



Aetna Dental Maintenance Organization (DMO) Plan

This document, along with the [Aetna Life Insurance Company Booklet-Certificate \("Booklet-Certificate"\)](#), is a Summary Plan Description (SPD), as defined by the Employee Retirement Income Security Act of 1974 (ERISA), of the Toys“R”Us, Inc. Aetna Dental Maintenance Organization (DMO) Plan (“Plan”). If there is any discrepancy between the information contained in this SPD, Booklet-Certificate, and Plan documents, the Plan documents will always govern. If there are legal rules that require changes that are not yet written into the Plan document, the Plan document will be interpreted by the Plan Administrator as including those legal rules.

Please note that nothing in this SPD is meant to imply a contract or guarantee of employment. Participation in the Plan does not preclude the Company from terminating your employment at any time, whether or not for cause, with or without notice.

Please read this SPD and Booklet carefully and share the information with your family. If you have any questions about this Plan, please contact the “R”Benefits Service Center at **1-844-TRU-BENS**.

This Summary Plan Description supersedes and replaces any previous SPDs you have received describing the Aetna DMO Plan.

Contents

The Aetna DMO Plan	3
ID Cards.....	3
Qualified Medical Child Support Order (QMCSO)	3
In the Event of Your Death.....	4
Termination of Coverage.....	4
Continuation of Coverage (COBRA)	4
Aetna Life Insurance Company Booklet-Certificate	5
Requirements for Coverage	5
Clinical Review Criteria Requests	5
How Your Aetna Dental Plan Works	6
About the Managed Dental Plan.....	7
Changing Your PCD	7
Availability of Providers	8
Using Your Dental Plan	8
How Referrals Work	8
When You Do Not Need a PCD Referral	8
What The Plan Covers	9
Replacement Rule	16
Tooth Missing but Not Replaced Rule	16
Alternate Treatment Rule	16
What The Managed Dental Plan Does Not Cover.....	18
Coordination of Benefits - What Happens When There is More Than One Health Plan.....	20
When You Have Medicare Coverage	23
Right to Receive and Release Required Information	24
General Provisions	25
Schedule of Benefits	29
Glossary	31
Confidentiality Notice	38

The Aetna DMO Plan

The Aetna DMO Plan promotes good dental health by providing coverage for a broad range of dental services and supplies. For highlights on what your plan covers and how benefits are paid, refer to the Booklet-Certificate that accompanies this SPD. For information about participation requirements, see [Eligibility and Enrollment](#); see [Administrative and Legal Information](#) for continuation coverage, how to file a claim, legal notices and where to obtain additional information.

To receive benefits, you must use a DMO dentist – either your primary care dentist or a participating specialist dentist. The DMO does not provide coverage for care received by a non-DMO dentist, except for emergency pain relief if you are more than 50 miles away from home.

Under the DMO, if you use a participating dentist:

- You pay coinsurance only for specified covered services
- You have no deductibles to pay
- There are no claim forms to fill out
and
- You don't have to wait to be reimbursed (subject to certain limitations and exclusions).

If you select the DMO, you choose a network primary care dentist for you and each enrolled dependent. The dentist you select provides your dental care and will make referrals when appropriate to specialists within the DMO network. No referral is needed to see a network orthodontist. As with other dental plans, there are restrictions on the frequency and/or age limitations of certain procedures, which are described in the list of covered services.

You and your covered dependents can choose the same network primary care dentist or you can each select a different dentist. The DMO network is nationwide, so even students away from home at school can choose their own network primary care dentist. You can change your network primary care dentist once a month. If you call by the 15th of the month, the change will be effective the first of the following month. All you do is call Aetna Member Services at **1-877-238-6200** or log on to www.aetna.com.

ID Cards

You will not receive an ID card when you enroll in the Aetna Dental DMO Plan. If you want to print an ID card, from Aetna's website, go to www.aetna.com (you must register and log on to Aetna Navigator™ to access this feature). You or your provider can also contact Aetna Member Services to verify your coverage.

Qualified Medical Child Support Order (QMCSO)

Federal law requires group health plans to honor qualified medical child support orders (QMCSOs) which apply to the Aetna DMO Plan.

In general, a QMCSO is a state order requiring a parent to provide medical support to a child in case of separation or divorce and under certain statutory conditions. Upon receipt of a medical child support order (MCSO), you and the affected child will receive notice that the order is being reviewed by the Plan to determine if it is qualified and the procedures being used to do so. If the Plan determines that the order is qualified, it will pay benefits directly to the child, the child's custodial parent or legal guardian. The child as well as you will be enrolled in the Plan automatically.

In the Event of Your Death

If you die while you are an active team member covered under the Aetna DMO Plan, your covered dependents will receive 60 days of COBRA (See Continuation of Coverage on next page) coverage at no cost. At the end of the 60 days, continued coverage is available for up to an additional 34 months at full COBRA rates. In order to receive this coverage, you must apply for and elect COBRA continuation coverage for dental benefits. See the [Administrative and Legal SPD](#) for more information on electing COBRA coverage.

Termination of Coverage

Aetna DMO Plan coverage stops when:

- You stop making the required contributions
- Your employment ends or you are transferred to an ineligible class of employment
- The Plan ends
- The Plan is amended to exclude the class of employees that includes you
- You are no longer eligible.

Your dependent's coverage ends when yours does or when he or she:

- Loses his or her eligibility due to age or change in marital status – except for a disabled child for whom coverage can continue (see [Eligibility and Enrollment](#) for more information)
- Becomes covered as an “R”Us team member.

Continuation of Coverage (COBRA)

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA) requires that the Aetna DMO Plan offer team members and their covered family members the opportunity for a temporary extension of coverage (called “continuation coverage”) when coverage under the Aetna DMO Plan would otherwise end. Please refer to the [Administration and Legal SPD](#) for your rights and obligations under the continuation coverage provisions of the law.

Aetna Life Insurance Company Booklet-Certificate

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

Requirements for Coverage

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Booklet-Certificate;
 - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.
2. The service or supply must be provided while coverage is in effect.
3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of dental practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or **dental provider** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

Clinical Review Criteria Requests

If you or your covered dependent needs additional information on a specific clinical issue, you may request a clinical review criteria by submitting written request to Aetna. The written request must contain the following information:

- Person's name; address; and telephone number.

A request for the clinical review criteria; which Aetna would utilize in making a coverage determination involving a specific condition, treatment or device.

The written request should be sent to the following address:

Aetna

CRC Requests - Mail Code: F074

3 Independence Way

Princeton, N.J. 08540

Aetna will take into consideration the person's individual situation in applying the clinical review criteria.

Important Note

Not every service or supply fitting the definition for medical necessity is covered by the plan.

Exclusions and limitations apply to certain dental services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your *What the Plan Covers* and *Schedule of Benefits* for the plan limits and maximums.

In case of a denial of coverage, you have full advantage of all appeal rights available under New York State insurance law.

How Your Aetna Dental Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna** dental plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage and general administration of the plan.

Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to the Eligibility section for a complete definition of "you".

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental plan.

Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms

Many terms throughout this Booklet-Certificate are defined in the *Glossary* Section at the back of this document.

Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About the Managed Dental Plan

Under the Managed Dental Plan, you access care through the **primary care dentists (PCD)** you select when you enroll. Each covered family member may select a different **PCD**. Your **PCD** provides basic and routine dental services and supplies, and will refer you to other **dental providers** in the network.

You may select a **PCD** from the **Aetna network provider directory** or by logging on to **Aetna's** website at www.Aetna.com. You can search **Aetna's** online **directory**, DocFind, for names and locations of **network providers**.

Out-of-network services and supplies are not covered, except in the event of a **dental emergency**.

Important Reminder

You must have a **referral** from your **PCD** in order to receive coverage for any services a **specialist dentist** provides. Please refer to the *Referral Process* section.

Accessing Network Providers

- The plan pays a higher level of benefits when your **PCD** provides your care or refers you to a **specialist dentist**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).
- The coinsurance for primary dental services is a percent of the **PCD's** usual fee* for that service, reviewed by **Aetna** for reasonableness.
- The **coinsurance** for specialty dental services is a percent of the **specialist dentist's** fee for that service or supply. The "fee" may be a fee negotiated with the specialist dentist and approved by **Aetna**. In that case, the **coinsurance** will be based on the actual, negotiated fee. If **Aetna** compensates a specialist dentist on another basis, the "fee" will be the **specialist dentist's** usual fee*, reviewed by **Aetna** for reasonableness.

*"Usual fee" means the fee the PCD or specialist dentist charges patients in general. Your PCD will give you a copy of the usual fee schedule, upon request. You will be informed of the fee when you visit a specialist dentist. It is not part of this booklet-certificate and may be changed from time to time. It is used only for the purpose of calculating your **coinsurance** and is not the basis of compensation to the **network provider**. **Aetna** compensates network providers based on separate, negotiated agreements that may be less than or unrelated to the network provider's usual and customary charges. These agreements may vary among dentists.

If you need a service that is not available from a **network provider**, your **PCD** may refer you to an **out-of-network provider**. You will receive the **network** level of coverage if your **PCD** gets approval from **Aetna** for this referral.

Changing Your PCD

You may change your **PCD** at any time on **Aetna's** website, www.Aetna.com, or by writing to **Aetna** or calling the Member Services toll-free number on your identification card. The change will be effective as follows:

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

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **PCD** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between **Aetna** and your selected **PCD** is terminated, **Aetna** will notify you of the termination and request you to select another **PCD**.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductibles, copayments, coinsurance** and maximum benefit limits. There is a separate deductible and maximum that applies to **orthodontic treatment**.

Using Your Dental Plan

The Referral Process

There may be times when you need services and supplies that only a dental **specialist** can provide. In these cases, your **PCD** will make a **referral** to a **specialist dentist**. A **PCD referral** is not required for any orthodontic services.

Having a **referral** from your **PCD** keeps your out-of-pocket expenses lower for services of a **specialist dentist** and any necessary follow-up treatment. The **referral** is important because it is how your **PCD** arranges for you to receive care and follow-up treatment.

Important Reminder

You must have a **referral** from your **PCD** in order to receive the network level of coverage for any services received from a **specialist dentist**.

How Referrals Work

Here are some important points to remember:

When your **PCD** determines that your treatment should be provided by a **specialist dentist**, you'll receive a written or electronic **referral**. The **referral** will be good for 90 days, as long as you remain covered under the plan.

Go over the **referral** with your **PCD**. Make sure you understand what types of services have been recommended and why.

When you visit the **specialist dentist**, bring the **referral** (or check in advance to verify that they have received the electronic **referral**).

You cannot request a **referral** from your **PCD** *after* you have received services from a **specialist dentist**.

If a service you need isn't available from a **network provider**, your **PCD** may refer you to an **out-of-network provider**. Your **PCD** must get **precertification** from **Aetna** and issue a special out-of-network referral for services from **out-of-network providers** to be covered at the network level of coverage.

When You Do Not Need a PCD Referral

You do *not* need a **PCD referral** for:

- Emergency care**. Please refer to the "*In the case of a Dental Emergency*" section.
- Direct Access Services. Orthodontic services and supplies do not require a **referral**.

In Case of a Dental Emergency

If you need dental care for the palliative treatment (pain relieving, stabilizing) of a **dental emergency**, you are covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:

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

Follow the guidelines below when you believe you have a **dental emergency**.

If you have a **dental emergency**, call your **PCD**. If you cannot reach your **PCD** or are away from home, you may get treatment from any **dentist**. You may also call Member Services for help in finding a **dentist**. The care must be for the temporary relief of the **dental emergency** until you can be seen by your **PCD**. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given.

The plan pays a benefit up to the **dental emergency** maximum.

All follow-up care should be provided by your **PCD**.

If you seek care from an **out-of-network provider** for a non-emergency dental condition (that is, one that does not meet the definition above), no benefit will be payable.

What The Plan Covers

Managed Dental Plan

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

Important Reminder

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

- The services and supplies must be **medically necessary**.
- The service and supplies must be listed in the dental care schedule.
- You must be covered by the plan when you incur the expense.

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

The next sentence applies if:

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

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

Dental Care Schedule for the Managed Dental Plan

The Dental Care Schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses** that are focused on keeping your teeth healthy: diagnostic, preventive and restorative services and supplies.

Coverage is also provided for a **dental emergency**. For additional information, please refer to *In Case of a Dental Emergency*.

Important Reminder

The **copays, deductible, and coinsurance** that apply to each type of dental care are shown in the *Schedule of Benefits*.

Managed Dental Expense Coverage Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent

if you have medical coverage insured or administered by **Aetna** and have at least one of the following conditions:

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

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

The **plan coinsurance** applied to the other covered dental expenses above will be 100%. These additional benefits will not be subject to any frequency limits except as shown above.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Network Benefits

This Dental Care Schedule applies to covered services and supplies provided by **Primary Care Dentists** and other **network providers** upon referral from your PCD. The plan covers only the services and supplies in the list below.

- Office visit for oral exam (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Adult

- Child
- Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to 1 application every 3 years for permanent molars only), and to covered persons under age 16
- Pulp vitality test
- Diagnostic casts

X-Rays and Pathology

- Bitewing X-rays (limited to 1 set per year)
- Entire series, including bitewings, or panoramic films (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

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

- Fixed, band type
- Removable acrylic with round wire clasp

Type B Expenses

Endodontics

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
- Anterior
- Bicuspid

Restoration and Repair

- Amalgam restoration
- 1 surface
- 2 surfaces
- 3 or more surfaces
- Resin restoration (other than for molars)
- 1 surface

- 2 surfaces
- 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures

Periodontics

- Scaling and root planing - per quadrant (limited to 4 separate quadrants, every 2 years)
- Scaling and root planing - 1 to 3 teeth, per quadrant (limited to once per site, every 2 years)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per year)
- Full mouth debridement-once per lifetime

Oral Surgery (Includes local anesthetics and routine post-operative care)

- Extractions, erupted tooth or exposed root
- Extractions, coronal remnants
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissues)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft issue
- Suture of soft tissue injury

Type C Expenses

Restorations

- Inlays
- 1 surface
- 2 surfaces
- 3 or more surfaces
- Onlays
- 2 surfaces
- 3 surfaces
- 4 or more surfaces

- Crowns (including build-ups when necessary)
- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- Metallic (3/4 cast)
- Post and core
- Pontics
- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Dentures and Partials (includes relines, rebases, and adjustments within 6 months after installation).

- Full (upper and lower)
- Partial
- Stress breakers (per unit)
- Interim partial denture (stayplate), anterior only
- Crown and bridge repairs
- Adding teeth to an existing denture
- Full and partial denture repairs
- Relining/rebasing dentures (including adjustments within six months after installation)
- Occlusal guard (for bruxism only) limited to 1 every 3 years

Specialty Dental Services

Type B Expenses:

Endodontics (Includes local anesthetics where necessary)

- Apexification/recalification
- Apicoectomy (per tooth) - first root
- Apicoectomy (per tooth) - each additional root

- Retrograde Filling
- Root Amputation
- Hemisection

Oral Surgery (Includes local anesthetics where necessary and post-operative care)

- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula

Periodontics

- Gingivectomy or gingivoplasty - per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty - 1 to 3 teeth (limited to 1 per site, every 3 years)
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure - 1 to 3 teeth per quadrant (limited to 1 per site, every 3 years)
- Occlusal adjustment (other than with an appliance or by restoration)

Type C Expenses:

Endodontics (Includes local anesthetic where necessary)

- Molar root canal therapy, including necessary X-rays

Intravenous Sedations and General Anesthesia

Oral Surgery (Includes local anesthetics where necessary and post-operative care)

- Surgical removal of impacted teeth
- Partially bony
- Completely bony
- Completely bony with unusual surgical implications

Periodontics

- Osseous surgery (including flap entry and closure), per quadrant, limited to 1 per quadrant, every 3 years
- Osseous surgery (including flap entry and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
- Soft tissue graft procedure
- Clinical crown lengthening - hard tissue

Orthodontics

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

Rules and Limits That Apply to the Dental Plan

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding

expenses that are not covered by the plan.

Orthodontic Treatment Rule

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

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

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

Orthodontic Limitation for Late Enrollees

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

Replacement Rule

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

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

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

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

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

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

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

Coverage for Dental Work Begun Before You Are Covered by the Plan

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

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

Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

Late Entrant Rule

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

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

This exclusion does not apply to charges incurred:

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

What The Managed Dental Plan Does Not Cover

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

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**. But this exclusion will not apply to dental care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, or to dental care or treatment necessary due to a congenital disease or anomaly.

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

Except as covered in the *What the Plan Covers* section, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint

disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

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

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth; and
- Cleaning of teeth.

Additional Items Not Covered By A Health Plan

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

Costs for services resulting from the commission of, or attempt to commit a felony by the covered person.

Examinations:

- Any dental examinations:
- required by a third party, including examinations and treatments required to obtain or maintain employment,

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

- required by any law of a government, securing insurance or school admissions, or professional or other licenses;

- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Non-**medically necessary** 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**.

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

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

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

Getting Started - Important Terms

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

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

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

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

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

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

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

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

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

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

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

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

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

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

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

Which Plan Pays First

To find out whether the regular benefits under this plan will be reduced, the order in which the various plans will pay benefits must first be figured. This will be done as follows:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- A plan which covers a person as other than a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.

1. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers a person as a dependent of a person whose birthday comes later in the year; however:

(a) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

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

2. In the case of a dependent child whose parents are divorced or separated:

(a) If there is a court decree which makes one parent financially responsible for the health care expenses with respect to the child and the entity obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that plan which covers the child as a dependent of such parent shall be determined before the benefits of any other plan which covers the child as a dependent child.

(b) If there is no such court decree, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the **custodial parent**;
- The plan of the non**custodial parent**; and then

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

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

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

How Coordination of Benefits Works

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

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

Under the COB provision of **This Plan**, the amount normally reimbursed for covered benefits or expenses under **This Plan** is reduced to take into account payments made by other plans. The general rule is that

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

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

When You Have Medicare Coverage

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

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

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

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:

1. Refused it;
2. Dropped it; or
3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays.

Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits.

Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works When the Plan is Primary

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

When Medicare is Primary

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

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

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

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

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

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

Right to Receive and Release Required Information

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

General Provisions

Type of Coverage

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

Physical Examinations

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

Legal Action

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

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage:

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

Assignments

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

- The benefits due under this group insurance policy;

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

Misstatements

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

Recovery of Overpayments

Health Coverage

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

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

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

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible.

Payment of Benefits Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than: (a) 30 days of receipt of a claim transmitted electronically or via the internet; or (b) 45 days for a claim submitted by other means.

Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim. **Aetna** will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

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

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

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company

151 Farmington Avenue

Hartford, CT 06156

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

Effect of Benefits Under Other Plans

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

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

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

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.

Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage.

There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extension of dental benefits under this plan will not apply on or after the date of a change to an HMO Plan. No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Schedule of Benefits

Group Policy Number: GP-820362
Issue Date: September 11, 2013
Effective Date: July 1, 2013
Schedule: 1A
Cert Base: 1

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Managed Dental Plan

Schedule of Managed Dental Benefits

Primary Care Dentists and Specialty Care Dentist (Network Dental Provider) Covered Expenses

Coverage is provided only for services shown in the Dental Care Schedule (see *What the Plan Covers* section). This dental expense coverage is segmented into four service types. The **copayments** shown below apply.

Dental Care Schedule Copayment Amounts

Service Type Primary Care Services Specialty Care Services

Type A Expenses 0% Not Applicable

Type B Expenses 20% 20%

Type C Expenses 50% 50%

Orthodontics Expenses 50%

Orthodontic Lifetime Maximum: 24 months of active treatment plus 24 months of retention.

Dental Emergency Maximum: \$100

Expense Provisions

The following provisions apply to your health expense plan.

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

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

Keep This Schedule of Benefits With Your Booklet-Certificate.

Coinsurance Provisions

Coinsurance

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

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits.

Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form.

Coverage is underwritten by Aetna Life Insurance Company

Glossary

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

Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

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

Coinsurance

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

Copay or Copayment

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

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

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

Deductible

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

Dental Provider

This is:

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

legally qualified to furnish dental services or supplies.

Dental Emergency

Any dental condition that:

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

Dentist

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

Directory

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

Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

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

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
 - drug;
 - device;
 - procedure; or
 - treatment,

that states that it is **experimental or investigational**, or for research purposes.

Hospital

This means a short-term, acute, general hospital which:

- Is primarily engaged in providing, by or under the continuous supervision of **physicians**, to inpatients, diagnostic services and therapeutic services for diagnostic, treatment and care of injured and sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a **physician** or dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861k of U.S. Public Law 89-97 (42 USCA 1395x(k));
- Is duly licensed by the agency responsible for licensing such hospitals;
- Makes charges; and
- Is not, other than incidentally, a place for rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Illness

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

Injury

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

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

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

Medically Necessary or Medical Necessity

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

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

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

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

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

Negotiated Charge

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

Network Provider

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

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

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCD**.

Non-Occupational Illness

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

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

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

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

Non-Occupational Injury

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

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

Occupational Injury or Occupational Illness

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

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

Occurrence

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

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

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCD**.

Out-of-Network Provider

A **dental provider** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Prescriber

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

Prescription

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

Prescription Drug

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

This includes:

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

Primary Care Dentist (PCD)

This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Dentists** in the **directory**;
- Supervises, coordinates and provides dental services to a person;
- Initiates **referrals** for **specialist dentist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **primary care dentist**.

If you do not choose a **PCD**, **Aetna** will have the right to make a selection for you. You will be notified of the selection.

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to dental expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- 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.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are

grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

□ 64s Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information

Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Referral

This is a written or electronic authorization made by your **primary care physician** (PCP) or **primary care dentist** (PCD) to direct you to a **network provider**, for **medically necessary** services or supplies covered under the plan.

Referral Care

Covered services given to you by a **specialist dentist** who is a **network provider** after **referral** by your **primary care dentist** and providing that **Aetna** approves coverage for the treatment.

R.N.

A registered nurse.

Specialist

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

Specialist Dentist

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

Specialty Care

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

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 antifraud 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.