Board of Franklin County Commissioners

DMO Dental

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

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

Your Group Coverage Plan

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

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

President

Group Policy:	GP-659146
Cert. Base:	1
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0020

Dental Expense Coverage

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

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

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

0740, 7669, 7672

Dental Care Plan

What Are The Benefits?

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

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

These services and supplies must be:

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

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

Benefits

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

Copayment

Each covered person must pay part of the cost of the services or supplies for which coverage is provided under the **Dental Care Plan**. This is a copayment.

A copayment is separate from Aetna's compensation to **Participating Dental Providers**. For certain dental services, the copayment may represent the full payment to the **Participating Dental Provider**.

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

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

Deductible for Services Provided by Non-Participating Dental Providers

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

Dental Care Schedule

The Dental Care Schedule shows:

- those services for which a copay is required; and
- the amount of each copay, except that no copayment is shown in the Dental Care Schedule for the Alternate Treatment Rule described in the "limitations" section. If the Alternate Treatment Rule is applied to a service, an added copayment may apply.

7456

Out-of-Area Emergency Dental Care

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

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

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

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

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

7463

Exclusions and Limitations

Coverage is not provided for the following charges:

- Those for services or supplies which are covered in whole or in part:

  under any other part of this Plan; or
  under any other plan of group benefits provided by or through your Employer.
- Those for services and supplies furnished to diagnose or treat a disease or injury that is not a **non-occupational disease** or **non-occupational injury**.
- Those for services not listed in the Dental Care Schedule, unless otherwise specified.
- Those for replacement of a lost, missing, or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

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

  in the next calendar year.

  Facings on molar crowns and pontics will always be considered cosmetic.
- Those for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental, or still under clinical investigation by health professionals.
- Those for:

  dentures;
  crowns;
  inlays;
  onlays;
  bridgework; or
  other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Those for any of the following services:

  an appliance, or modification of one, if an impression for it was made before the person became a covered person;
  a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services which Aetna defines as not **necessary** for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending **physician** or **dentist**.
- Those for services intended for treatment of any **jaw joint disorder**, unless otherwise specified.
- Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; unless otherwise specified.
- Those for general anesthesia and intravenous sedation.
- Those for treatment by other than a **dentist**, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.

- Those in connection with a service given to a person age 5 or more if that person becomes a covered person other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:

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

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

  for a service in the Dental Care Schedule that applies shown under the headings Visits and Exams, and X-rays and Pathology.
- Those for services given by a **Non-Participating Dental Provider** to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
- Those for a crown, cast, or processed restoration unless:

  it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or

  the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast, or processed restorations made with high noble metals, unless otherwise specified.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
7465, 7466

Alternate Treatment Rule

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

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

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

the copayment for the approved less costly service; plus

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

Replacement Rule

The replacement of; addition to; or modification of:

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

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

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

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

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

Tooth Missing But Not Replaced Rule

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

7467

Orthodontic Treatment

Coverage for **orthodontic treatment** is limited to those services and supplies listed on the Dental Care Schedule that applies.

Aetna has arranged for **Participating Specialist Dentists** to furnish the Orthodontic Procedures. A copayment applies to the Orthodontic Procedures done on a covered person.

Comprehensive **orthodontic treatment** is limited to a lifetime maximum of:

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

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

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;
treatment of primary dentition;
treatment of transitional dentition; or
lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”).

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.

Coverage is not provided for any charges for an orthodontic procedure for which an active appliance has been installed within the two years starting with the date the person became a covered person for the benefit. This applies only to a person who does not become such a covered person by the 31st day after the first day the person is eligible to become such a covered person.

7468

Benefits After Termination of Coverage

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

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

As to a denture:

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

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

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

89330

Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

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

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

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

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

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a **semi-private** room in the **hospital** and the private room (unless the patient's stay in the private **hospital** room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.

5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

Claim Determination Period means the Calendar Year.

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

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

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

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

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

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

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

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

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

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

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Order Of Benefit Determination.

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

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained 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.

C. 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.

D. 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:

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

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

9362, 11554

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

(3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

(4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

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

Effect On Benefits Of This Plan.

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

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

9363, 11554

Right To Receive And Release Needed Information.

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

Facility Of Payment.

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

Right of Recovery.

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

9361, 11554

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

If you are in an Eligible Class and have chosen dental coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Dental Expense Coverage on the date of your coverage under such HMO Plan.

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

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

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

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

7312

Effect of Medicare

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

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

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

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

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

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

5090

Effect of Prior Coverage - Transferred Business

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

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

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

6051

Appeals Procedure

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

Definitions

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

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

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

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

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

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

Post-Service Claim: Any claim that is submitted for completed services.

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

11600

Claim Determinations – Group Health Coverage

Urgent Care Claims

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

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

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies 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 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. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

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

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

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

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

Level One Appeal – Group Health Claims

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

Urgent Care Claims

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

Post-Service Claims

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

Level Two Appeal

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

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

Urgent Care Claims

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

Post-Service Claims

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

11600

External Review

External Review Procedure

Aetna shall afford you an opportunity for an External Review for a coverage denial when requested by you or an authorized person if:

- Aetna has determined that the health care service is not **necessary**.
- The service, plus any ancillary services and follow-up care, will cost you more than $ 500.00.

Aetna does not need to afford External Review if:

- The Department of Insurance has determined that the health care service is not a Covered Medical Expanse under the Plan.
- You fail to exhaust Aetna's Appeals Procedure.
- No new clinical information has been submitted to Aetna for a previous External Review for the same denial of coverage.

Your request for External Review must be made within 60 days after receipt of notice from the Department of Insurance of Aetna upholding a denial of coverage. External Review may be requested by you, your authorized person, your provider, or a health care facility rendering health care service to you.

External Review must be requested in writing. Expedited review may be requested orally or by electronic means. Written confirmation must be submitted to Aetna within 5 days after the request is made.

For an expedited review, your provider must certify that your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing your health, or with respect to a pregnant woman, the health of your or the unborn child, in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

External Review Procedure for Terminal Illness

Aetna has an External Review process for coverage decisions for you if all of the following apply:

- You have a terminal condition that has a high probability of causing death with 2 years.
- You request a review within 60 days of receipt of notice from the Department of Insurance that determination requires resolution of medical necessity.
- Standard therapies have not been effective, are not **necessary**, or no standard therapies covered under the plan is more beneficial for your condition.
- Your **dentist** recommends a drug, device, procedure, or other therapy that is likely to be more beneficial than standard therapy; or you request a therapy found in peer-reviewed published studies to have effective clinical outcomes for the same condition.
- You have exhausted Aetna's Appeals Procedure.
- The drug, device, procedure, or other therapy, for which coverage has been denied would be covered under the Plan except for Aetna's determination that the treatment if experimental or investigational.

The External Review shall be conducted by an independent review organization assigned by the Department of Insurance.

You are not required to pay any part of the cost of the review. The cost of the review shall be borne by Aetna.

11600

General Information About Your Coverage

Termination of Coverage

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

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

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

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Employer for this definition.

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

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

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

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

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

Dependents Coverage Only

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

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

6080

Handicapped Dependent Children

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

6130

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

11048

Dental Expense Benefits After Termination

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

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

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

6180

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

6180

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

6180

Type of Coverage

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

6450

Physical Examinations

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

7671

Legal Action

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

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

6470-1

Additional Provisions

The following additional provisions apply to your coverage.

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

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

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

6470

Assignments

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

6430

Recovery of Overpayment

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

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

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

9352

Reporting of Claims

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

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

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

6320

Payment of Benefits

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

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

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

6350, 9265

Records of Expenses

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

Very important are:

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

6380

Glossary

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

9990

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

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

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

Dental Provider
This is:

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

legally qualified to furnish dental services or supplies.

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

Emergency Condition
This is any traumatic injury or condition which:

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

Jaw Joint Disorder
This is:

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

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

To be appropriate, the service or supply must:

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

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

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

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

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

Non-Occupational Disease

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

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

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

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

Non-Occupational Injury

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

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

Non-Participating Dental Provider

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

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

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

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

whether or not for the purpose of relieving pain.

Out-of-Area Emergency Dental Care

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

Participating Dental Provider

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

Participating Specialist Dentist

Any **dentist** who, by virtue of advanced training:

- is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry, and
- who has entered into a written agreement with Aetna to provide the dental care described under the **Dental Care Plan** to covered persons.

Physician

This means a legally qualified physician.

Primary Care Dentist

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

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

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

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

The change will be effective as follows:

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

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

Reasonable Charge

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

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

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

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

Aetna may take into account factors, such as:

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

Referral Care

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

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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