CAMERON COUNTY PURCHASING
1100 East Monroe St,
Brownsville, Texas 78520
(956) 544-0871 Fax: (956) 550-7219

ADDENDUM # 2 - PAGE 1 of 4

DATE OUT: 8/08/23

RFP TITLE: INSURANCE: VOLUNTARY (EMPLOYEE PURCHASED) – DENTAL)

RFP NUMBER # 1466-D

DEADLINE: August 15, 2023 at 3:00 p.m.

(IN ORDER TO AVOID DISQUALIFICATION – ALL ADDENDUMS MUST BE SIGNED AND RETURNED BY DEADLINE AND INCLUDED IN THE SEALED BID PACKAGE SUBMITTED)

Response to questions and clarifications submitted by participants:

RFP 1460 – EAP Questions and Answers

Not for release – Requestor	Question	Answer
C. Young, 7/25	We have received the census file however I do not see that current dental elections are on the census file. It is only showing life, DI, and worksite elections. Can you please forward a census file with the dental elections added	The corrected Census is provided.
Y. Ortegon, 7/25/23	The census provided did not have the dental elections. Can you please provide that information? Also, are you releasing the 2023 renewal?	The corrected census file is attached. The incumbent carrier's response to the RFP Will constitute their renewal.
T. Binley, 7/27/23	How does this group reimburse their OON claims (MAC, 80th, 90th, etc.)?	80th percentile
	Can we please get a full certificate?	The complete dental benefit booklet is attached
	Can we please get the dental elections added to the census?	There is only one plan offered and the coverage tiers elected are indicated in the census file.

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Response to questions and clarifications submitted by participants:

1. Will electronic signatures be accepted? Yes, as long as the authorized representative is signing
   Electronic signatures will be accepted as long as the authorized representative is signing document electronically.
2. What are the correct labeling instructions for mailing the hardcopies? The RFP has three different ways listed: (pg 1)
   I. Roberto C. Luna, Interim Purchasing Agent RFP #1460-A County Courthouse (Dancy Bldg.)1100 E. Monroe St., 3rd Floor, Room 345, Brownsville, TX 78520 (pg 12)
3. Is there a specific layout we should follow to build the hardcopies? I saw a checklist of what to include but no layout on how they want them put together.
   Get consultant to assist with this – There are no specific requirements regarding the layout of your hard copy response.
4. Please define the request to submit a soft-copy proposal; how does the County wish to receive this? Is this an email of the proposal?
   Original and copies are to be submitted hard copy and an electronic copy with searchable files (pdf, word, excel) in a memory stick
5. The General Questionnaire on page 18 states that all questions are to be answered/provided in an Excel-compatible format; however, the questionnaire was provided in PDF. Is an Excel version of the questionnaire available?
   Consultant to assist with answer – The Dental Questionnaire was posted in an Excel file and should be returned in an Excel file format.
6. Can an extension for submission be granted until August 17th due to delivery concerns in the area? In order to avoid this we plan on sending our proposal out for one day delivery on Friday the 11th ---which usually equates to 2 or 3 day delivery. The 17th would allow proposals to be sent out on M or Tuesday and be delivered during your working hours. -Most of these questions were self-evident and addressed in the solicitation and none of issues or questions delays their response except for their lack of understanding instructions. RFP DUE EXTENSION ***WILL NOT BE GRANTED AT THIS TIME***

The RFP has the following request but no sheets were provided in the RFP, please provide or advise.

Cost RFP Proposal (1 page max.)

Proposer's cost proposals must include an itemized list of all direct and indirect costs associated with the performance of this contract. To answer this section, you can include the pricing sheets provided in the next few pages.

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Response to questions and clarifications submitted by participants:

1) Page 17 of the RFP mentions pricing sheets, but they do not appear to be included. Can you please provide the pricing sheets we need to complete? Provide your pricing in your standard format
2) If pricing sheets are required, please confirm if the County will accept a copy of our financial proposal as well. Provide your pricing in your standard format
3) Please confirm if we should copy and paste the General Questionnaire included on pages 18-19 of the RFP into Excel or if an Excel version of this questionnaire is available. There is a separate Excel file questionnaire already posted on the website. Complete that questionnaire and return it in the excel file format.
4) Please confirm the effective date. 10/1/23
5) How is enrollment handled? The County uses an online enrollment platform
6) Please confirm OON reimbursement (MAC or UCR) UCR, 80th percentile
7) Please confirm current and requested commissions. If commissions are being included, identify the recipient of the commissions and the amount of the commission load.

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ADDENDUM # 2 - PAGE 4 of 4

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Response to questions and clarifications submitted by participants:

Questions:

1. Please confirm which is the correct Conflict of Interest Questionnaire to be completed. On page 5, link provided to Conflict of Interest Questionnaire or Attachment G Conflict of Interest Questionnaire included on page 26.

Fill out attachment G on page 26 of 39

2. Please confirm the Attachments to be included in the proposal response. Within the RFP, on page 5, there is mention to complete Attachments A, B, C, D, E, F, G, H, and I; however the Checklist on page 4 lists Attachments as A, B, C, D, E, F, G, H, I, J & K to be completed. If the latter, please provide Attachments J & K to be completed.

Please disregard Attachments ~~J and K~~. Only submit attachments A to I

3. Please confirm whether a Bid Bond or Performance Bond is required at the time of submission or upon award notification.

No bid bond is required for this RFP (It is general language that is included with all packages) Please omit bid bond

4. Please confirm that the correct Disclosure of Interests questionnaire to be completed is Attachment H. The link provided on page 6 of the RFP is for a Local Government Officer Conflict Disclosure Statement which is not applicable.

Please submit Attachment H and omit link provided on page # 6.

5. On page 5 of the RFP, under "Governing Forms", the RFP refers to a "minimum specifications form". If applicable, could you please provide us with a copy of this form?

This particular section refers to the scope of work/services (page 13 of 39) and proposal requirements (page 16 of 39). This RFP does not contain any technical specifications that are usually used to equipment and/or labor services.

Please find Cameron County Dental UPDATED Census (excel sheet). In addition, please also find Aetna "Benefit Plan" and "Schedule of benefits".

Note:

This addendum shall become part of the RFP and all RESPONDERS/PARTICIPANTS shall be bound by its content. All aspects of the scope of work/services not covered herein shall remain the same.

Company Name_____ **Phone #** _____

Vendor Signature_____ **Date** _____

Must include and return with Bid package
END OF ADDENDUM #2

BENEFIT PLAN

Prepared Exclusively For
Cameron County

Comprehensive Dental Plan

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

aetna™

ID Cards

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

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Preface *(GR-9N-02-005-01 TX)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

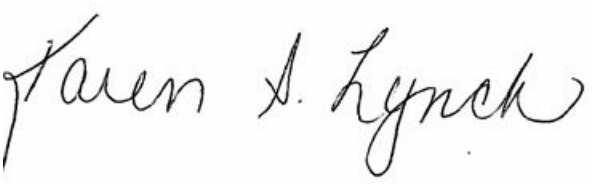
The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits*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

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	Cameron County
Group Policy Number:	GP-143726
Group Control Number:	CN-169664
Effective Date:	October 1, 2020
Issue Date:	October 30, 2020
Booklet-Certificate Number:	1

THE GROUP INSURANCE POLICY UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

THIS CERTIFICATE IS GOVERNED BY APPLICABLE FEDERAL LAW AND THE LAWS OF TEXAS.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Important Information Regarding Availability of Coverage *(GR-9N-02-005-01 TX)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss, disability, or expense for a health care service or supply incurred before coverage starts or after it ends.

This applies even if the loss, disability, or expense was incurred because of an accident that occurred, began or existed while coverage was in effect. This will not apply for individuals who are eligible for Creditable Coverage. Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the *Group Insurance Policy* or this *Booklet-Certificate*.

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

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

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

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

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

Treatment Outcomes of Covered Services *(GR-9N-02-020-01 TX)*

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

When Your Coverage Begins

(GR-9N 29-005-01-TX LG)

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

Who Can Be Covered

Employees

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

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

Determining if You Are in an Eligible Class *(GR-9N 29-005-01-TX)*

You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer's IRS-qualified retirement plan.
- You are a regular full-time employee, as defined by your employer, who is scheduled to work at least 30 hours per week on a regular basis.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of your plan, your eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are in an eligible class on the date of hire, your eligibility date is the first day of the calendar month coinciding with or next following the date you complete 30 days of continuous service with your employer. This is defined as the probationary period.

If you enter an eligible class after your date of hire, your eligibility date is the first day of the calendar month coinciding with or next following the date you complete 30 days of continuous service with your employer. This is defined as the probationary period. If you have already satisfied the probationary period with your employer before you enter the eligible class, your eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01 TX) (GR-9N 29-010 09 TX)*

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

- Your legal spouse; and
- Your dependent children.

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

(GR-9N-29-010ng-06 TX) (GR-9N-29-010-06 TX)

Coverage for Dependent Children

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

To be eligible, a dependent grandchild must be:

- The unmarried child of your child; and
- Under age 25; and
- Supported by you for Federal Income Tax purposes on the date of his or her initial application for coverage. Coverage will not terminate solely due to the child's loss of such Federal Income Tax dependency status.

Your children can include the following:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought;
- Your foster children;
- Any child for whom you or your covered spouse is under court order for medical support. This child is covered immediately upon Aetna's notification of such order;
- Any other child who lives with you in a parent-child relationship.

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

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N-29-015-01 TX)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

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

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins *(GR-9N 29-025 01 TX)*

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under *Rules and Limits That Apply to the Dental Plan* section will apply.

Your Dependent's Effective Date of Coverage

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

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

Retired Employees *(GR-9N 29-025 01 TX)*

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

Requirements For Coverage

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

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

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

Important Note

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

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

Comprehensive Dental Plan
Schedule of Benefits for the Comprehensive Dental Plan

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

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

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

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

Dental Care Schedule

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

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

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

Comprehensive Dental Expense Coverage Plan *(GR-9N-19-006-01)*

(GR-9N-19-006-01)
The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage insured or administered by **Aetna** and have at least one of the following conditions:

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

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root 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).

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

The **plan coinsurance** applied to the other covered dental expenses above will be 100% for care provided from contracting providers and 100 % for care provided by non-contracting providers. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Important Reminder *(GR-9N-18-010-01 TX)*
The **deductible**, **coinsurance** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from **Contracted** and **Non-contracted providers**. Services and supplies given by a **Contracted provider** are covered at the **contracted** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by a **Non-contracted provider** are covered at the non-contracted level of benefits shown in the *Schedule of Benefits*.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays
Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every year)
- Problem-focused examination (limited to 2 visits every year)

Prophylaxis (cleaning) (limited to 2 treatments per year)
- Adult
- Child

Topical application of fluoride, (limited to one course of treatment per year and to children under age 16)
Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
Bitewing X-rays (limited to 1 set per year)
Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
Vertical bitewing X-rays (limited to 1 set every 3 years)
Periapical x-rays (single films up to 13)

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

Type B Expenses: Basic Restorative Care

Visits And X-Rays
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit

X-Ray And Pathology
Intra-oral, occlusal view, maxillary or mandibular
Upper or lower jaw, extra-oral
Biopsy and histopathologic examination of oral tissue

Oral Surgery
Extractions
- Erupted tooth or exposed root
- Coronal remnants
- Surgical removal of erupted tooth/root tip

Impacted Teeth
- Removal of tooth (soft tissue)

Removal of tooth (partially bony)
Removal of tooth (completely bony)
Odontogenic Cysts and Neoplasms
Incision and drainage of abscess
Removal of odontogenic cyst or tumor
Other Surgical Procedures
Alveoplasty, in conjunction with extractions - per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Excision of hyperplastic tissue
Removal of exostosis
Transplantation of tooth or tooth bud
Closure of oral fistula of maxillary sinus
Sequestrectomy
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

Periodontics
Occlusal adjustment (other than with an appliance or by restoration)
Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
Periodontal maintenance procedures following active therapy (limited to 2 per year)
Clinical crown lengthening, hard tissue
Full mouth debridement, one per lifetime
Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Repairs: crowns and bridges
Office reline
Laboratory reline

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

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)
Pins
    Pin retention—per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
    Prefabricated stainless steel
    Prefabricated resin crown (excluding temporary crowns)
Recementation
    Inlay
    Crown
    Bridge

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

Type C Expenses: Major Restorative Care

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

Endodontics
Root canal therapy including necessary X-rays
Molar

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 8 years- see *Replacement Rule*).
Inlays/Onlays
Labial Veneers
    Laminate-chairside
    Resin laminate – laboratory
    Porcelain laminate – laboratory
Crowns
    Resin
    Resin with noble metal
    Resin with base metal
    Porcelain/ceramic substrate
    Porcelain with noble metal
    Porcelain with base metal
    Base metal (full cast)
    Noble metal (full cast)
    3/4 cast metallic or porcelain/ceramic
Post and core
Core buildup, including any pins

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

Porcelain with noble metal
Porcelain with base metal
Resin with noble metal
Resin with base metal

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

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
Complete upper denture
Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Special tissue conditioning, per denture
Rebase, per denture
Adjustment to denture more than 6 months after installation

Adding teeth to existing partial denture
Each tooth
Each clasp

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

Orthodontics

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

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

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

Orthodontic Treatment Rule

Orthodontic coverage is only for covered dependent children who are under age 20 on the date active orthodontic treatment begins.

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

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")

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

Orthodontic Limitation for Late Enrollees

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

Replacement Rule *(GR-9N 20-010-01)*

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

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 8 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule *(GR-9N-20-015-01)*

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

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

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

Coverage for Dental Work Begun Before You Are Covered by the Plan *(GR-9N 20-020-01)*

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

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

Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

Late Entrant Rule *(GR-9N 20-025-01)*

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

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

This exclusion does not apply to charges incurred:

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

What The Comprehensive Dental Plan Does Not Cover (*GR-9N 28-025 03-TX)*

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

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

Any instruction for diet, plaque control and oral hygiene.

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

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

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

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

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

Services that do not meet broadly accepted national standards of care, including but not limited to:

- more than two quadrants of scaling and root planing in a single office visit, unless necessary due to the need for pre-medication, significant travel distance or patient management difficulty;
- services where diagnostic information does not support the proposed treatment;
- services that will inadequately treat the covered person's condition; and
- prosthetic replacement dependent on severely compromised abutment teeth.

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth; and
- Cleaning of teeth.

Additional Items Not Covered By A Health Plan *(GR-9N 28-015 06 TX)*

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

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

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

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

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

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

Examinations:

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

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

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

When Coverage Ends for Retirees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit.

It is your employer's responsibility to let **Aetna** know when your coverage ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Reinstatement After Your Dental Coverage Terminates *(GR-9N 30-005 01 TX)*

If your coverage ends because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage ends. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be subject to the rules under the Late Enrollment section, and will be effective as described in the *Effective Date of Coverage* section.

When Coverage Ends for Dependents *(GR-9N-30-015-02 TX ER)*

Coverage for your dependents will end if:

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

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

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

Continuing Health Care Benefits - State of Texas *(GR-9N 31-015 02 TX)*

You may continue coverage under the plan which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 60 days of the later to occur of:

- the date coverage would otherwise cease; and
- the date your employer or group policy holder provides you with the notice of your right to continue coverage.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Continuation for a person may not terminate until the earliest of:

- 6 months after the date the COBRA continuation has ended, if the person is eligible for COBRA; or
- 9 months after the date the election is made if the person is not eligible for COBRA.
- The end of the period for which required contributions are made.
- The date the person is or could be covered by Medicare.
- The date the person is covered or is eligible for similar benefits under another medical expense plan.
- The date the person has similar benefits available pursuant to any state or federal law, other than COBRA.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent under this plan; or
- becomes eligible for other coverage under the group contract.

You and your dependents can elect this continuation in lieu of or following any other continuation offered under this plan. If this continuation is elected, the conversion privilege will not be available.

Continuation of Coverage for Your Former Spouse

If coverage for a person covered as your dependent spouse would terminate due to divorce, the person may continue to be covered. Continuation has to be requested within 60 days of the divorce.

Premium payments must be continued. Coverage will not continue beyond the first to occur of:

- The end of a 36 month period after the date of the divorce.
- The date the person becomes eligible for like coverage under any group plan.
- The date dependent coverage ceases under this Plan.
- The end of the period for which contributions have been made.

If any coverage being continued terminates, the person may apply for a personal policy in accordance with the conversion privilege.

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N-31-015-02 TX)*

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

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

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

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

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

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

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

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

Continuation of Coverage During a Labor Dispute

This continuation of coverage provision only applies if this plan is subject to a collective bargaining agreement.

If your coverage under this plan would cease because you cease work due to a labor dispute, you can arrange to continue your coverage during your absence from work if the Texas Insurance Code applies. Coverage may continue for up to 6 months.

Continuation will cease when the first of these events occurs:

- You fail to make the required payments to your collective bargaining unit representative.
- Your representative fails to make the required premium payments to Aetna.
- You go to work full time for any other employer.
- Any premium due date when less than 75% of the affected employees have elected to continue their coverage.
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable rate in effect on the date you cease work. **Aetna** has the right to change premium rates under the terms of this Plan at any time during this continuation of coverage.

Texas Health Insurance Risk Pool

You may be eligible for coverage under the Texas Health Insurance Risk Pool. Not later than 30 days prior to the end of your coverage under any State of Texas continuation, Aetna will provide you with the Texas Health Insurance Risk Pool's address and toll-free telephone number.

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

Extension of Benefits *(GR-9N 31-020 01 TX)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are experiencing the complete inability to perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you would earn substantially the same compensation earned before the disability.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N 31-020 01 TX)*

Dental Benefits (other than Basic Dental benefits): Coverage will be available while you are totally disabled, for up to the earlier of 90 days or the end of the disability. Coverage will be available only if covered services and supplies have been rendered and received, including delivered and installed, prior to the end of that period.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage *(GR-9N-31-025-01-TX)*

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

Continuing Coverage through COBRA

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

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

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.
If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

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

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

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

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

When You Acquire a Dependent During a Continuation Period

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

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

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

When Your COBRA Continuation Coverage Ends

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

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

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

(GR-9N-33-005-02)

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

Allowable Expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. The following are examples of expenses and services that are not allowable expenses:

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

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

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

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

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

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

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

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

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

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

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

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

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

Which Plan Pays First *(GR-9N 33-010 01-TX)*

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

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

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works *(GR-9N-33-015 01 TX)*

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

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

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

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

If **This Plan** pays benefits on your behalf under this **Booklet-Certificate** for expenses incurred due to an automobile accident, then **Aetna** retains the right to seek repayment of the full cost of such benefits. **Aetna** has the right in this situation to recover from any medical payments coverage or personal injury protection/no-fault coverage available under any automobile policy. **Aetna** also retains the right to seek recovery as outlined in the **Subrogation and Right of Reimbursement** section of this **Booklet-Certificate**.

When You Have Medicare Coverage

(GR-9N-33-020 01-TX)

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available when you are enrolled in **Medicare**.

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

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

- Covered under it by reason of age, disability, or
- End Stage Renal Disease

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

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

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

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

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

- If the result is more than the benefit paid by Medicare, the plan will pay the difference, up to 100% of plan expenses. Plan expenses are any medically necessary health expenses which are covered, in whole or in part, under the plan.
- If the result is less than the benefit paid by Medicare, then plan will not pay a benefit, except as required by law.

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

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

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

Right to Receive and Release Required Information *(GR-9N-33-025-01 TX)*
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

(GR-9N-32-005-01 TX)

Type of Coverage

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

Physical Examinations *(GR-9N-32-005-03)*

Aetna will have the right and opportunity to have a **physician** or **dentist** of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations, and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

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

Confidentiality *(GR-9N-32-005-01 TX)*

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

Additional Provisions *(GR-9N-32-005-01 TX)*

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this plan because you are connected with more than one Policyholder.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the *group* contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your Policyholder or **Aetna**.
- Your Policyholder hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N-32-005-03)*

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

All coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.

Misstatements *(GR-9N-32-005-03)*

If any fact as to the Policyholder or you is found to have been an intentional misstatement of material fact, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

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

Statement Made by Policyholder or Insured

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Incontestability *(GR-9N-32-005-03)*

As to Accident and Health Benefits:

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

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

Reimbursement to Texas Department of Human Services

All health expenses payable on behalf of your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify Aetna in writing that the following applies and you request such direct payment be made:

- the Texas Department of Human Services is paying benefits for your child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and you either
- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.

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

Health Coverage

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

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

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

Reporting of Claims

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

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

You may also contact **Aetna** for claim forms. If the forms for a proof of loss are not provided before the 16th day after the date Aetna has received notice of a claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

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

Payment of Benefits *(GR-9N-32-025-04)*

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

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

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

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

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

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

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

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

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

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

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

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

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

Effect of Prior Coverage - Transferred Business *(GR-9N-32-040 01 TX)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

Glossary

(GR-9N-34-005-02 TX)

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

A *(GR-9N-34-005-03 TX ER)*

Aetna

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

C *(GR-9N-34-015-01 TX)*

Coinsurance

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

Contracted Provider

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

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

Contracted Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **contracted provider**

Copay or Copayment

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

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

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

D *(GR-9N 34-020 02 TX)*

Deductible

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

Dental Provider
This is:

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

legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

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

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

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

E *(GR-9N 34-25 09)*

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

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

H *(GR-9N 34-040-02-TX)*

Hospital
An institution that:

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

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

I *(GR-9N 34-045 01 TX)*

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

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

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

J *(GR-9N 34-050 01 TX)*

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder affecting the jaw joint where treatment is **medically necessary** as a result of:
  (1) an accident;
  (2) a trauma;
  (3) a congenital defect;
  (4) a developmental defect; or
  (5) a pathology.

L *(GR-9N 34-055 01-TX)*

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

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

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

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

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

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

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

N *(GR-9N 34-070-07-TX)*

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

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

Non-Contracted Service(s) and Supply(ies)
Health care service or supply that is:

- Furnished by a **Non-contracted provider**.

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

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

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

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

Non-Occupational Injury

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

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

O *(GR-9N 34-075-01-TX)*

Occupational Injury or Occupational Illness

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

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

Occurrence

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

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

Orthodontic Treatment *(GR-9N 34-075-01-TX)*

This is any:

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

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

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

whether or not for the purpose of relieving pain.

P *(GR-9N-34-80-09)*

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Preauthorization, Preauthorize

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable. However, if **Aetna** has preauthorized a service or supply, **Aetna** will not deny or reduce payment to the **provider** for those services based on **medical necessity** or appropriateness of care unless the **provider** has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

Prescriber

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

Prescription

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

Prescription Drug

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

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

R *(GR-9N 34-090-01-TX)*

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

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

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

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

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

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

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

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

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

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

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

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

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

Aetna reimbursement policies are based on our review of:

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

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

Special terms used
Geographic area and Prevailing Charge Rates are defined as follows:

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

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

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

R.N.
A registered nurse.

S *(GR-9N 34-95-10)*

Skilled Nursing Facility
An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

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

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

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

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

Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment *(GR9N APPEALS 005)*

Policyholder:	Cameron County
Group Policy No.:	GP-143726
Group Control No.:	CN-169664
Rider:	Texas Complaint and Appeals Health Rider
Issue Date:	October 30, 2020
Effective Date:	This Booklet-Certificate Amendment is effective on October 1, 2020

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A determination by **Aetna** that the health care services provided or proposed to be provided to the covered person are not **medically necessary** or appropriate, or are **experimental or investigational**.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- Coverage determinations, including Plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not **Medically Necessary**.

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

Claim Subject to Preauthorization: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

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

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

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

Experimental or Investigational: With regard to an **adverse benefit determination**, this means a service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by Aetna at the exhaustion of the appeals process.

Post-Service Claim: Any claim that is not a "**Claim Subject to Preauthorization**."

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse benefit determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Time Frames for Adverse Benefit Determination Notifications

If the claim is being denied for post-stabilization care requested by the treating physician or other health care provider following Emergency Medical Care, (an "urgent claim"):

Aetna will notify the treating **physician** or other health care provider within one hour of notification of the request.

If the patient is hospitalized at the time the claim is made (an "urgent claim"):

Aetna will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make a decision in either of these two circumstances described, above, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The **claimant** has 48 hours after receiving such notice to provide Aetna with the additional information. **Aetna** will notify the **claimant** within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

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

If the patient is not hospitalized at the time the claim is made:

Aetna will make notification of a claim decision within three working days, in writing, to the provider of record and the patient.

In all other circumstances, other than as described in the sections, above or below:

Aetna will make written notification of an **adverse benefit determination** within the time appropriate to the circumstances relating to the delivery of the services and to the patient's condition.

Contents of Notifications
If it is an **adverse benefit determination Aetna** will send notice of that determination accompanied by the following:

(1) the principal reasons for the **adverse benefit determination**;
(2) the clinical basis for the **adverse benefit determination**;
(3) a description of or the source of the criteria used as the guideline in making the **adverse benefit determination;** and
(4) a description of the procedure for the appeal process, including notice of the covered person's right to appeal an **adverse benefit determination** to an independent External Review Organization and of the procedures to obtain that review. If the covered person has a life-threatening condition, you the covered person have the right to an immediate independent External Review. **Aetna's** appeal process in this circumstance is not required.

Concurrent Care Claim Extensions, Reductions or Terminations

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, **Aetna** will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Post-service Claims

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

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an **Appeal** if **Aetna** gives notice of an **adverse benefit determination**. It will also provide an option to request an external review of the **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to **Aetna**.

Your appeal may be submitted orally or in writing and should include:

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

Send in your appeal to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number listed on such notice.

Aetna will acknowledge receipt, in writing, of your **appeal** within 5 working days of receiving it.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Group Health Claims

The review of an appeal of an **adverse benefit determination** shall be provided by an **Aetna** physician not involved in making the **adverse benefit determination**.

Non-Expedited Appeals
(Applies for Claims Subject to Preauthorization and Post-Service Claims)

Claims Subject to Preauthorization
(May Include Concurrent Care Claim Reduction or Termination)

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

If an **adverse benefit determination** concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The **adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 working days of its receipt of the request.

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

Expedited Appeals

(Applies for Claims for Post-Stabilization Care following an Emergency or for Claims When the Patient is Hospitalized -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)

Aetna shall issue a decision on the appeal of an **adverse benefit determination** for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by **Aetna**. If **Aetna** has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is an urgent claim, you may immediately appeal **Aetna's adverse benefit determination** to an independent External Review Organization. You are not required to first comply with **Aetna's appeals** process. Please see the section entitled "External Independent Review", below.

External Independent Review

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician,** selected by an independent External Review Organization, who has expertise in the problem or question involved.

You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an **adverse benefit determination** concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is **experimental** or **investigational** and/or is not **medically necessary**.

If your **adverse benefit determination** is for a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust **Aetna's** internal appeals processes.

The claim denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

Expedited Reviews

An expedited review is possible if either (a) or (b), below applies:

(a) You have an urgent claim, as described above. The External Review Organization will inform both you and **Aetna** of the decision within four business days or fewer, (depending on the urgency of the medical specifics of the case), from the date of receipt of the request for the expedited External Review of the urgent claim. If the External Review Organization provides an oral notification, it must follow that oral communication with a written notice of the decision within 48 hours of the oral notification.

(b) Your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Such expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of the external review.
For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

Important Note:

If **Aetna** does not meet all of the **appeal** timeline requirements outlined above, you are considered to have exhausted the **appeal** requirements and may proceed with an **External Review.**

Exhaustion of Process

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

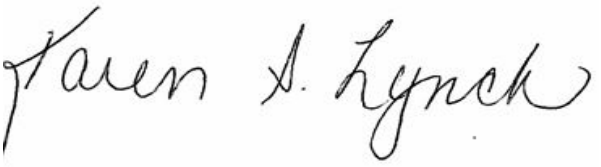
- contact the Texas Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the Texas Department of Insurance; or
- establish any:

  litigation;
  arbitration; or
  administrative proceeding;

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

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or
(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Rider: Appeals
Issue Date: October 30, 2020

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

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

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

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

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

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

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

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

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

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

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

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

Schedule of Benefits

(GR-9N S-01-001-01)

Employer: **Cameron County**

Group Policy Number: **GP-143726**
Group Control Number: **CN-169664**

Issue Date: October 30, 2020
Effective Date: October 1, 2020
Schedule: 1A
Cert Base: 1

For: Comprehensive Dental Plan

Comprehensive Dental Plan

Schedule of Comprehensive Dental Benefits *(GR-9N-S-21-005-01TX)*

PLAN FEATURES	CONTRACTING PROVIDERS	NON CONTRACTING PROVIDERS
Calendar Year **Deductible**	Individual $50 Family $150	Individual $50 Family $150

The Calendar Year **deductible** applies to all covered expenses except Type A Expenses.

(GR-9N-S-20-010-01TX)
Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN COINSURANCE	CONTRACTING PROVIDERS COINSURANCE	NON CONTRACTING PROVIDERS COINSURANCE
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%
Orthodontic Treatment	50%	50%

Calendar Year Maximum Benefit
Calendar Year Maximum: $1,500

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to **contracting providers and non contracting providers covered** dental expenses combined.

Orthodontic Lifetime Maximum Benefit
Orthodontic Lifetime Maximum: $1,500

Expense Provisions *(GR-9N 09-05 01 TX)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N 09-05 01 TX)*

Contracted Calendar Year Deductible
This is an amount of **contracted covered expenses** incurred each Calendar Year for which no benefits will be paid. The **contracted** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **contracted** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Non-Contracted Calendar Year Deductible
This is an amount of **non-contracted covered expenses** incurred each Calendar Year for which no benefits will be paid. The **non-contracted** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **non-contracted** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Covered expenses applied to the **non-contracted deductible** will be applied to satisfy the **contracted deductible** and **covered expenses** applied to the **contracted deductible** will be applied to satisfy the **non-contracted deductible**.

Contracted Family Deductible Limit
When you incur **contracted covered expenses** that apply toward the **contracted** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **contracted** Calendar Year family **deductible** limit. Your **contracted** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **contracted** family **deductible** limit in a Calendar Year.

Non-contracted Family Deductible Limit
When you incur **non-contracted covered expenses** that apply toward the **non-contracted** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **non-contracted** Calendar Year family **deductible** limit. Your **non-contracted** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **non-contracted** family **deductible** limit in a Calendar Year.

Covered expenses applied to the **non-contracted deductible** will be applied to satisfy the **contracted deductible** and **covered expenses** applied to the **contracted deductible** will be applied to satisfy the **non-contracted deductible**.

Copayments and Benefit Deductible Provisions *(GR-9N 09-15 01 TX)*

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Benefit Provisions *(GR-9N S-09-025 01)*

Calendar Year Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

The Calendar Year maximum benefit applies to **contracting care** and **non-contracting care** expenses combined.

Lifetime Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit will not deny benefits for certain covered expenses.

General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.