# BENEFIT PLAN

**Prepared for**
**Truist Financial Corporation**

**Dental Maintenance Organization - Texas**

**What Your Plan Covers and How Benefits are Paid**

**Aetna Dental Inc.**
**Evidence of coverage (EOC)**

This evidence of coverage (EOC) is part of the group agreement between **Aetna** Dental Inc. and the contract holder

**Aetna Dental Inc.**
**Three Sugar Creek Boulevard, Sugar Land, TX 77478**
**1-877-238-6200**
**www.aetna.com**

# Evidence of coverage (EOC)

# Dental DMO Plan

## Prepared for

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|---|---|
| **Contract holder**: | Truist Financial Corporation |
| **Contract holder** number: | GP- 0141938-TX |
| Evidence of coverage: | 1 |
| **Group agreement** effective date: | January 1, 2024 |
| Plan name: | Dental Maintenance Organization - Texas |
| Plan effective date: | January 1, 2024 |
| Plan issue date: | December 21, 2023 |

**Important Note:**
**A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.**

**You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).**

**If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.**

**If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.**

**You may obtain a current directory of network physicians and providers at the following website: www.aetna.com or by calling the toll-free number on your ID card for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of- network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.**

**Underwritten by Aetna Dental Inc.**

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# Have a complaint or need help?

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

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

**Aetna, Inc.**

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

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

**The Texas Department of Insurance**

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

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

## ¿Tiene una queja o necesita ayuda?

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

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

**Aetna, Inc.**

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

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

**El Departamento de Seguros de Texas**

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

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

**IMPORTANT NOTICE**

**To obtain information or make a complaint:**

**You may call Aetna's toll-free telephone number for information or to make a complaint at:**

**1-877-238-6200**

**You may also write to Aetna at:**

**Aetna Dental Inc.**
**Three Sugar Creek Boulevard, Sugar Land, TX 77478**

**You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:**
**1-800-252-3439**
**You may write the Texas Department of Insurance:**

**P. O. Box 149104**
**Austin, TX 78714-9104**

**Fax: (512) 490-1007**

**Web: www.tdi.texas.gov**

**E-mail: ConsumerProtection@tdi.texas.gov**

**PREMIUM OR CLAIM DISPUTES:**
**Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.**

**ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.**

**AVISO IMPORTANTE**

**Para obtener información o para presentar una queja:**

**Usted puede llamar al número de teléfono gratuito de Aetna's para obtener información o para presentar una queja al:**
**1-877-238-6200**

**Usted también puede escribir a Aetna:**

**Aetna Dental Inc.**
**Three Sugar Creek Boulevard, Sugar Land, TX 77478**

**Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:**
**1-800-252-3439**
**Usted puede escribir al Departamento de Seguros de Texas a:**
**P. O. Box 149104**
**Austin, TX 78714-9104**

**Fax: (512) 490-1007**

**Sitio web: www.tdi.texas.gov**

**E-mail: ConsumerProtection@tdi.texas.gov**

**DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONESS:**
**Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.**

**ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solomente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.**

# Welcome

Thank you for choosing **Aetna®**.

This is your evidence of coverage, or "EOC" for short. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

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

The third document is the **group agreement** between **Aetna Dental Inc**. ("**Aetna**") and your contract holder. Ask your contract holder if you have any questions about the **group agreement**.

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

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

Welcome to your **Aetna** plan.

# Table of Contents

# Let's get started!

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

## Some notes on how we use words in the EOC and schedule of benefits

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

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

## What your plan does – providing covered benefits

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

## How your plan works – starting and stopping coverage

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

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

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

## How your plan works while you are covered in-network

Your in-network coverage helps you:

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

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

## Eligible dental services

**Eligible dental services** meet these requirements:

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

## Aetna's network of dental providers

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

**In-network providers not reasonably available** – You can get **eligible dental services** under your plan that are provided by an **out-of-network provider** if an appropriate **in-network provider** is not reasonably available. Your **Primary care dentist** (**PCD**) must request access to the **out-of-network provider** in advance and we must agree.

We will make a decision as soon as your dental condition requires but no later than 5 working days after we receive all of the information we need from your **provider**. We may decide not to approve your request. Before we disapprove the request, a **specialty dentist** of the same or similar specialty as the **provider** you are requesting to see will review your request. If access is approved, we will pay the **out-of-network provider** at our usual and customary charge or an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**. Call us if you receive a bill from the **out-of-network provider**. See the *How to contact us for help* section.

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

**Important notes:**
**For dependents under a qualified medical or dental support order:**
If you are required to cover a dependent who lives outside the **service area** under a qualified medical or dental support order, we will provide your dependent with coverage that is comparable health or dental coverage to that provided to other dependents.

**For other dependents (not under a qualified medical or dental support order) outside the service area:**
If you have a dependent outside of the **service area**, their coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

## Paying for eligible dental services– the general requirements

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

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

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

## Paying for eligible dental services– sharing the expense

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

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

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

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

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

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

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

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

## How to contact us for help

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

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

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

You can also contact us by:

- Calling **Aetna** at **1-877-238-6200**
- Writing us at **Aetna Dental Inc**., Three Sugar Creek Center Boulevard, Sugar Land, TX 77478

## Your ID card

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

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

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

# Who the plan covers

You will find information in this section about:

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

## Who is eligible

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

## When you can join the plan

As an employee you can enroll yourself and your dependents if you live, work or reside in the **service area**:

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

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

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

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

- Your legal spouse
- Your domestic partner who meets any contract holder rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under age 26
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including any children placed with you for adoption and any child when you become a party in a suit to adopt the child.*
    - Foster children
    - Children you are responsible for under a qualified medical or dental support order or court order
    - Grandchildren in your legal custody
    - Grandchild who, at the time of application, is your dependent for federal tax purposes
    - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *Adding new dependents* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

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

## Adding new dependents

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

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

## Inform us of any changes

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

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

## Special times you and your dependents can join the plan

You can enroll in these situations:

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

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

## Effective date of coverage

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

# Medical necessity and referral requirements

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

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

## Medically necessary/medical necessity

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

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

## Referrals

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

# What are your eligible dental services?

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

Your plan covers many kinds of dental care services and supplies. It also includes coverage health care services or procedures delivered by a preferred or contracted **health professional** as a **teledentistry** service. But some are not covered at all or are covered only up to a limit.

You can find out about exceptions and exclusions in the:

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

## Your dental plan

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

## Schedule of benefits

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

## Dental provider services

You can get **eligible dental services**:

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

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

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

- Acupuncture, acupressure and acupuncture therapy.
- Asynchronous dental treatment.
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the schedule of benefits.
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**.
- Instruction for diet, tobacco counseling and oral hygiene.

- Mail order and at-home kits for **orthodontic treatment**.
- **Orthodontic treatment** except as covered in the schedule of benefits.
- Prefabricated porcelain/ceramic crown – permanent tooth
- Services and supplies provided by an **out-of-network provider** except for **dental emergency services** or **eligible dental services** from an **out-of-network provider** if an appropriate **in-network provider** is not reasonably available. See the *Aetna's network of dental providers* section for details.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
- Replacement of teeth beyond the normal complement of 32.
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons.
- **Temporomandibular joint dysfunction/disorder (TMJ)**.

## Dental emergency services

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

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

If you get treatment from an **out-of-network provider** for a **dental emergency**, the plan pays a benefit at the in-network cost-sharing level of coverage. We will pay the **out-of-network provider** at our usual and customary charge or an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**.

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

## Dental care services and anesthesia in a hospital or surgery center

**Eligible dental services** include dental care and anesthesia in a hospital or surgery center only if your **provider** tells us you:

- Have a physical, mental, or medical condition that requires you be treated in a hospital or surgery center
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

## Coverage of dental treatment in progress

**Eligible dental services** include benefits for covered dental treatment in progress on the date you become covered under this plan. But this in-progress treatment will need to be completed by a **network provider**.

## Dental disease

**Eligible dental services** include services for preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal disease.

# What rules and limits apply to dental care?

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

## Alternate treatment rule

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

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

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

The benefit will be based on the **in-network provider**'s **negotiated charge** for the **eligible dental service**.

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

## Orthodontic treatment rule

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

This benefit does not cover charges for the following:

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

Comprehensive **orthodontic treatment** is limited to a:

- **Lifetime maximum** of 24 months of active; usual and customary **orthodontic treatment** on permanent dentition; plus an extra 24 months of post-treatment retention.
- **Lifetime maximum** of one full course of active, usual and customary **orthodontic treatment**, plus post-treatment retention.

## Reimbursement policies

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

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

**Aetna** reimbursement policies are based on our review of:

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

## Replacement rule

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

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

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

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

# What your plan doesn't cover – exclusions

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

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

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

## Exclusions

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

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

### Charges for services or supplies

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

### Charges in excess of any benefit limits

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

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

- **Cosmetic** services and supplies including:
  - Plastic surgery
  - Reconstructive surgery
  - **Cosmetic** surgery
  - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons.

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

### Court-ordered services and supplies

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

### Dental services and supplies

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

### Examinations

Any dental examinations needed:

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

### Experimental or investigational

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

### Non-medically necessary services

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

### Other primary payer

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

### Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

### Personal care, comfort or convenience items

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

### Providers and other health professionals

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

### Services provided by a family member

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

## Teledentistry

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

## Work related illness or injuries

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

# Who provides the care

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

## In-network providers

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

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

The exceptions are:

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

When **in-network providers** are not available to provide the **eligible dental service** that you need, we will make a decision as soon as your dental condition requires but no later than 5 working days after we receive all of the information we need from your **provider**. We may decide not to approve your request. Before we disapprove the request, a **specialty dentist** of the same or similar specialty as the **provider** you are requesting to see will review your request. If access is approved, we will pay the **out-of-network provider** at our usual and customary charge or an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**. Call us if you receive a bill from the **out-of-network provider**. See the *How to contact us for help* section.

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

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

## Your PCD

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

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

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

### How do you choose your PCD?

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

If you have a chronic, disabling or life-threatening **illness**, you can request to use a network **specialty dentist** as your **PCD**. Your network **specialty dentist** must let us know that they agree to act as your **PCD**. Call us to apply for this exception. See the *How to contact us for help* section.

Designation of your network **specialty dentist** as your **PCD** will not be retroactive. If your request is denied, you may appeal the decision. See the *When you disagree - claim decisions and appeals procedures* section.

### What will your PCD do for you?

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

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

### How do I change my PCD?

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

The change will become effective as follows:

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

### What happens if I do not select a PCD?

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

Your **eligible dental services** will be limited to care provided by direct access **in-network providers** and **dental emergency services**.

# What the plan pays and what you pay

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

- Your **copayments**

## The general rule

When you get **eligible dental services**:

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

  And then

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

  And then

- You are responsible for any amounts above the **maximum**.

## Important note – when you pay all

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

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

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

## Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

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

## Where your schedule of benefits fits in

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

### How your copayment works

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

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

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

# When you disagree - claim decisions and appeals procedures

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

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

## Claim procedures

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

The table below explains the claim procedures as follows:

| Notice | Requirement | Deadline |
|---|---|---|
| Submit a claim | • You should get a claim form from our self-service website or call us<br>• The claim form will provide instructions on how to complete and where to send the forms. | • We must send you a claim form within 15 business days of your request<br>• You must send us notice and proof as soon as reasonably possible.<br>• If you are unable to complete a claim form, you may send us:<br>– A description of services<br>– Bill of charges<br>– Any dental documentation you received from your **dental provider**. |
| Proof of claim<br><br>When you have received a service from an eligible **dental provider**, you will be charged.<br><br>The information you receive for that service is your proof of loss. | • A completed claim form and any additional information required by us. | • You must send us notice and proof as soon as reasonably possible. |
| Benefit payment | • Written proof must be provided for all benefits.<br>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss. | • We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms.<br>• Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent.<br>• If we reject the claim the written notice will include the reason for denial |

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

## Communicating our claim decisions

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

### Retrospective claim

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

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

If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

## Adverse determinations

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

An adverse determination is our determination that the health care services you have received or may receive, are:

- **Experimental or investigational**
- Not **medically necessary**

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for the denial
- The clinical basis for the denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves a life-threatening condition.

The chart below tells you how much time we have to tell you about an adverse determination.

| Type of notice | When you need care to make sure you are stable following emergency treatment (post-stabilization) | While you are in the hospital | When not hospitalized at the time of the decision | Retrospective |
|---|---|---|---|---|
| Initial decision | No later than 1 hour after the request to the treating **provider** | Within 1 business day by phone or email to your **provider** followed by written notice within 3 business days to you and your **provider** | within 3 business days to you and your **provider** | Within 30 days after the date on which the claim is received |
| Extensions | Not applicable | Not applicable | Not applicable | 15 days |
| Additional Information Request (us) | Not applicable | Not applicable | Not applicable | 30 days |
| Response to additional information request (you) | Not applicable | Not applicable | Not applicable | 45 days |

**Important note:**
We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell you no later than the times shown in the chart above.

## The difference between a complaint and an appeal

### A complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. See the *How to contact us for help* section. Your complaint should include a description of the issue. Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

If your complaint concerns an emergency, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

We will not take action against you, including cancelling or refusing to renew your coverage, because you filed a complaint.

### An appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complaint* and *Appeal of adverse determinations* sections below explain the appeal processes for both types of appeals.

### Appeal of a complaint

You can ask us to re-review your complaint. You can appeal to us by calling or writing. See the *How to contact us for help* section.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee HMO members.
- HMO representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in the initial decision. We will use a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physicians** or **providers** consulted during the review
- The name and affiliation of all HMO representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal**.** If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim or appeal. We will not charge you for the information.

## Appeals of adverse determinations

You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination or by calling us. See the *How to contact us for help* section. You need to include:

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

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

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

### Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions.

**Important note:**
You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

## Timeframes for deciding appeals of adverse determinations

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will also send you a letter within 3 calendar days after the oral notice.

| Type of notice | Retrospective appeal |
|---|---|
| Initial decision by us | As soon as possible but not later than 30 days |

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

## Exhaustion of appeals process

In most situations, you must complete an appeal before you appeal through an independent review process. If you have a life-threatening condition, you can have your appeal reviewed through the independent review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

## Independent review

Independent review is a review done by people in an organization outside of **Aetna**. This is called an independent review organization (IRO).

You have a right to independent review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental or investigational**
- You have received an adverse determination

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination or final adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the Request for Independent Review form.

You must submit the Request for Independent Review form:

- To **Aetna**
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

**Aetna** will send your independent review request to the Texas Department of Insurance (TDI). The TDI will assign it to an IRO and notify us of the assignment. We will send your request and supporting information to the assigned IRO no later than the third business day after we receive it.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

### How long will it take to get an IRO decision?

The IRO will notify you of their decision. The amount of time they have to make their decision is based on the services you are requesting. The chart below tells you how much time the IRO has to review your request.

| **IRO Decisions** | |
|---|---|
| **When your request involves:** | **The IRO will notify you within:** |
| **Emergency services** | 72 hours |
| Any other service | The earlier of:<br>• 15 days after the IRO receives all necessary information<br>• 20 days after the IRO receives the request |

## Recordkeeping

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

## Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

# Coordination of benefits

The Coordination of benefits ("COB") provision applies when a person has dental coverage under more than one plan. If you do, we will work together with your other plans to decide how much each plan pays. This is called coordination of benefits (COB). Plan is defined below *Key terms*.

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

## Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

<table>
<tr><td colspan="2">Plan:<br>A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.</td></tr>
<tr><td>• It includes:</td><td>• Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage<br>• Individual and group health maintenance organization evidences of coverage<br>• Individual accident and health insurance policies<br>• Individual and group preferred provider benefit plans and exclusive provider benefit plans<br>• Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care<br>• Dental care components of individual and group long-term care contracts<br>• Limited benefit coverage that is not issued to supplement individual or group in-force policies<br>• Uninsured arrangements of group or group-type coverage<br>• The dental benefits coverage in automobile insurance contracts<br>• Medicare or other governmental benefits, as permitted by law</td></tr>
</table>

| | |
|---|---|
| • It does not include: | • Disability income protection coverage<br>• The Texas Health Insurance Pool<br>• Workers' compensation insurance coverage<br>• Hospital confinement indemnity coverage or other fixed indemnity coverage<br>• Specified disease coverage<br>• Supplemental benefit coverage<br>• Accident only coverage<br>• Specified accident coverage<br>• School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis<br>• Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services<br>• Medicare supplement policies<br>• A state plan under Medicaid<br>• A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan<br>• Other nongovernmental plan<br>• An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable **deductible** |
| • Each plan for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan | |
| | |
| This plan:<br>This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans | |
| • How this plan coordinates with like benefits: | Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits. |

| | |
|---|---|
| • The order of benefit determination rules for this plan: | The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.<br>• When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits<br>• When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense |
| | |
| Allowable expense:<br>Allowable expense is a health or dental care expense, including deductibles, **copayment percentage** and **copayments**, that is covered at least in part by any plan covering the person. | |
| • Allowable expense for benefits provided in the form of services: | When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. |

| | |
|---|---|
| • Expenses that are not allowable expenses: | An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.<br><br>Some expenses and services are not allowable expenses. Here are some examples:<br>• The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.<br>• If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.<br>• If a person is covered by two or more plans that provide benefits or services on the basis of **negotiated charges**, an amount in excess of the highest of the **negotiated charges** is not an allowable expense.<br>• If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different than the primary plan's payment arrangement and if the health care **provider's** or **physician's** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits.<br>• The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and **network provider** and **physician** arrangements. |
| | |

Allowed amount:
Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider**. The amount includes both the carrier's payment and any applicable deductible, **copayment**, or **copayment percentage** amounts for which the insured is responsible.

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

Custodial parent:
Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

## Order of benefit determination rules

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

- The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan.
- A plan that does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:
  - Coverage that you have because of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are:
    - Major medical coverages that are superimposed over base plan hospital and surgical benefits
    - Insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an **out-of-network provider** or **physician**, except for **emergency services** or authorized **referrals** that are paid or provided by the primary plan.
- When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with these rules.
- If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

| If you are: | Primary plan | Secondary plan |
|---|---|---|
| Covered under the plan as an employee, retired employee or dependent | The plan covering you as an employee, member, contract holder, subscriber or retired employee | The plan covering you as a dependent |
| Eligible for Medicare | If you or a dependent have Medicare coverage, the rule above may be reversed so that the plan covering you or your spouse as an employee, member, contract holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. See the *How to contact us for help* section if you have questions | |
| **COB rules for dependent children**<br>Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply. | | |
| Child of:<br>• Parents who are married or living together, whether or not they have ever been married | The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**<br><br>*Same birthdays--the plan that has covered a parent longer is primary | The plan of the parent born later in the year (month and day only)*<br><br>*Same birthdays--the plan that has covered a parent longer is primary |
| Child of:<br>• Parents separated or divorced or not living together, whether or not they have ever been married<br>• With court-order | The plan of the parent whom the court said is responsible for dental coverage<br><br>But if that parent has no coverage then their spouse's plan is primary | The plan of the other parent<br><br>But if that parent has no coverage, then their spouse's plan is primary |
| Child of:<br>• Parents separated or divorced or not living together, whether or not they have ever been married – court-order states both parents are responsible for coverage or have joint custody | Primary and secondary coverage is based on the birthday rule | |

| | | |
|---|---|---|
| Child of:<br>• Parents separated or divorced or not living together, whether or not they have ever been married and there is no court-order | The order of benefit payments is:<br>• The plan of the custodial parent pays first<br>• The plan of the spouse of the custodial parent (if any) pays second<br>• The plan of the noncustodial parents pays next<br>• The plan of the spouse of the noncustodial parent (if any) pays last | |
| Child covered by:<br>• Individual who is not a parent (i.e. stepparent or grandparent) | Treat the person the same as a parent when making the order of benefits determination:<br><br>See *Child of* content above. | |
| Child of:<br>• Persons, who are not his or her parents | The rules shown for parents will apply, as if the persons were parents of the child. | |
| Child of:<br>• Parents, who is also covered under a spouse's plan | The plan that has covered the person longer is primary.<br><br>If coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse. | |
| Active or inactive employee<br><br>This rule does not apply if:<br>• The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits<br>• The "Non-dependent or Dependent" paragraph, above, can determine the order of benefits | The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee). | A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee). |

| | | |
|---|---|---|
| COBRA or state continuation<br><br>This rule does not apply if:<br>• The other plan does not have this rule, and as a result, the plans do not agree on the order of benefits<br>The "Non-dependent or Dependent" paragraph, above, can determine the order of benefits | The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage. | COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree. |
| Longer or shorter length of coverage | If none of the above rules determine the order of payment, the plan that has covered the person longer is primary. | |
| Other rules do not apply | If none of the above rules apply, the plans share expenses equally.<br><br>This plan will not pay more than it would have paid had it been the primary plan. | |

## Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
  - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
  - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
  - Must credit to its plan deductible (if any) any amounts it would have credited to its deductible in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

## Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

## Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

## Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from 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 the benefits provided in the form of services.

## Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

# When coverage ends

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

## When will your coverage end?

Coverage under this plan will end if:

- This plan is no longer available
- You voluntarily stop your coverage
- The group agreement ends
- You are no longer eligible for coverage, including when you no longer live, work, or reside in the **service area**
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage for one of the reasons shown in this section
- You choose to become covered under another dental plan offered by your contract holder

## When coverage may continue under the plan

Your coverage under this plan will continue if:

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

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

## Notification of when your employment ends

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

## When will coverage end for any dependents?

Coverage for your dependent will end if:

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

**Important note:**

Your employer will notify **Aetna** of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

- Your employer notifies us at least 30 days before coverage ends
- You and your dependents are covered under COBRA or state continuation
- You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

## Why would we end your coverage?

We will give you 30 days advance written notice before we end your coverage because:

- You no longer reside, live or work in the **service area**.
- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

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

We will not end your coverage based on your health care status or needs. We also will not end your coverage because you used your rights under the *When you disagree – claim decisions and appeals procedures* section of this EOC.

# Special coverage options after your plan coverage ends

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

## Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

The qualifying events are:

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

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

# Continuation of coverage - State of Texas

## Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods.

<table>
<tr><th>Qualifying event causing loss of coverage</th><th>Covered persons eligible for continued coverage</th><th>Length of continued coverage<br>(starts from the day you lose current coverage)</th></tr>
<tr><td>• Death of employee</td><td rowspan="3">• Dependent who has been covered under the plan for at least one year<br>• An infant under one year of age</td><td rowspan="3">3 years</td></tr>
<tr><td>• Retirement of employee</td></tr>
<tr><td>• Divorce or legal separation</td></tr>
</table>

### When do I receive state continuation information?

The chart below lists who must give the notice, the type of notice required, and the time period to give the notice.

| Notice | Requirement | Deadline |
|---|---|---|
| You or your covered spouse | Send written notice to your employer | Within 15 days of the qualifying event |
| Your employer | Will provide you with an enrollment form to continue coverage | No later than 15 days after they receive notification |
| You or your covered spouse | Complete the enrollment form to continue coverage | Within 60 days of the qualifying event. |

You must send the completed enrollment form within 60 days of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

## Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first **premium** payment must be made within 45 days after the date of the coverage election. After that, **premium** payments are due no later than the end of the grace period after the **premium** due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date the election is made, if you are not eligible for COBRA
- The date you fail to pay **premiums**
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

## Continuation of coverage for other reasons

### What exceptions are there for dental work when coverage ends?

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

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

Ordered means:

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

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

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

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

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

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

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

# General provisions – other things you should know

## Administrative provisions

### How you and we will interpret this EOC

We prepared this EOC according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws.

If the EOC contains any provision or a part of a provision not in conformity with the Texas Insurance Codes (Insurance Code Chapter 1271) or other applicable laws, the remaining provision or parts of provisions are not rendered invalid. The remaining provisions or parts of provisions not invalid must be construed and applied as if they were in compliance with the Texas Insurance Codes (Insurance Code Chapter 1271) and other applicable laws.

### How we administer this plan

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

### Who's responsible to you

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

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

## Coverage and services

### Your coverage can change

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

## Financial sanctions exclusions

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

## Legal action

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

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

## Physical examinations and evaluations

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

## Records of expenses

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

Things that would be important to keep are:

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

## Honest mistakes and intentional deception

### Honest mistakes

You or the contract holder may make an honest mistake in your application for coverage. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

#### Intentional deception

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

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

We also may report fraud to criminal authorities.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty.

## Some other money issues

### Assignment of benefits

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

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

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

### Recovery of overpayments

We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

### Premium contribution

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

### Payment of premiums

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

### Premium – rate increase

We will let the contract holder know in writing of any change in premium rate 60 days before they take effect.

## Your dental information

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

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

## Effect of prior plan coverage

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

# Glossary

## Aetna®
**Aetna Dental Inc**., an affiliate, or a third party vendor under contract with **Aetna**.

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

## Contract year
A 12 month period beginning on the effective date of the **group agreement** and the same date each following year, unless we agree to another period.

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

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

Your **copayment percentage** for:

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

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

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

## Dental emergency
Any dental condition that:

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

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

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

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

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

## Effective date of coverage
The date your coverage begins under this EOC as noted in our records.

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

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

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

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

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

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

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

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

## Lifetime maximum

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

## Medically necessary/medical necessity

Dental care services or supplies that prevent, evaluate, diagnose or treat an **illness, injury**, disease or its symptoms, and that are all of the following as determined by us:

- In accordance with "generally accepted standards of dental practice"
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your **illness, injury** or disease
- Not primarily for your convenience, the convenience of your **dentist**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your **illness, injury** or disease

Generally accepted standards of dental practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community and
- Following the standards set forth in our clinical policies and applying clinical judgment.

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

## Negotiated charge

This is either:

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

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

## Orthodontic treatment

This is any:

- Medical service or supply
- Dental service or supply

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

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

whether or not for the purpose of relieving pain.

## Out-of-network provider
A **provider** who is not an **in**-**network provider** and does not appear in the **directory** for your plan, or a **specialty dentist** that is seen without a **referral**.

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

## Premium
The amount you or the contract holder are required to pay to **Aetna** to continue coverage.

## Primary care dentist (PCD)
A **provider** who:

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

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

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

## Service area
The geographic area where **in-network providers** for this plan are located. See *Appendix A-Service area map* for a **service area** map and a detailed list of counties within the **service area**.

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

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

## Teledentistry
**A health professional** acting under the delegation and supervision of a **dentist**, acting within the scope of the **dentist**'s or **health professional's** license or certification to a patient at a different physical location than the **dentist** or **health professional** using telecommunications or information technology.

## Temporomandibular joint dysfunction/disorder (TMJ)

This is:

- A **TMJ** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw

Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

## Usual fee

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

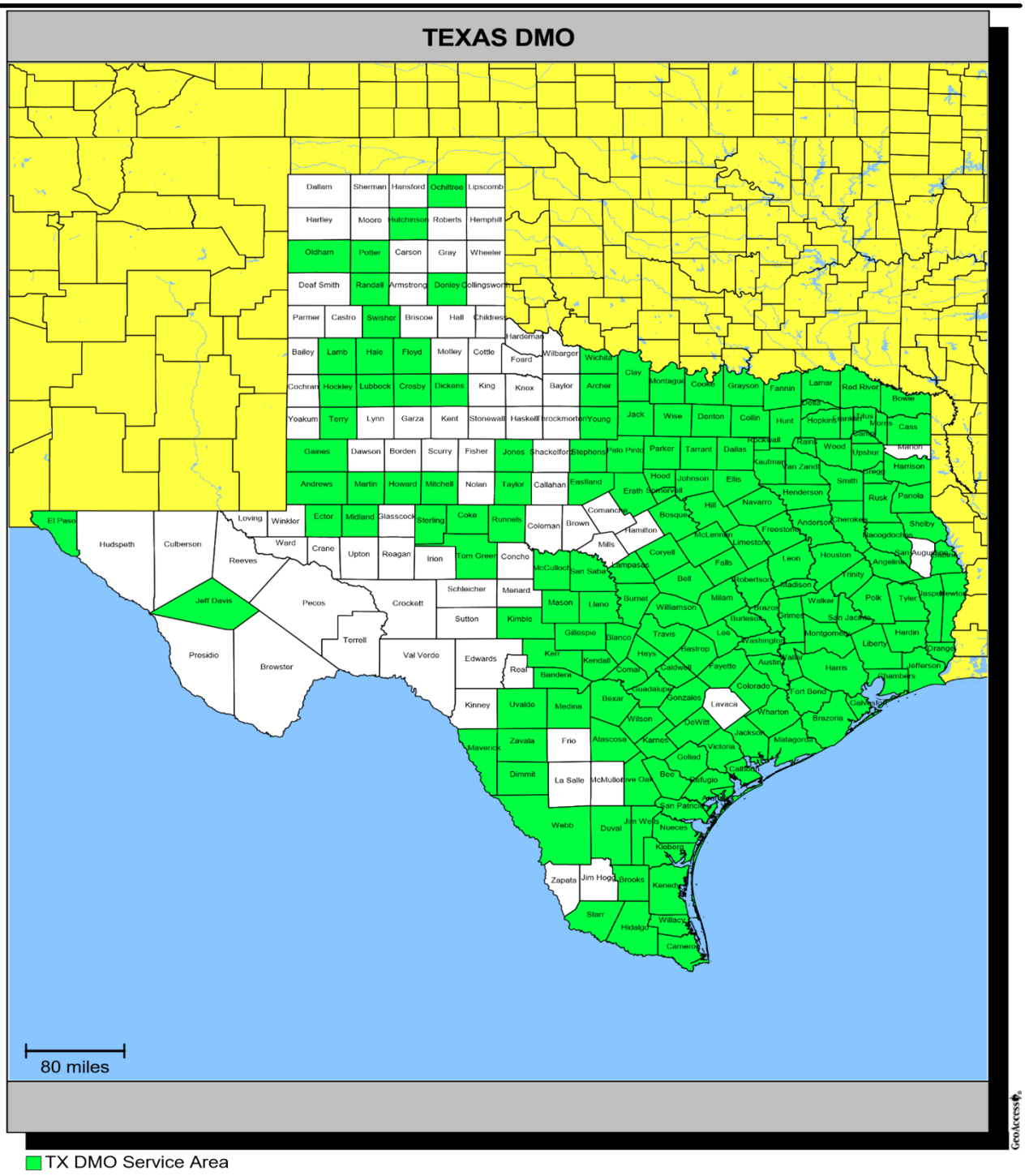
## Wellness and other rewards

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

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

The award of a participation incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. And we won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

## Geographic overview



## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Anderson |
| TX | Andrews |
| TX | Angelina |
| TX | Aransas |
| TX | Archer |
| TX | Atascosa |
| TX | Austin |
| TX | Bandera |
| TX | Bastrop |
| TX | Bee |
| TX | Bell |
| TX | Bexar |
| TX | Blanco |
| TX | Bosque |
| TX | Bowie |
| TX | Brazoria |
| TX | Brazos |
| TX | Brooks |
| TX | Burleson |
| TX | Burnet |
| TX | Caldwell |
| TX | Calhoun |
| TX | Cameron |
| TX | Camp |
| TX | Cass |
| TX | Chambers |
| TX | Cherokee |
| TX | Clay |
| TX | Coke |
| TX | Collin |
| TX | Colorado |

## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Comal |
| TX | Cooke |
| TX | Coryell |
| TX | Crosby |
| TX | Dallas |
| TX | Delta |
| TX | Denton |
| TX | DeWitt |
| TX | Dickens |
| TX | Dimmit |
| TX | Donley |
| TX | Duval |
| TX | Eastland |
| TX | Ector |
| TX | El Paso |
| TX | Ellis |
| TX | Erath |
| TX | Falls |
| TX | Fannin |
| TX | Fayette |
| TX | Floyd |
| TX | Fort Bend |
| TX | Franklin |
| TX | Freestone |
| TX | Gaines |
| TX | Galveston |
| TX | Gillespie |
| TX | Goliad |
| TX | Gonzales |
| TX | Grayson |
| TX | Gregg |

## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Grimes |
| TX | Guadalupe |
| TX | Hale |
| TX | Hardin |
| TX | Harris |
| TX | Harrison |
| TX | Hays |
| TX | Henderson |
| TX | Hidalgo |
| TX | Hill |
| TX | Hockley |
| TX | Hood |
| TX | Hopkins |
| TX | Houston |
| TX | Howard |
| TX | Hunt |
| TX | Hutchinson |
| TX | Jack |
| TX | Jackson |
| TX | Jasper |
| TX | Jeff Davis |
| TX | Jefferson |
| TX | Jim Wells |
| TX | Johnson |
| TX | Jones |
| TX | Karnes |
| TX | Kaufman |
| TX | Kendall |
| TX | Kenedy |
| TX | Kerr |
| TX | Kimble |

## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Kleberg |
| TX | Lamar |
| TX | Lamb |
| TX | Lampasas |
| TX | Lee |
| TX | Leon |
| TX | Liberty |
| TX | Limestone |
| TX | Live Oak |
| TX | Llano |
| TX | Lubbock |
| TX | Madison |
| TX | Martin |
| TX | Mason |
| TX | Matagorda |
| TX | Maverick |
| TX | Mcculloch |
| TX | Mclennan |
| TX | Medina |
| TX | Midland |
| TX | Milam |
| TX | Mitchell |
| TX | Montague |
| TX | Montgomery |
| TX | Morris |
| TX | Nacogdoches |
| TX | Navarro |
| TX | Newton |
| TX | Nueces |
| TX | Ochiltree |
| TX | Oldham |

## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Orange |
| TX | Palo Pinto |
| TX | Panola |
| TX | Parker |
| TX | Polk |
| TX | Potter |
| TX | Rains |
| TX | Randall |
| TX | Red River |
| TX | Refugio |
| TX | Robertson |
| TX | Rockwall |
| TX | Runnels |
| TX | Rusk |
| TX | Sabine |
| TX | San Jacinto |
| TX | San Patricio |
| TX | San Saba |
| TX | Shelby |
| TX | Smith |
| TX | Somervell |
| TX | Starr |
| TX | Stephens |
| TX | Sterling |
| TX | Swisher |
| TX | Tarrant |
| TX | Taylor |
| TX | Terry |
| TX | Titus |
| TX | Tom Green |
| TX | Travis |

## Aetna Dental Inc. Service Area
## County List

| STATE | COUNTY |
|---|---|
| TX | Trinity |
| TX | Tyler |
| TX | Upshur |
| TX | Uvalde |
| TX | Van Zandt |
| TX | Victoria |
| TX | Walker |
| TX | Waller |
| TX | Washington |
| TX | Webb |
| TX | Wharton |
| TX | Wichita |
| TX | Willacy |
| TX | Williamson |
| TX | Wilson |
| TX | Wise |
| TX | Wood |
| TX | Young |
| TX | Zavala |

# Additional Information Provided by

# Truist Financial Corporation

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Name of Plan:**
Refer to your Plan Administrator for this information

**Employer Identification Number:**
56-2054897

**Plan Number:**
Refer to your Plan Administrator for this information

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Truist Financial Corporation
214 N Tryon Street 45th Floor
Charlotte, NC 28202
Telephone Number: (336) 733-2030

**Agent For Service of Legal Process:**
Truist Financial Corporation
214 N Tryon Street 45th Floor
Charlotte, NC 28202

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer and Employee

## Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

## ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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