state law; and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

Other plan means any other plan of dental expense coverage under:

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional “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.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, HMO will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of Allowable Expenses less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a Member covered under this Certificate during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

When the benefits under the plan which determines its benefits first are reduced because a Member does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense.

Facility of Payment.

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

Recovery of Overpayments.

If the benefits paid under this Certificate, plus the benefits paid by other plans, exceeds the total amount of Allowable Expenses, HMO has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at HMO’s discretion. A Member shall execute any documents and cooperate with HMO to secure its right to recover such overpayments, upon request from HMO.
THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

If HMO provides dental care benefits under this Certificate to a Member for injuries or illness for which a third party is or may be responsible, then HMO retains the right to recover the cost of all benefits provided by HMO on behalf of the Member that are associated with the injury or illness for which the third party is or may be responsible. HMO’s right of recovery applies to any recoveries made by or on behalf of the Member from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any workers’ compensation or disability award or settlement; dental payments coverage under any automobile policy, premises or homeowners dental payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Member for injuries resulting from alleged negligence of a third party.

If a Member has a claim for damages or a right to recover damages from a third party for any illness or injury for which benefits are payable under this plan, HMO may have a right of recovery. HMO’s right of recovery shall be limited to the recovery of any benefits paid under this Certificate, but shall not include nondental items. Money received for future dental care or pain and suffering may not be recovered. HMO’s right of recovery may include compromise settlements. The Member or Member’s attorney must inform HMO of any legal action or settlement agreement at least ten days prior to settlement or trial. HMO will then notify the Member or Member’s attorney of the amount it seeks to recover for Covered Benefits paid. Where required by law, HMO’s recovery may be reduced by the pro-rata share of the Member’s attorney’s fees and expenses of litigation.

The Member and the Member’s representatives further agree to:

A. Notify HMO promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Member that may be the legal responsibility of a third party; and

B. Cooperate with HMO and do whatever is necessary to secure HMO's right of recovery; and

C. Do nothing to prejudice HMO's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by HMO.

HMO may recover the full cost of all benefits provided by HMO under this Certificate without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from HMO’s recovery without the prior express written consent of HMO. In the event the Member or the Member’s representative fails to cooperate with HMO, the Member shall be responsible for all benefits paid by HMO in addition to costs and attorney’s fees incurred by HMO in obtaining repayment.
RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to HMO such application or other forms or statements as HMO may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to HMO incident to enrollment under this *Certificate* or the administration herein shall be true, correct, and complete to the best of the Member’s knowledge and belief.

B. The Member shall notify HMO immediately of any change of address for the Member or any of the Member’s Covered Dependents.

C. The Member understands that HMO is acting in reliance upon all information provided to it by the Member at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this *Certificate*, or accepting benefits hereunder, all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by HMO to Members pursuant to this *Certificate* is for identification purposes only. Possession of an HMO identification card confers no right to services or benefits under this *Certificate*. To be eligible for services or benefits under this *Certificate*, the holder of the card must be a Member on whose behalf all applicable Premium charges under this *Certificate* have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this *Certificate* shall be charged for such services or benefits at billed charges.

B. **Reports and Records.** HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this *Certificate* subject to all applicable confidentiality requirements as defined in the General Provisions section of this *Certificate*. By accepting coverage under this *Certificate*, the Subscriber, for himself or herself, and for all Covered Dependents covered hereunder, authorizes each and every Provider who renders services to a Member hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the Member to HMO, or a dental professional that HMO may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the Member to HMO, or a dental professional that HMO may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the Member’s records by HMO.

C. **Refusal of Treatment.** A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Dental Provider. If Member unreasonably refuses to follow the recommended treatment or procedure, neither the Participating Dental Provider, nor HMO, will have further responsibility to provide any of the benefits available under this *Certificate* for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance Procedure set forth in the Grievance Procedure section of this *Certificate*. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the Member to receive benefits hereunder are personal to the Member and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against HMO for any expense or bill unless and until the appeal process has been exhausted, and in no even prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this Group Agreement. No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.
F. Independent Contractor Relationship.

1. No Participating Dental Provider or other Provider, institution, facility or agency is an agent or employee of HMO. Neither HMO nor any Member of HMO is an agent or employee of any Participating Dental Provider or other Provider, institution, facility or agency.

2. Neither the Contract Holder nor a Member is the agent or representative of HMO, its agents or employees, or an agent or representative of any Participating Dental Provider or other person or organization with which HMO has made or hereafter shall make arrangements for services under this Certificate.

3. Participating Dental Providers maintain the physician-patient relationship with Members and are solely responsible to Member for all Dental Services which are rendered by Participating Dental Providers.

4. HMO cannot guarantee the continued participation of any Provider with HMO. In the event a PCD terminates its contract or is terminated by HMO, HMO shall provide notification to Members in the following manner:
   a. within 30 days of the termination of a PCD contract to each affected Subscriber, if the Subscriber or any Dependent of the Subscriber is currently enrolled in the PCD’s office; and
   b. services rendered by a PCD to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the Member at the Member’s last known address shall continue to be Covered Benefits.

5. Restriction on Choice of Providers: Unless otherwise approved by HMO, Members must utilize Participating Dental Providers and facilities with which HMO has contracted with HMO to provide services.

G. Inability to Provide Service. In the event that due to circumstances not within the reasonable control of HMO, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the rendition of dental benefits or other services provided under this Certificate is delayed or rendered impractical, HMO shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by HMO on the date such event occurs. HMO is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. Confidentiality. Information contained in the dental records of Members and information received from Dentists incident to the physician-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except for use incident to bona fide dental research and education as may be permitted by law, or reasonably necessary by HMO in connection with the administration of this Certificate, or the compiling of aggregate statistical data.

I. Limitation on Services. Except in cases of an Emergency Condition, as provided under the Covered Benefits section of this Certificate, services are available only from Participating Dental Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, Skilled Nursing Facility, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by HMO.

J. Incontestability. In the absence of fraud, all statements made by a Member shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim unless the statement was contained in a written application signed by the Member or Subscriber with a copy furnished to the Subscriber, Member or his/her beneficiary.

K. This Certificate applies to coverage only, and does not restrict a Member’s ability to receive dental care benefits that are not, or might not be, Covered Benefits.

L. Contract Holder hereby makes HMO coverage available to persons who are eligible under the Eligibility and Enrollment section of this Certificate. However, this Certificate shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between HMO and Contract Holder without the consent of Members.
M. HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Certificate.

N. No agent or other person, except an authorized representative of HMO, has authority to waive any condition or restriction of this Certificate, to extend the time for making a payment, or to bind HMO by making any promise or representation or by giving or receiving any information. No change in this Certificate shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This Certificate, including the Dental Schedule of Benefits, any Riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire Certificate. The Certificate is part of the Group Agreement. The Group Agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Certificate shall be binding unless executed in writing by authorized representatives of the parties.

P. This Certificate has been entered into and shall be construed according to applicable state and federal law.

Q. Proof of Loss and Claims Payment.

1. Proof of Loss: Written proof of loss must be furnished to HMO within 90 days after a Member incurs Covered Benefits. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the proof of loss within 90 days, provided the proof of loss is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than one year from the date when the proof of loss was originally required. A proof of loss form may be obtained from HMO or the Contract Holder. If the Member does not receive such form before the expiration of 15 working days after HMO receives the request, the Member shall be deemed to have complied with the requirements of this Certificate upon submitting written proof covering the occurrence, character and extent of the loss for which claim is made. HMO shall pay interest to the Member equal to 18% per annum on the proceeds or benefits due under the terms of this Certificate for failure to comply with the requirements of this paragraph.

2. Time for Payment of Claim: Benefits payable under this Certificate will be paid within 15 days after the receipt by HMO of satisfactory proof of loss. If any portion of a claim is contested by HMO, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by HMO.

3. Payment of Claims: All or any portion of any indemnities provided by the Certificate on account of Hospital, nursing, medical or surgical services shall be paid to the Provider rendering such services; but it is not required that the service be rendered by a particular Hospital or person the Subscriber. Any payment made by HMO in good faith pursuant to this provision will fully discharge HMO’s obligation to the extent of the payment. The Member may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to HMO not later than the time of filing proof of loss. Payment made prior to receipt of the Member’s written request at HMO’s principal executive office will be deemed to be payment made in good faith.

The Member shall be responsible for the payment of all charges for any service or supply in excess of the Reasonable Charges or otherwise not covered by this Certificate.

R. Time Limitations on Service. To be eligible for consideration as a Covered Benefit, any service or supply sought or received by a Member must be billed to and received by HMO no later than 12 months after the date the service was provided unless it is shown to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.
DEFINITIONS

The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the Subscriber’s regular duties for the Contract Holder (the Subscriber’s employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be Actively at Work on a non-scheduled work day only if such person is Actively at Work on the last regularly scheduled work day immediately preceding such non-scheduled work day.

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the Member for whom claim is made.

- **Certificate.** This Certificate of Coverage, including the Dental Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a Subscriber and Covered Dependents according to the Group Agreement.

- **Contract Holder.** An employer or organization who agrees to remit the Premiums for coverage under the Group Agreement payable to HMO. The Contract Holder shall act only as an agent of HMO Members in the Contract Holder’s group, and shall not be the agent of HMO for any purpose.

- **Contract Year.** A period of one year commencing on the Contract Holder’s Effective Date of Coverage and ends at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for dental care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this Certificate for a description of the Coordination of Benefits provision.

- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits, if any, as set forth in the Dental Schedule of Benefits. Copayments may be changed by HMO upon 30 days written notice to the Contract Holder.

- **Covered Benefits.** Those necessary services and supplies set forth in this Certificate, which are covered subject to all of the terms and conditions of the Group Agreement and Certificate.

- **Covered Dental Services.** Dental services and supplies set forth in this Certificate, provided to a Member, while the person is a Member subject to the limitations and exclusions of the Dental Care Plan.

- **Covered Dependent.** Any person in a Subscriber’s family who meets all the eligibility requirements of the Eligibility and Enrollment section of this Certificate and the Dependent Eligibility section of the Dental Schedule of Benefits, has enrolled in HMO, and is subject to Premium requirements set forth in the Premiums section of the Group Agreement.

- **Covered Orthodontic Expenses.** Orthodontic services and supplies set forth in this Certificate, given to a Member; while the person is a Member, and subject to the limitations and exclusions of the Dental Care Plan and the terms of the Dental Schedule of Benefits.

- **Dental Care Plan(s).** The plan(s) of benefits provided under the Dental Care Plan coverage.

- **Dental Community.** A majority of Physicians who are Board Certified in the appropriate specialty.

- **Dental Consultant.** A Dentist who has agreed to provide consulting services in connection with the Dental Care Plan.

- **Dental Provider.** Is any:

  1. Dentist;
  2. group;
  3. organization;
  4. dental facility; or
  5. other institution or person legally qualified to furnish dental services or supplies.

- **Effective Date of Coverage.** The commencement date of coverage under this Certificate as shown on the records of HMO.

- **Emergency Condition.** A condition which requires dental services administered in a dentist’s office, dental clinic or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson, possessing average knowledge of dentistry to believe that immediate care is needed.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
1. there is not sufficient outcome 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

2. required FDA approval has not been granted for marketing; or

3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

5. it is not of proven benefit for the specific diagnosis or treatment of a Member’s particular condition; or

6. it is not generally recognized by the Dental Community as effective or appropriate for the specific diagnosis or treatment of a Member’s particular condition; or

7. it is provided or performed in special settings for research purposes.

- **Group Agreement.** The Group Agreement between HMO and the Contract Holder, including the Group Application, Cover Sheet, this Certificate, the Dental Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **HMO.** Aetna Health Inc., a Georgia corporation licensed by the Georgia Department of Insurance as a Health Maintenance Organization.

- **Jaw Joint Disorder.** 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 related muscles and nerves.

- **Member.** A Subscriber or Covered Dependent as defined in this Certificate.

- **Non-Participating (Non-Par) Dental Provider.** A Dental Provider who has not entered into a written agreement with HMO to provide Dental Care Plan covered services to Members.

- **Open Enrollment Period.** A period of not less than ten (10) consecutive working days, each calendar year, when eligible enrollees of the Contract Holder may enroll in HMO without a waiting period or exclusion or limitation based on health status or, if already enrolled in HMO, may transfer to an alternative plan offered by the Contract Holder.

- **Out-Of-Area Emergency Dental Care.** Dental Care that is given to Members by a Non-Par Dental Provider for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the Member’s home address. Coverage for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this Dental Care Plan.

- **Participating.** A description of a Provider that has entered into a contractual agreement with HMO for the provision of services to Members.

- **Participating (Par) Dental Provider.** Any Dental Provider who has entered into a written agreement with HMO to provide dental care described under the Dental Care Plan to Members.

- **Participating (Par) Specialist Dentist.** Any Dentist who; by virtue of advanced training; is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry. In addition, this Dentist has entered into a written agreement with HMO to provide dental care described under the Dental Care Plan to Members.

- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides Medical Services which are within the scope of the individual’s license or certificate.

- **Premium.** The amount the Contract Holder or Member is required to pay to HMO to continue coverage.

- **Primary Care Dentist (PCD).** A Participating Dental Provider currently chosen by you to provide dental care to a Member.

A PCD chosen by you takes effect as a Member’s PCD on the effective date of that person’s coverage.
If you do not choose a PCD, HMO will have the right to make a selection for you. HMO will notify you of the selection.

- **Reasonable Charge.** The charge for a Covered Benefit which is determined by the HMO to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. HMO may take into account factors such as the complexity, degree of skill needed, type or specialty of the Provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

- **Referral Care.** Covered services given to a Member by a Participating Specialist Dentist after Referral by the Member’s PCD and provided HMO approves coverage for the treatment.

- **Referral.** Specific directions or instructions from a Member’s PCD, in conformance with HMO’s policies and procedures, that direct a Member to a Participating Provider for Medically Necessary care.

- **Service Area.** The geographic area, established by HMO and approved by the appropriate regulatory authority.

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this Certificate and on the Dental Schedule of Benefits, has enrolled in HMO, and is subject to Premium requirements as set forth in the Premiums section of the Group Agreement.

- **Totally Disabled or Total Disability.** A Member shall be considered Totally Disabled if:

  1. the Member is a Subscriber and is prevented, because of injury or disease, from performing any occupation for which the Member is reasonably fitted by training, experience, and accomplishments; or

  2. the Member is a Covered Dependent and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.
CONFIDENTIALITY NOTICE

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

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

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

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

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.
You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

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

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

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

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

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)
CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW

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

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

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

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

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

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

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

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

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

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

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your Booklet-Certificate. Your Plan Administrator has determined that this information together with the information contained in your Booklet-Certificate is the Summary Plan Description required by ERISA.

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

**Employer Identification Number:**

58-0566256

**Plan Number:**

502

**Type of Plan:**

Welfare

**Type of Administration:**

Group Insurance Policy with:

Aetna Health Inc.
4050 Piedmont Parkway
High Point, NC 27265

**Plan Administrator:**

Emory University
1599 Clifton Road
Atlanta, GA 30322

**Agent For Service of Legal Process:**

Emory University
1599 Clifton Road
Atlanta, GA 30322

**End of Plan Year:**

December 31

**Source of Contributions:**

You and Emory share in the cost of this Plan.

**Procedure for Amending the Plan:**

Emory may amend the Plan from time to time by a written instrument signed by the senior officer of Emory University.
ERISA RIGHTS

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

**Receive Information about Your Plan and Benefits**

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

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

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

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

**Continue Group Health Plan Coverage**

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

**Prudent Actions by Plan Fiduciaries**

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

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

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

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

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

ASSISTANCE WITH YOUR QUESTIONS

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

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

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

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

ADDITIONAL INFORMATION

Provider Networks
If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at www.aetna.com.
AETNA HEALTH INC.
GEORGIA

DENTAL EXPENSE COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2019

The Aetna Health Inc. Group Agreements, Certificates of Coverage, Schedules of Benefits, riders, amendments, endorsements, inserts and attachments (the “Plan Documents”) are hereby amended as follows:

The following dental services will be considered covered dental expenses under the Managed Dental Expense Coverage under certain conditions as follows.

Additional dental services are provided for a covered person who:

• is pregnant; or
• has coronary artery disease/ cardiovascular disease; or diabetes; and
• is a covered person for medical coverage insured by Aetna.

Covered Dental Expenses

If the above conditions are met, the following dental services will be considered Covered Dental Expenses:

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

With respect to the additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

With respect to the other dental services above, the Copayment will be waived and will not be subject to any frequency limits except as shown above.

All other terms and conditions of the Certificate shall remain in full force and effect except as amended herein.

CONTRACT HOLDER

By: See Master Application
Title: ______________________________
Date: ______________________________

AETNA HEALTH INC.

By: ________________________________
Title: Vice President
Date: November 29, 2018

HMO GEN AMEND DMI FX COPAY AMEND 09/06