Aetna Dental Preferred Provider Organization (PPO) Plan

This document 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 Preferred Provider Organization (PPO) Plan (“Plan”). This SPD is a summary of the main features of the Plan in effect as of July 1, 2017. If there is any discrepancy between the information contained in this SPD and the 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 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 Dental PPO Plan.

Contents

The Aetna Dental PPO Plan at a Glance

Here are the highlights of the Aetna Dental PPO Plan. Benefits may be subject to certain limits and restrictions. Be sure to review the rest of this Summary Plan Description for a more complete description of Plan benefits. For information about participation requirements, see **Eligibility and Enrollment**; see **Administrative and Legal Information** for how to file a claim, continuation coverage, legal notices and where to obtain additional information.

Aetna Dental PPO Plan		
	In-network *(Benefits are based on negotiated charge)*	**Out-of-network** *(Benefits are based on the recognized charge)*
Plan Year Deductible	$50 for each covered person	
Preventive and Diagnostic Services, including: • Routine oral exams • Cleaning and scaling of teeth • X-rays • Fluoride treatment • Space maintainers • Sealants	100% no deductible	100% no deductible
Basic Services, including: • Fillings • Extractions • Endodontics • Periodontics • Osseous surgery • Oral surgery	80% after deductible	70% after deductible
Major Services, including: • Crowns • Bridgework and dentures • Inlays and onlays	50% after deductible	50% after deductible
Orthodontic Care	50% up to a $1,500, after deductible Individual lifetime maximum	Not covered
Plan Year Maximum Benefit	$1,500 for each covered person	

The Aetna Dental PPO Plan

The Aetna Dental PPO Plan promotes good dental health by providing coverage for a broad range of dental services and supplies. Plan benefits are highest – and you pay less out of your own pocket – whenever you use an in-network dentist. If you choose to see an out-of-network dentist, orthodontic care is not covered and Plan benefits are generally less. While in-network dentists agree to a contracted rate, charges for out-of-network dentists will be based on recognized charge rates as determined by Aetna. To locate a participating Aetna dentist near you, contact Aetna Member Services.

ID Cards

You will not receive an ID card when you enroll in the Aetna Dental PPO 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.

Covered Expenses

The Plan covers only the dental services listed below, provided they are necessary, customarily used nationwide, professionally appropriate and meet broadly accepted national standards of dental practice for the condition being treated.

Preventive and Diagnostic Services

The PPO pays the following benefits for Preventive and Diagnostic services with no deductible:

The PPO pays	If Preventive and Diagnostic services are provided by
100% of the negotiated charge for in-network coverage 100% of the recognized charge for out-of-network coverage	An in-network and out-of-network dentist

Covered Preventive and Diagnostic services include:

- ***Visits and Exams***
  - Routine oral exams – limited to once every six months
  - Prophylaxis (cleaning and scaling of teeth) − limited to once every six months
  - Topical application of sodium or stannous fluoride for covered individuals under age 17 – limited to one treatment per plan year
  - Sealants for covered dependent children under age 16 – limited to one application every three years for permanent molars only
  - Space maintainers, including all adjustments within the first six months following installation (for covered dependents under age 17):
    - fixed, band type
    - removable acrylic with round wire clasp

- ***X-rays***
  - Full mouth series or panoramic film – limited to once every 5 years
  - Bitewing X-rays – limited to one set every 12 months
  - Vertical bitewing X-rays
  - Periapical X-rays
  - Intra-oral X-rays, occlusal view, maxillary or mandibular
  - Extra-oral X-rays of the upper or lower jaw.

Basic Services

The PPO pays the following benefits for Basic services:

The PPO pays	If Basic services are provided by
80% of the discounted rate after the deductible	An in-network dentist
70% of recognized charges after the deductible	An out-of-network dentist

Covered Basic services include:

- ***Restorations and Repairs***
  - Amalgam fillings
  - Resin fillings
  - Retention pins
  - Sedative fillings
  - Prefabricated resin crowns (but not temporary crowns)
  - Recementing inlays, crowns, bridges and space maintainers
  - Tissue conditioning for dentures
  - Emergency palliative treatment (emergency relief of pain)
  - Crown and bridge repairs
  - Full and partial denture repairs, including relining, rebasing and adjustments within six months after installation.
  - Adding teeth to an existing denture

- ***Endodontics (Root Canal)***
  - Pulp capping
  - Pulpotomy
  - Surgical exposure for rubber dam isolation
  - Root canal therapy, including necessary X-rays
  - Apexification/recalcification
  - Apicoetomy (per tooth) – first root
  - Apicoetomy (per tooth)
  - Retrograde filling
  - Root amputation
  - Hemisection
- ***Periodontics***
  - Scaling and root planing
  - Periodontal maintenance procedures following active periodontal therapy
  - Gingivectomy or gingivoplasty – per tooth or per quadrant
  - Gingival flap procedure – per quadrant
  - Periodontics for osseous surgery (including flap entry and closure).
- ***Oral Surgery –*** including local anesthetics and routine post-operative care
  - Simple extractions (non-surgical)
  - Surgical removal of:
    - erupted tooth
    - tooth impacted in soft tissue
    - tooth impacted in bone (partially bony, completely bony, and completely bony with unusual surgical complications)
    - hyperplastic tissue
    - pericoronal gingiva
  - Intravenous sedation and general anesthesia, only when medically necessary and provided in conjunction with a covered surgery
  - Removal of residual root
  - Closure of oral fistula
  - Frenectomy
  - Transplantation of tooth or tooth bud
  - Alveoplasty in conjunction with extractions – per quadrant
  - Alveoplasty not in conjunction with extractions – per quadrant
  - Removal of exostosis.

Major Services

The PPO pays the following benefits for Major services:

The PPO pays	If Major services are provided by
50% of the discounted rate after the deductible	An in-network dentist
50% of recognized charges after the deductible	An out-of-network dentist

Covered Major services include:

- Restorations
- Inlays
- Onlays
- Implants, including prosthetic replacement
- Crowns (including build-ups when necessary)
- Stainless steel crowns
- Porcelain with noble metal, base metal, base metal (full cast), noble metal (full cast), metallic (3/4 cast), post and core
- Pontics with 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

To be eligible for reimbursement, Aetna must receive satisfactory proof of the following:

- The removable denture, fixed bridgework or other prosthetic service is needed to replace one or more natural teeth removed while the individual was covered under the Plan

  and

- The removable denture, fixed bridgework or other prosthetic service is not an abutment to an existing partial denture, removable bridge or fixed bridge installed during the prior five years.

To be eligible for replacement, Aetna must receive satisfactory proof of the following:

- The replacement, addition or modification is necessary to replace teeth extracted while the individual was covered under the Plan, and after the denture, bridge or other prosthetic was installed
- The existing denture, bridgework or other prosthetic is at least five years old and cannot be made serviceable

  and

- The existing denture:
  - is temporary to replace one or more natural teeth extracted while the patient was a Plan participant
  - cannot be made permanent and replacement by a permanent denture is needed
  - is replaced within 12 months after the temporary was first installed.

Orthodontics

The PPO pays 50% of the cost of services and supplies for Orthodontic treatment for dependent children and adults. Benefits are provided only if you use an in-network orthodontist. *If you use an out-of-network orthodontist, no benefits will be paid by the Plan.*

Covered Orthodontic expenses include:

- Comprehensive orthodontic treatment
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits
- Occlusal guard for bruxism.

Emergency Care

The Plan provides coverage for any emergency which:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment

  and
- Involves severe pain and bleeding due to an abscess, infection or chewing incident

For emergency care the Plan pays up to $75 for the initial visit. It doesn't matter if you receive the service from an in-network or out-of-network dentist. For any follow-up care, the Plan pays its regular benefits.

Dental Medical Integration (DMI)

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you or your covered dependent 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)

Payment of Benefits

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

The payment percentage applied to the other covered dental expenses above will be 100% for network expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Plan Year maximum.

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

Maximum Benefits

You and each covered dependent can receive up to $1,500 in benefits each plan year for Preventive and Diagnostic, Basic and Major services combined – whether care is received in-network or out-of-network. However, frequency of treatment and/or age limitations may apply, as described in the list of covered dental services and supplies. Orthodontic care has a separate individual lifetime maximum benefit of $1,500 for each eligible member.

Tooth Missing but Not Replaced Rule

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.

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.

Exclusions

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 Covered Expenses section. Charges made for the following are not covered except to the extent listed under the Covered Expenses section. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

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

- Any instruction for diet, plaque control and oral hygiene.
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.
- 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 contract holder.
- 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 Covered Expenses 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 Covered Expenses 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;
    - Cleaning of teeth; and
    - Topical application of fluoride.

Pre-treatment Review

Whenever your dentist estimates that his or her services will exceed $350, you should have your dentist file an advance claim review with Aetna. Aetna will estimate the benefits and let you and your dentist know before the work begins.

Effect of Benefits under Other Plans

Some persons have health or dental coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

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

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

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, 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;

The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

    - covers the person as other than a dependent; and
    - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

Shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

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

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a plan year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other 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.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a plan year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Claiming Benefits

Aetna administers all Aetna Dental PPO claims. Dental services you receive from an in-network dentist generally require no claim forms. As a courtesy, all in-network dentists are required to submit dental forms for you. If you receive care from an out-of-network dentist you will need to file a claim form for reimbursement. Submit the completed form to Aetna at the address shown on the form. Be sure to include all of the necessary documentation.

Recovery of Overpayment

If you receive a benefit payment for more than it should be, the Claims Administrator reserves the right to have the extra amount returned or reduce any future payments to make up the difference.

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 Dental PPO 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 Dental PPO Plan, your covered dependents can receive 60 days of continued coverage under COBRA (see Continuation of Coverage on next page) 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 **Administration and Legal SPD** for more information on electing COBRA coverage.

Termination of Coverage

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

Your Aetna Dental benefits coverage will end if:

- The Aetna Dental benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another dental plan offered by your employer;
- You have exhausted your overall maximum annual or lifetime benefit under your dental plan, if your plan contains such a maximum benefit; or
- Your employer notifies Aetna that your employment is ended (unless COBRA is elected).

It is your employer's responsibility to let Aetna know when your employment ends.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall annual or lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends the last day of the pay period following the date your dependent is no longer eligible for coverage.
  or;
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

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

Continuation of Coverage (COBRA)

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA) requires that the Aetna Dental PPO 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 Dental PPO 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.

Glossary of Key Terms

To help you understand how the Aetna Dental PPO Plan works, you should familiarize yourself with the following key terms.

Aetna Member Services – Call 1-800-589-4811 or log on to **www.aetna.com**.

Plan year – The 12-month period beginning on July 1 and ending on June 30, used to determine annual dental plan benefit limitations (deductible, annual maximum benefit and frequency of certain dental services).

Claims Administrator – Aetna Inc.

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 - dental, services and supplies shown as covered under this Booklet-Certificate

Deductible – The amount you must pay each plan year before the Aetna Dental PPO Plan pays any benefits.

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 – An individual holding a degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who practices within the scope of his or her license under the laws of the state or jurisdiction in which services are provided.

Directory - A listing of all network providers serving the class of employees to which you belong. The contract holder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

Doctor (or physician) – An individual holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) or Doctor of Chiropractic (DC), who practices within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition

of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or

- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research

In-network dentist – A state licensed dentist who has a written agreement with Aetna to perform services and receive payment at a discounted rate under this program.

Jaw Joint Disorder -

- 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.

Out-of-network dentist – A state licensed dentist who does not have an agreement with Aetna.

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 amount the Plan will consider for a service or supply. The Claims Administrator determines the negotiated charge taking into consideration the usual amount charged for such a service in a given locality. If you receive out-of-network care, amounts in excess of the Recognized charges are not covered by the Plan.

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.

"R"Benefits Service Center – Call **1-844-TRU-BENS**, Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time for assistance with benefit-related questions. If you or your dependent experiences a COBRA qualifying event, contact ADP COBRA Services at **1-844-TRU-BENS.**

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

Your plan's recognized charge applies to all out-of-network covered expenses. In all cases, the recognized charge is determined based on the Geographic Area where you receive the service or supply.

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

- For dental expenses, the recognized charge for a 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

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

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

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and

- The views of physicians and dentists practicing in the relevant clinical areas.

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

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