BENEFIT PLAN

Prepared for
Board of Franklin County Commissioners
AKA - Franklin County Cooperative Dental Plan

Dental Maintenance Organization

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-certificate

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

Booklet-certificate

Managed dental insurance plan

Prepared for:

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Underwritten by Aetna Life Insurance Company

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Welcome

Thank you for choosing **Aetna®**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible dental services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** ("**Aetna**") and your policyholder. Ask your policyholder if you have any questions about the **group policy**.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they're part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the booklet-certificate and schedule of benefits

- When we say "you" and "your", we mean you and any covered dependents
- When we say "us", "we", and "our", we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

Sometimes we use technical dental language that is familiar to **dental providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

You can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for **eligible dental services**
- Pay less when you use **in-network providers**

Important note:
See the schedule of benefits for any **deductibles, copayments**, **coinsurance**, and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in these sections:
  - *What are your eligible dental services?*
  - *What rules and limits apply to dental care?*
  - *What your plan doesn't cover – exclusions*. We refer to this section as "Exclusions".
- They are not beyond any limits in the *What rules and limits apply to dental care?* section and the schedule of benefits.

Aetna's network of dental providers

Aetna's network of **dental providers** is there to give you the care you need. You can find **in-network providers** and see important information about them most easily on our online **provider directory**. Log onto our self-service website.

For more information about the **provider directory**, **PCDs** and other **in-network providers,** see the *Who provides the care* section.

Paying for eligible dental services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible dental service**. They are:

- The **eligible dental service** is **medically necessary**
- You get your care from:
  - Your **PCD**
  - A **specialty dentist** after you get a **referra**l from your **PCD**

You will find details on **medical necessity** and **referral** requirements in the *Medical necessity and referral requirements* section. You will find the requirement to use an **in-network provider** and any exceptions in the *Who provides the care* section.

Paying for eligible dental services– sharing the expense

Generally your plan and you will share the expense of your **eligible dental services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section and see the schedule of benefits.

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from **dental providers** who are not part of the **Aetna** network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider.**
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Out-of-network providers** and any exceptions in the *Who provides the care* section
- Cost sharing in the *What the plan pays and what you pay* section and your schedule of benefits
- Claim information in the *When you disagree - claim decisions and appeals procedures* section

Keeping a dental provider you go to now (continuity of care)

You may have to find a new **dental provider** when:

- You join the plan and the **dental provider** you have now is not in the network
- You are already in an **Aetna** plan and your **dental provider** stops being in our network

However, in some cases, you may be able to keep going to your current **dental provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **dental provider**, we will tell you how long you can continue to see the **dental provider**.

We will authorize coverage only if the **dental provider** agrees to our usual terms and conditions for contracting **dental providers**.

How to contact us for help

We are here to answer your questions. You can contact us by registering and logging onto our self-service website available 24/7 that requires registration and logon at https://www.aetna.com/.

From our website you can get reliable dental information, tools and resources. Online tools will make it easier for you to:

- Make informed decisions about your dental care
- View claims
- Research care and treatment options
- Access information on health and wellness

You can also contact us by:

- Calling **Aetna** at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your ID card

You don't need to show an ID card. When visiting a **dentist**, just provide your:

- Name
- Date of birth
- ID card number or social security number

The dental office can use that information to verify your eligibility and benefits. Your ID number is located on your digital ID card which you can view or print by going to our self-service website. If you don’t have internet access, call us. You can also access your ID card when you’re on the go. To learn more, visit us at https://www.aetna.com/.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period the policyholder requires
- Once each **Calendar Year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you don't enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".):

- Your legal spouse
- Your domestic partner who meets any policyholder rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
    - Dependent children must be:
        - Under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order
        - Grandchildren in your legal custody

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your dental plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child – Your newborn child is covered on your dental plan from the moment of birth and for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- An adopted child – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other dental plan

Late entrant rule

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

- The first 31 days the person is eligible for this coverage
- Any period of open enrollment agreed to by the policyholder and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of **injuries** sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included)

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group dental plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- You have added a dependent because of marriage, birth, adoption, placement for adoption or foster care. See the *Adding new dependents* section for more information
- When a court orders that you cover a current spouse, domestic partner, or a minor child on your dental plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for dental benefits.

Medical necessity and referral requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible dental services** and **medically necessary**. See the *Eligible dental services* and *Exclusions* sections plus the schedule of benefits.

This section addresses the **medical necessity** requirements.

Medically necessary/medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity**".

Referrals

You need a **referral** from your **PCD** in order to receive coverage for any services a **specialty dentist** provides. If you do not have a **referral** when required, we won't pay the **provider**. You will have to pay for services if your **PCD** fails to send the **referral** to us. Refer to the *What the plan pays and what you pay* section.

What are your eligible dental services?

The information in this section is the first step to understanding your plan's **eligible dental services**. If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of dental care services and supplies. But some are not covered at all or are covered only up to a limit.

You can find out about exceptions and exclusions in the:

- *Dental provider services* benefit below
- *What rules and limits apply to dental care?* section
- *Exclusions* section

Your dental plan

Your dental plan includes **in-network** and **out-of-network providers**. This means that it is a network plan. We explain how this plan works in the *Let's get started!* section.

Schedule of benefits

Eligible dental services include dental services and supplies provided by **dental providers**. Your schedule of benefits includes a detailed list of **eligible dental services** under your dental plan (including any maximums and limits that apply to them).

Dental provider services

You can get **eligible dental services**:

- At the **dental provider's** office
- By way of **teledentistry**

Important note:
Eligible dental services for **teledentistry** are paid based upon the cost share features that apply to the type of **eligible dental service** that you get. See your schedule of benefits for details.

The following are not **eligible dental services** under your plan except as described in the *What rules and limits apply to dental care?* section of this booklet-certificate, the schedule of benefits, or a rider or amendment issued to you for use with this booklet-certificate:

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the schedule of benefits
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for **orthodontic treatment**
- **Orthodontic treatment** except as covered in the schedule of benefits
- Prefabricated porcelain/ceramic crown – permanent tooth
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- 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
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder (TMJ)**

Dental emergency services

Eligible dental services include **dental emergency services** provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, and are over 50 miles from home, you should consider calling your **PCD** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is an **out-of-network provider**. If you need help in finding a **dentist**, call us.

If you get treatment from an **out-of-network provider** for a **dental emergency**, the plan pays a benefit at the in-network cost-sharing level of coverage up to the **dental emergency services maximum**.

For follow-up care to treat the **dental emergency**, you should use your **PCD** so that you can get the maximum level of benefits.

What rules and limits apply to dental care?

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

Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service but an **eligible dental service** would have provided acceptable results, then your plan will pay a benefit for the **eligible dental service**.

If a charge is made for an **eligible dental service** but a different **eligible dental service** would have provided acceptable results and is less expensive, then your plan will pay a benefit based upon the least expensive **eligible dental service**.

The benefit will be based on the **in-network provider**'s **negotiated charge** for the **eligible dental service** or, in the case of an **out-of-network provider**, on the **recognized charge**.

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 your plan will cover.

Coverage for dental work begun before you are covered by the plan

Your 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
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Orthodontic treatment rule

Orthodontic treatment is covered on the date active **orthodontic treatment** begins.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer
- A surgical procedure to correct malocclusion

This benefit does not cover charges for 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
- 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.

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.
- **Lifetime maximum** of one full course of active, usual and customary **orthodontic treatment**, plus post-treatment retention.

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 2 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.

Reimbursement policies

We reserve the right to apply our reimbursement policies to all services including involuntary services. Those policies may affect the **negotiated charge** or **recognized charge**. These policies consider:

- 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
- The educational level, licensure or length of training of the **provider**

Aetna reimbursement policies are based on our review of:

- Generally accepted standards of dental practice
- The views of **providers** and **dentists** practicing in the relevant clinical areas

Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge or other prosthetic item and:
    - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or other prosthetic item installed during the prior 12 months.
    - 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.
- The present item cannot be made serviceable and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.

Congenital defects treatment rule

- For newly born children, eligible dental services are covered for medically diagnosed congenital defects and birth abnormalities to the same extent as other dental conditions. Any waiting periods will apply.

What your plan doesn't cover – exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *What are your eligible dental services?* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exclusions

The following are not **eligible dental services** under your plan except as described in:

- The *What are your eligible dental services?* section
- The *What rules and limits apply to dental care?* section
- The schedule of benefits
- A rider or amendment issued to you for use with this booklet-certificate

Charges for services or supplies

- Provided by an **out-of-network provider** in excess of the **recognized charge**
- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority

Charges in excess of any benefit limits

- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the schedule of benefits)

- **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 services to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons.

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

Court-ordered services and supplies

- This includes those court ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are an **eligible dental service** under this plan.

Dental services and supplies

- Those covered under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures

Non-medically necessary services

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

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride
- Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

Teledentistry

- Services given by **dental providers** that are not contracted with **Aetna** as **teledentistry providers**
- Services given when you are not present at the same time as the **dental provider**
- Services including:
  - Telephone calls
  - **Teledentistry** kiosks
  - Electronic vital signs monitoring or exchanges

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "not work related" regardless of cause.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible dental services**, the foundation for getting covered care is through our network. This section tells you about **in-network providers**, **out-of-network providers** and **PCD's**.

In-network providers

We have contracted with **dental providers** to provide **eligible dental services** to you. These in-**network providers** make up the network for your plan.

For you to receive the in-network level of benefits you must use **in-network providers** for **eligible dental services**.

The exceptions are:

- **Dental emergency services** – Refer to the *What are your eligible dental services?* section
- I**n-network providers** are not available to provide the **eligible dental service** that you need

You can find **in-network providers** and see important information about them by logging onto our self-service website. You can search our online **provider directory**, for names and locations of **in-network providers**.

You will not have to submit claims for treatment received from **in-network providers**. Your **in-network provider** will take care of that for you. And we will directly pay the **in-network provider** for what the plan owes.

Your PCD

Your **primary care dentist** (we call that **dentist** your **PCD**) will provide you with routine care and get you a **referral** to a **specialty dentist**.

You are required to select a **PCD.** Each covered family member can select their own **PCD**. You must select a **PCD** for your covered dependent if they are a minor or cannot choose a **PCD** on their own.

For you to receive the in-network level of benefits, **eligible dental services** must be accessed through your **PCD's** office. They will provide you with primary care services and initiate **referrals** for **specialty dental** care.

How do you choose your PCD?

You choose your **PCD** from the list of **PCDs** in our **provider directory** which is on our self-service website.

What will your PCD do for you?

Your **PCD** will coordinate your dental care or may provide treatment. They may send you to other **in-network providers**.

Your **PCD** will give you a written or electronic **referral** to see other **in-network providers**.

How do I change my PCD?

You may change your **PCD** at any time. You can call us or log onto our self-service website to make a change.

The change will become effective as follows:

If we receive the request:	The change will become effective on:
On or before the 15th day of the month	The 1st day of the next month
After the 15th day of the month	The 1st day of the month following the next month

What happens if I do not select a PCD?

Because having a **PCD** is so important, we may choose one for you. We will notify you of the **PCD's** name, address and telephone number. If you wish, you can change the **PCD** by following the directions above for *How do I change my PCD?.*

Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **eligible dental services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible dental services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

What the plan pays and what you pay

Who pays for your **eligible dental services** – this plan, both this plan and you, or just you? That depends. This section gives the general rule and explains these key terms:

- Your out-of-network **deductible**
- Your **copayments**
- Your out-of-network **orthodontic treatment** maximum
- Your **dental emergency services** maximum

The general rule

When you get **eligible dental services**:

- You pay your out-of-network **deductible** or office visit **copayment.** The schedule of benefits lists the office visit copayment amount that you pay.

  And then

- You pay your **eligible dental services copayment**. The schedule of benefits lists the **copayment** that you pay. The **copayment** amount may vary by the type of expense.

  And then

- You are responsible for any amounts above the maximum.

Important note – when you pay all

You pay the entire expense for an **eligible dental service**:

- When you get a dental care service or supply that is not **medically necessary**. See the *Medical necessity and referral requirements* section.
- When you get an **eligible dental service** without a **referral** when your plan requires a **referral**. See the *Medical necessity and referral requirements* section.

In both of these cases, the **dental provider** may require you to pay the entire charge.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

Where your schedule of benefits fits in

This section explains some of the terms you will find in your schedule of benefits.

How your out-of-network deductible works

Your out-of-network **deductible** is the amount you need to pay for **eligible dental services** per **Calendar Year** before your plan begins to pay for **eligible dental services.** Your schedule of benefits shows the out-of-network **deductible** amount for your plan.

How your copayment works

Your **copayment** is the amount you pay for **eligible dental services** after you have paid your office visit **copayment**. Your schedule of benefits shows you which **copayments** you need to pay for specific **eligible dental services**.

You will pay your **copayment** when you receive **eligible dental services**.

How your out-of-network orthodontic treatment maximum works

The out-of-network **orthodontic treatment** maximum is the most your plan will pay for **eligible dental services** per lifetime incurred by you after any applicable **deductible** and **coinsurance**. You are responsible for any amounts above this **maximum**.

Important note:
See the schedule of benefits for any **deductibles, copayments,** maximums, maximum age, visit limits, and other limitations that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible dental services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **dental provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **dental provider** or to you as appropriate.

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	• You should notify us in writing within 20 days and request a claim form from us. You can send your written notice of claim to us at: Aetna, P.O. BOX 14094, Lexington, KY 40512-4094. If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proof of loss. • You can get a claim form from our self-service website or call us • The claim form will provide instructions on how to complete and where to send the forms	• You must send us notice and proof within 90 days or as soon as reasonably possible • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any dental documentation you received from your **provider** • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.
Proof of claim When you have received a service from an eligible **dental provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof within 90 days or as soon as reasonably possible • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

Benefit payment	• Written proof must be provided for all benefits • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss • Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, the indemnity will be payable to your estate. Any other accrued indemnities unpaid upon your death may, at our option, be paid either to your beneficiary or to your estate. All other indemnities will be payable to you.	• Benefits will be paid immediately or as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 27 months after the deadline.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with an **in-network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision".

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

You can also file a written complaint with the Superintendent of Insurance at:

Ohio Department of Insurance
Consumer Services Division
Attn: Superintendent of Insurance
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215
Phone: 614-644-2673 / Toll Free in Ohio: 1-800-686-1586 / Fax: 614-644-3744
Online at: https://www.insurance.ohio.gov/Pages/ComplaintMain.aspx

An appeal

You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal by calling us.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling us. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **dental provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **dental provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	**Post-service appeal**
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Exhaustion of appeals process

You must complete the appeal process with us before you can take these actions:

- Contact the Ohio Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Ohio Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete our appeals process before you may take other action. These are when:

- We decide to waive this requirement
- You did not receive a written decision from us on the appeal review within the required time frame
- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally.
- We did not follow all of the claim determination and appeal requirements of the State of Ohio.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

Coordination of benefits

The Coordination of Benefits (COB) provision applies when a person has dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expenses.

Key terms

- A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    - Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    - Plan does not include: **hospital** indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
    - Health Insuring Corporation (HIC): A HIC is a corporation that pays for, reimburses, or makes available health care services.

Each plan for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.
    - When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

- Allowable expense is a health care expense, including **deductibles**, **coinsurance** and **copayments**, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

- The following are examples of expenses that are not allowable expenses:
    - The difference between the cost of a semi-private **hospital** room and a private **hospital** room is not an allowable expense, unless one of the plans provides coverage for private **hospital** room expenses.
    - If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
    - If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
    - If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
    - The amount of any benefit reduction by the primary plan because a member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, **precertification** of admissions, and preferred **provider** arrangements.

- Closed panel plan is a plan that provides health care benefits to members primarily in the form of services through a panel of **providers** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other **providers**, except in cases of emergency or referral by a panel member.

- Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of benefit determination rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.
- Except as provided in the following paragraph, a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
    - Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the policy 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 calculating payment of its benefits only when it is secondary to that other plan.

- Each plan determines its order of benefits using the first of the following rules that apply:
  - Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. 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, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
  - Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The Plan of the parent whose birthday falls earlier in the **contract year** is the primary plan; or
      - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
      - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always the primary plan), we will follow the rules of that plan.

    - For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      - If a court decree states that one of the parents is responsible for the dependent 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 plan years commencing after the plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of the above paragraph shall determine the order of benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of the above paragraph shall determine the order of benefits; or
      - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The plan covering the custodial parent;
        - The plan covering the spouse of the custodial parent;
        - The plan covering the non-custodial parent; and then
        - The plan covering the spouse of the non-custodial parent.

    - For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of the above paragraphs shall determine the order of benefits as if those individuals were the parents of the child.

- Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the allowable expense rule can determine the order of benefits.

- COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the allowable expense rule can determine the order of benefits.

- Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

- If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.

- If a member 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.

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 payable under this plan and other plans. **Aetna** may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. **Aetna** need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give **Aetna** any facts it needs to apply those rules and determine benefits payable.

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 term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, **Aetna** may pay that amount to the organization that 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" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Coordination disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Please direct your phone call to the Member Services toll-free phone number located on the back of your identification card. You may also contact us at www.aetna.com. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://www.insurance.ohio.gov.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Coverage under this plan will end if:

- This plan is no longer available
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage
- You become covered under another dental plan offered by your policyholder

Your coverage will end on either the date your employment ends or the day before the first **premium** contribution due date that occurs after you stop active work.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because either: • Your job has been eliminated • You have been placed on severance • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.

Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

Notification of when your employment ends

It is the policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners
- The date the domestic partnership ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

Your dependent's coverage will end on the earlier of the date the **group policy** terminates or as defined by the policyholder.

Why would we end your coverage?

We will give you 30 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more. It gives employees and most of their covered dependents the right to keep their dental coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?

Your dental coverage may end while you or your covered dependent are 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)
- 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
  - Impressions have been taken from which the item will be prepared

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end on the earlier of:

- The date the child is no longer disabled and dependent upon you for support
- As explained in the *When will coverage end for any dependents* section

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments and riders too. Under certain circumstances, we or the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive requirements under the plan or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Financial sanctions exclusions:

If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible dental services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

You must complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures or Exhaustion of appeals* sections. You cannot take any action until 60 days after we receive written submission of claim.

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

After 2 years from when we issue the **group policy,** no misstatements made in the application for the **group policy** will be used to cancel the policy. That is not true if you make a fraudulent misstatement. That can be used to terminate coverage or deny a claim after this 2 year period. Please see the *Honest mistakes and intentional deception* section.

Physical examinations and evaluations

At our expense, we have the right to have a **provider** of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **dental providers**, **dentists** and other **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when facts are shared with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Some other money issues

Assignment of benefits

When you see **in-network providers** they will bill us directly. If you see **out-of-network providers** as allowed under this plan, we may choose to pay you or to pay the **providers** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group policy**. This may include:

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

To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

Recovery of overpayments

We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. We can only recover overpayments if we made the payment within 2 years. Our payment is final and we cannot recover the payment if it has been more than 2 years.

Premium contribution

This plan requires the policyholder to make **premium** contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your dental information

We will protect your dental information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your **providers**' claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call us. When you accept coverage under this plan, you agree to let your **providers** share your information with us.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Glossary

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

Calendar year
A period of 12 months beginning on January 1st and ending on December 31st.

Coinsurance
Coinsurance is the percentage of the bill that you and this plan have to pay for an **eligible dental service**. The schedule of benefits shows the percentage that you have to pay.

Your **coinsurance**, once you meet any applicable **deductibles**, for:

- **PCD** services is based on the **PCD's negotiated charge** or, if there is no **negotiated charge**, then on the **PCD's usual fee**
- In-network **specialty care** services is based on the **negotiated charge**
- Out-of-network **dentists** is based on the **recognized charge**

Copayments
Copayments are flat fees you pay for certain **eligible dental services.**

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible
The amount you pay for **eligible dental services** per **calendar year** before your plan starts to pay.

Dental emergency
Any dental condition that:

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

Dental emergency services
Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental emergency services maximum
The most the plan will pay for **eligible dental services** incurred by any one covered person for any one **dental emergency**.

Dental provider
Any individual legally qualified to provide dental services or supplies.

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

Directory
The list of **in-network providers** for your plan. The most up-to-date **provider directory** for your plan appears on our self-service website. When searching for an **in-network provider**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered **in-network providers** for certain **Aetna** plans.

Effective date of coverage
The date your coverage begins under this booklet-certificate as noted in our records.

Eligible dental services
The benefits, subject to varying cost shares, covered in this plan. These are:

- Listed and described in the schedule of benefits.
- Not listed as an exception or exclusion in these sections:
  - *What are your eligible dental services?*
  - *What rules and limits apply to dental care?*
  - *Exclusions*
- Not beyond any maximums and limitations in the *What rules and limits apply to dental care?* section and schedule of benefits.
- **Medically necessary**. See the *Medical necessity and referral requirements* section and the *Glossary* for more information.

Experimental or investigational
A drug, device, procedure, or treatment that we find is **experimental** or **investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the Food and Drug Administration (FDA) has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Group policy
The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificates
- The schedules of benefits
- Any amendments or riders to the **group policy** the booklet-certificate, and the schedule of benefits

Health professional
A person who is licensed, certified or otherwise authorized by law to provide medical or dental care services to the public. For example, **providers** and dental assistants.

Illness
Poor health resulting from disease of the teeth or gums.

Injury or injuries
Physical damage done to the teeth or gums.

In-network provider
A **provider** listed in the **directory** for your plan.

Lifetime maximum
This is the most this plan will pay for **eligible dental services** incurred by a covered person during their lifetime.

Medically necessary/medical necessity
Dental care services or supplies that prevent, evaluate, diagnose or treat an **illness**, **injury**, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with "generally accepted standards of dental practice"
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your **illness**, **injury** or disease
- Not primarily for your convenience, the convenience of your **dentist**, or other health care **provider**
- 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 your **illness**, **injury** or disease

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 and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of dental practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *How to contact us for help* section.

Negotiated charge

This is either:

- The amount **in-network providers** have agreed to accept
- The amount we agree to pay directly to **in-network providers** or third party vendors (including any administrative fee in the amount paid)

for providing **eligible dental services** to covered **persons** in the plan.

Orthodontic treatment

This is any:

- Medical service or supply
- Dental service or supply

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

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

whether or not for the purpose of relieving pain.

Out-of-network provider

A **provider** who is not an **in**-**network provider** and does not appear in the **directory** for your plan, or a **specialty dentist** that is seen without getting a **referral** from your primary care dentist (PCD).

Physician

A skilled **health professional** trained and licensed to practice medicine under the laws of the state where they practice, specifically, doctors of medicine or osteopathy.

Premium

The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

Primary care dentist (PCD)

A **provider** who:

- Is selected by a person from the list of **PCDs** in the **directory**
- Supervises, coordinates and provides initial care and basic dental services to a covered person
- Initiates **referrals** for **specialty dental** care
- Is shown on **Aetna**'s records as your **PCD**

Provider

A **dentist**, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized charge

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

The **recognized charge** depends on the geographic area where you receive the **eligible dental service**. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge**
Eligible dental expenses	80% of the prevailing rate
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Recognized charge does not apply to involuntary services.

Special terms used:

- Geographic area is normally based on 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.
- Involuntary services are **eligible dental services** that are one of the following:
  - Not available from an **in-network provider**
  - **Dental emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from an **in-network provider**.
- Prevailing rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Get the most value out of your benefits:
We have online tools to help you decide the type of care to get and where. Our self-service website offers tools to help you determine the cost of **eligible dental services**, compare **in-network providers** and schedule office visits with them. See the *How to contact us for help* section for the website.

Referral

This only applies to in-network coverage and is a written or electronic authorization made by your **PCD** to direct you to an **in-network provider** for **medically necessary** services and supplies.

Specialty care services

Those services listed as "**specialty care services**" in the schedule of benefits. These are often performed by a **specialty dentist** with a **referral** from your **PCD**, or in some cases your **PCD** may perform them.

Specialty dentist

This is a **dental provider** who practices in any generally accepted dental or surgical sub-specialty.

Teledentistry

A consultation between you and a **dental provider** who is performing a clinical dental service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Any other method permitted by state law

Temporomandibular joint dysfunction/disorder (TMJ)

This is:

- A **TMJ** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Usual fee

This is the fee that a **PCD** charges its patients in general. Your **PCD** will give you a copy of the **usual fee** schedule if you ask for one. It is not part of this booklet-certificate and may change. It is used only to calculate your **coinsurance** amount and is not the basis upon which **Aetn**a pays the **PCD**. **Aetna** pays **PCDs** based upon separate agreements that may be less than, or unrelated to, the **PCD**'s **usual fee**.

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage and experience with us. We may encourage you to access certain dental services or categories of **dental providers**, participate in programs, including but not limited to financial wellness program, utilize tools, improve your health metrics or continue participation as an **Aetna** member through incentives. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment**, **deductible** or **coinsurance** amounts
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

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 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.