Your Group Plan

TW Ventures Inc.

DMO Dental - California
Employees

ID Cards

If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetna.com. You can also access your benefits information when you're on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.

Remember, DMO® members need to choose a primary care dentist in Aetna's network. Otherwise, you could end up paying more. You can use our provider search tool online or call us at 1-877-238-6200 to make your selection.

CA /AZ DMO® participants, if you have not selected a PCD, one may have been selected for you. View your digital ID card to determine if one was selected on your behalf.

This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Dental of California Inc. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.

Your Combined Evidence of Coverage and Disclosure Form for

Aetna Dental of California Inc.
P.O. Box 10462
Van Nuys, CA 91410
1-800-843-3661

Group: 861495

Agreement Number: 861495

Effective Date: August 1, 2014

Agreement Delivered In: California

THIS EVIDENCE OF COVERAGE DISCLOSES THE TERMS AND CONDITIONS OF COVERAGE. YOU HAVE A RIGHT TO VIEW THE EVIDENCE OF COVERAGE PRIOR TO ENROLLMENT IN THIS PLAN.

READ THIS ENTIRE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM ("CERTIFICATE") COMPLETELY AND CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND AETNA. IT IS THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM.

ADDITIONAL INFORMATION ABOUT THE BENEFITS OF THIS PLAN MAY BE OBTAINED BY CALLING MEMBER SERVICES AT 1-800-843-3661.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-843-3661 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Table of Contents

Section 1. Foreword

This Combined Evidence of Coverage and Disclosure Form is part of the Group Agreement ("**Agreement**") between Aetna Dental of California Inc. ("Aetna") and the employer ("Group"). **This Evidence of Coverage and Disclosure Form constitutes only a summary of the Agreement between Group and Aetna**. **The Agreement must be consulted to determine the exact terms and conditions upon which Coverage is Dependent**. A copy of the Agreement is available upon request from Aetna and may also be available from Group.

This Evidence of Coverage and Disclosure Form describes the **Coverage** available to **Members**. **Coverage** for services or supplies is provided only if furnished while a person is a **Member**. This Evidence of Coverage and Disclosure Form replaces and supersedes any Evidence of Coverage and Disclosure Form which may have been previously issued by Aetna.

If **Members** have any questions about **Coverage**, they should first contact the Group. For further assistance, contact Aetna at:

Member Services Department
Aetna Dental of California Inc.
P.O. Box 10462
Van Nuys, CA 91410
1-800-843-3661

Section 2. About the Dental Plan Coverage

A. Selecting a Primary Care Dentist PCD

Under the Dental Plan, the **Member** accesses care through a **PCD** selected at enrollment. Each Member may select a different **PCD**. If a **Member** fails to select a **PCD**, Aetna may select one for that **Member**. Aetna will notify **Member** of selection.

The **Member's PCD** provides basic and routine dental care, and will refer the Member to a **Participating (Par) Specialist Dentist** in the network.

Out-of-Network care is not **Covered**, except in the event of a **Dental Emergency**.

B. The Referral Process

There may be times when a **Member** needs care that only a dental specialist can provide. In these cases, a **Members PCD** will make a referral to a participating specialist or facility. A **PCD** referral is not required for any orthodontic services. Having a prior referral from your **PCD** keeps your out-of-pocket expenses lower for specialist services and any **Medically Necessary** follow-up treatment. The referral is important because it is how the Members **PCD** arranges for the **Member** to receive care and follow- up treatment.

Important Reminder
Member must have a prior written or electronic referral from **Members PCD** in order to receive the in-network care level of **Coverage** for any services received from a specialist **Dentist**.

How Referrals Work
Here are some important points to remember:

1. **Members** consult **PCD** first when dental care is needed.	**PCD** will determine whether he or she can provide the care needed.
2. If **PCD** determines that care should be provided by a specialist, **Member** will receive a written or electronic referral.	The referral will be good for 90 days, as long as **Member** remains **Covered** under the plan.
3. Go over the referral with **PCD**.	Make sure **Member** understand what types of services he or she is recommending – and why.
4. When **Member** visits the specialist or facility, bring the referral (or check in advance to verify that they've received the electronic referral).	Without the referral, treatment will not be **Covered**.
5. A referral cannot be obtained after **Member** visits a specialist.	**Member** must have a referral from his or her **PCD** before care is received from a specialist or facility.

If a service a **Member** needs is not available within Aetna's network, **Members PCD** may refer **Member** to an out-of-network provider. The **Member** will receive the in-network care level of benefits as long as the service is **Covered** under the plan, and the **Members PCD** gets approval from Aetna.

When Members Don't Need a PCD Referral
Members don't need a **PCD** referral for Emergency care. Please refer to the "**Out-of-Network Emergency Dental Care**" section above.

C. Orthodontic Services

The plan's **Coverage** for **Orthodontic Treatment** is limited to the services and supplies listed in the Dental Care Schedule.

Aetna has arranged for other **in-network providers** to provide orthodontic services.

Important Reminder

Refer to the Dental Care Schedule for details about the copay, and maximum that apply to **Orthodontic Treatment**.

D. Facilities

Information on **Par Dental Providers**, including names, addresses, specialties and hours of operation, is available to the **Member** through the Provider Directory; a copy of which is given to every Member. This information is also available by telephoning Aetna at 1-800-843-3661.

E. Requesting Continuity of Care

In order to provide for the transition of **Members** with minimal disruption, **Aetna** permits **Members** who meet certain requirements to continue an **Active Course of Treatment** with a terminated or (for new members) a non-participating **Provider** for a transitional period. In the case of new **Members**, benefits will be provided at the new plan benefit level in this **EOC.** Throughout this section "continuation care" refers to the services which the **Member** may be eligible to receive.

The following definitions apply to the Continuity of Care section of this **EOC**:

Acute Condition: A dental condition that involves a sudden onset of symptoms due to an infection, pain, swelling, bleeding or injury, or other dental problem that requires prompt dental attention and that has a limited duration.

Serious Chronic Condition: A dental condition due to a disease, illness, or other dental problem or disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Members who are undergoing an **Active Course of Treatment** are eligible to receive continuation of care as specified below.

- the **Member** has an Acute Condition, a Serious Chronic Condition,
- the **Member** is a child between birth and age 36 months. For purposes of this section well baby/well child care is considered an **Active Course of Treatment**.
- the **Member** has received authorization for a procedure by Aetna as part of a documented course of treatment that has been recommended and documented by the **Provider** to occur within 180 days of the **Provider's** termination or within 180 days of the **Member's Effective Date of Coverage**.

The timeframe for completion of **Covered Benefits** is:

- Acute Condition – for the duration of the Acute Condition
- Serious Chronic Condition – for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Dental Provider, as determined by Aetna in consultation with the Member and the Dental Provider, consistent with good professional practice. This time period shall not exceed 12 months from the contract termination date of the terminated Provider or 12 months from the Effective Date of Coverage for a new Member.
- Child between the ages of birth and 36 months – shall not exceed 12 months from the contract termination date of the terminated Dental Provider or 12 months from the Effective Date of Coverage for a new Member.
- Performance of an Authorized Procedure - within 180 days of the Dental Provider's contract termination date, or 180 days from the Effective Date of Coverage for a new Member.

In order for continuation care to be a **Covered Benefit** under this **EOC** the following conditions must be met.

- The Member must be enrolling as a new Member, or renewing in a different Aetna Dental of California Inc. plan that has a different provider network, or a current Member receiving an Active Course of Treatment from a terminated provider. If the other requirements listed in this section are met Members and their current treating Dental Providers may request continuing coverage according to the conditions of this Continuity of Coverage section.

- Member must be eligible for continuation care as described in item number 1 above.

- The Member must have begun an Active Course of Treatment prior to Effective Date Of Coverage with the new plan, or prior to the date the formerly Participating Dental Provider was terminated.

- The terminated Dental Provider must have terminated their contract with Aetna or been terminated by Aetna for reasons other than dental disciplinary action, fraud or other criminal activity.

- The transition request must be submitted to Aetna within 90 days after the enrollment or re-enrollment period, or within 90 days from the date of discontinuation of the Dental Provider's contract and prior to receiving services (except in an emergency) from the non-participating Provider; and

- If services are received prior to the approval of transition of benefits, the services must be approved by Aetna in order for coverage to be extended at the new benefit plan level.

In order for a **Dental Provider** to continue treating Aetna members during a transition period, the **Dental Provider** must agree in writing to:

- provide or continue to provide the Member's treatment and follow-up care;

- share or continue to share information regarding the treatment plan with Aetna;

- accept or continue to accept Aetna capitation rates and/or similar fee schedules as other non-capitated Dental Providers in the same geographic area for similar services; and in the case of a terminated Dental Provider to;

- continue to abide by the terms and conditions of the prior contract,.

Members may request a copy of the Transition of Care Coverage Policy and the "Transition Coverage Request Form" at the time of enrollment in the new plan or by calling the member services telephone number listed on their ID card and requesting the policy (which includes the form as an attachment). The **Member** and the **Member's** treating **Dental Provider** fill out and submit the Continuity of Care Form within the time frames described above. This continuity of care provision shall not be construed to require Aetna to provide coverage for services not otherwise covered by Aetna under this **EOC**. Members whose requests for Transition of Care Coverage are denied may file a grievance with the plan, in accordance with the Claim Procedures/Complaints and Appeals/External Independent Medical Review section of the **EOC**.

Section 3. What the Plan Covers

This section describes the dental care services and supplies **Covered** under the plan. Plan limits and exclusions can be found in this section, as well as in the Rules and Limits That Apply to the Dental Plan and Dental Plan Exclusions sections.

Medical services or supplies must meet **all** of the following requirements to be **Covered** by the plan:

Medically necessary. The service or supply is provided by a **dental provider** exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- Clinically appropriate, in accordance with generally accepted standards of or dental practice in term of type frequency, extent, site and duration;
- Considered effective, in accordance with generally accepted standards of dental practice for the illness, injury or disease;
- Not primarily for the convenience of the person, or a dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the 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. In the absence of such credible scientific evidence, Aetna's determinations of whether a service or supply meets "generally accepted standards of dental practice" will be:

- Consistent with or dental specialty society recommendations; and
- Otherwise based on the views of Dentist practicing in relevant clinical areas and any other relevant factors.

Examples of how this evidence is applied to specific treatments and conditions, called "Clinical Policy Bulletins," can be found on Aetna's website.

Not every service or supply that fits this definition is Covered by the plan. The plan **only** covers the expenses that are included in the What the Plan Covers section. There may also be limits on some services and supplies: for example, some benefits are limited to a certain number of visits, or to a dollar maximum. Refer to the Summary of Your Benefits for the plan limits.

Covered by the plan. For a service or supply to be **Covered** it should be:

- Included in the What the Plan Covers section; and

- Not excluded or limited. Refer to the Exclusions section for a list of services and supplies that are excluded. The What the Plan Covers section and the Dental Care Schedules also provide information about certain expenses limits.

Coverage in effect. Services and supplies should be provided or received while **Coverage** is in effect. See the Eligibility and the Termination, Continuation and Conversion sections for details on when **Coverage** begins and ends.

Section 4. Understanding Emergency and Urgent Dental Care

Members have **Coverage** 24 hours a day, 7 days a week, if care is needed to treat:

- An emergency dental condition; or
- An urgent condition.

In the Case of a Dental Emergency

A **Dental Emergency** is any traumatic injury or condition which occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and has symptoms such as severe pain and bleeding, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that failure to get immediate dental care could result in:

- placing the Member's health in serious jeopardy; or
- serious impairment of bodily function; or
- serious dysfunction of any body organ or part.

Examples of emergency conditions include:
Uncontrolled or severe bleeding of the gums

In Case of an Urgent Condition

An **urgent condition** is a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that cannot wait for your Dentist to become available.

Examples of urgent conditions include:	
Severe Tooth pain	Cracked tooth caused by chewing

Follow the guidelines below when **Members** believe emergency and urgent dental care may be needed:

The **Member** should contact their **PCD**.

If **Member's PCD** is unavailable, seek the nearest **Dentist**. The care or treatment must be for the temporary relief of the **Dental Emergency** until the **Member** can be seen by his or her **PCD**.

The treating **Dentist** may contact **Members PCD** to obtain information about **Members** dental history in order to assess and stabilize **Members** condition.

If **Member** seeks care from a **Non-Participating Dental Provider** for a non-emergency or non-urgent dental condition (that is, one that does not meet the definition below), no benefits will be payable.

When care for an emergency or urgent dental condition is received, a benefit will be paid for the **Reasonable Charges** incurred by the **Member** for such care. The amount paid will not be more than $100, regardless of the number of treatments needed for each separate emergency or urgent dental condition. When care for an emergency or urgent dental condition is received, the maximum amount payable by Aetna is the amount shown on the Dental Care Schedule that applies.

Follow-Up Care After Treatment of a Dental Emergency Condition

All follow-up care should be provided by **Members PCD**.
Regardless of where **Member** receives emergency dental care, if Member seeks follow-up care from an in-network provider who is not their **PCD**, **Member** must obtain a referral before any follow-up care can be **Covered**.

Section 5. Prepayment Fees and Other Charges

The Group is responsible for advance payment of **Premium** for dental **Coverage** in accordance with the Agreement.

Coverage is only provided for members whose **Premiums** have been received by Aetna. **Coverage** extends only for the period of which such payment is received, subject to any allowances stated in the Agreement.

The monthly dental charge for a **Subscriber** and his or her **Covered Dependents** is paid through the Group. A **Subscriber** may be required to pay a portion of that monthly charge as a payroll deduction. Information about the total monthly cost of **Coverage** and what portion of that cost, if any, must be paid by the **Subscriber**, is available through Group's personnel department.

Other charges (i.e., **Copayment**) which a **Member** may incur while obtaining **Covered Services**, are outlined in the "Dental Care Schedule" which is issued with the Evidence of Coverage and Disclosure Form.

Section 6. Eligibility, Enrollment and Effective Date of Coverage

This section contains information about who can be **Covered** under the plan, how to enroll and what to do when there's a change a **Member's** life that affects **Coverage**.

Eligibility

Employees, Members, Participants

The following requirements to be eligible for **Coverage** under this plan must be met:

- Be in an "eligible class," as defined below; and
- Satisfy the "eligibility date criteria" described below.

Eligible Class

Subscribers are in an eligible class if a person is

- A regular full-time employee, as defined by Group; and
- Either work or reside in the plan's **Service Area***.

Eligibility Date Criteria

A **Subscribers** eligibility date is the date **Subscribers** are eligible for the plan. A **Subscribers** eligibility date is determined as follows:

<u>On the Effective Date of the Plan</u>

- **If a Subscriber is in an eligible class on the effective date of the plan: Subscribers** eligibility date is the effective date of the plan.
- **If Subscriber is not in an eligible class on the effective date of the plan and later enters an eligible class: Subscribers** eligibility date is determined by the Plan Sponsor.

<u>After the Effective Date of the Plan</u>

- **If a Subscriber is in an eligible class on the date Subscriber begins working for the Group: Subscribers** eligibility date is determined by the Plan Sponsor
- **If a Subscriber is not in an eligible class on Subscribers date of hire and Subscriber later enters an eligible class: Subscribers** eligibility date is determined by the Plan Sponsor

Dependents

Subscribers may enroll the following people in the plan:

- Your spouse;
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children.

Aetna will rely upon the Group to determine whether or not a person meets the definition of a Dependent for **Coverage** under the plan. That determination will be conclusive and binding upon all persons for the purposes of this plan.

You may also cover as your dependent a person who is your domestic partner if you and your partner:

- meet the requirements under California law for entering into a domestic partnership; and
- have jointly executed and filed a Declaration of Domestic Partnership with the Secretary of State; or
- have completed and signed a "Declaration of Domestic Partnership" which is acceptable to your Employer.

You may also cover as your dependent a person who is your domestic partner if you and your partner:

- meet the requirements under California law for entering into a domestic partnership; and
- have jointly executed and filed a Declaration of Domestic Partnership with the Secretary of State; or
- are "domestic partners" as determined in accordance with rules set by your Employer.

You may also cover as your dependent a person who is your domestic partner if you and your partner:

- meet the requirements under California law for entering into a domestic partnership; and
- have jointly executed and filed a Declaration of Domestic Partnership with the Secretary of State.

Dependent Children

To be eligible, a Dependent child must be:

- Unmarried; and
- under age 26.

Your children include:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is **Covered** as a Dependent under the plan.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care **Coverage** to one or more children. The plan will extend **Coverage** to a child who is **Covered** under a QMCSO, if:

- The child meets the plan's definition of an eligible Dependent; and
- You request **Coverage**, for the child in writing within 31 days of the court order.

The **Coverage** will take effect on the date of the court order. Any provision in this plan that limits **Coverage** for a pre-existing condition will not apply, as long as you make a written request for **Coverage** within the 31-day period.

If you do not request **Coverage** within the 31-day period, you must wait until the next annual open enrollment period to elect **Coverage** for the child.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Coverage for a handicapped child may be continued past the age limits shown above. See If Your Child Is Handicapped.

Keep in mind that a person cannot be Covered:
- As both an employee and a Dependent under the plan; or
- As a Dependent of more than one employee.

Enrollment

Initial Enrollment in the Plan

You will be given benefit and enrollment information when you are first eligible to enroll in the plan. To complete the enrollment process, you must provide all requested information for yourself and your eligible Dependents. You must also agree to make required contributions for any contributory **Coverage**. The amount of your contributions is determined by the policyholder sponsoring this plan and may change.

You should enroll within 31 days of your eligibility date. If you miss this deadline, you will not be able to participate in the plan until the next open enrollment period, unless you qualify under a late enrollee exception, as described below.

Newborns are automatically **Covered** for 31 days after birth. To continue **Coverage** beyond 31 days, you must complete a change form and return it to the policyholder sponsoring this plan within the 31-day period.

Open Enrollment

During the open enrollment period, you have a chance to review your **Coverage** needs for the upcoming year and change your **Coverage** choices, if necessary. The choices you make during open enrollment will be in effect for the following year.

If you do not enroll yourself or a Dependent for **Coverage** when first eligible and you later wish to enroll, you may do so during the next open enrollment period.

Late Enrollee Exceptions

If you do not enroll yourself and/or a Dependent for **Coverage** when first eligible or during an open enrollment period, you cannot enroll unless you qualify under a late enrollee exception. There are three types of late enrollee exceptions. If one of them applies, you may enroll before the next open enrollment period.

For purposes of this late enrollee section, a "person" means you, your Dependent, or both you and your Dependent.

1. Loss of Other Health Care Coverage

A person qualifies for a late enrollee exception if:

You didn't enroll the person when first eligible or during any subsequent open enrollments because, at that time:

- The person was **Covered** under other creditable **Coverage**; and
- You refused **Coverage** and stated, in writing, at the time you refused **Coverage** that the reason was the person had other creditable **Coverage**; and

The person subsequently loses that other creditable **Coverage** because:

- He or she is no longer eligible for the other **Coverage** due to:
  - The end of employment;
  - A reduction in hours of employment (for example, moving from full-time to part-time);
  - The ending of the other plan's **Coverage**;
  - Death;
  - Divorce; or
  - Employer contributions toward that Coverage have been terminated; or
  - COBRA Coverage ends.

You must enroll a person for **Coverage** within 31 days of the date the person loses creditable **Coverage** for one of the above reasons. You will need to provide evidence of terminated creditable **Coverage**. If you do not enroll the person during this time and you later wish to enroll the person, you may only do so during the next open enrollment period.

2. New Dependents

You and your Dependents may qualify for a late enrollee exception if:

- You didn't enroll when you were first eligible for **Coverage**; and
- You later acquire a Dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect **Coverage** for yourself and any such Dependent within 31 days of acquiring the Dependent.

Your spouse or child who meets the definition of a Dependent under the plan may qualify for a late enrollee exception if:

- You didn't enroll them when they were first eligible; and
- You later elect **Coverage** for them within 31 days of a court order requiring you to provide **Coverage**.

You must report the change by completing a change form, available from the policyholder. Fill out the form and return it within 31 days of the change. If you miss this deadline, you must wait until the next annual open enrollment period to make any changes to your **Coverage**.

3. If Your Child Is Adopted

You may cover a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible Dependent on the date he or she is placed for adoption; and
- You request **Coverage** for the child in writing within 31 days of the placement.

"Placed for adoption" means you have taken on a legal obligation for total or partial support of a child whom you plan to adopt. You must show proof of placement.

Effective Date of Your Coverage

For Employees

Your **Coverage** takes effect on the later of:

- The date you are eligible for **Coverage**; or
- The date you return your completed enrollment information.

If you don't return your completed enrollment form within 31 days of the day you become eligible, the rules under Late Enrollee Exceptions will apply.

For Dependents

Your Dependents' **Coverage** takes effect on the same date as yours if, by then, you have enrolled them in the plan.

Note:
It's important to report new Dependents because they may affect your contributions. If you don't report a new Dependent within 31 days of his or her eligibility date, the rules under Late Enrollee Exceptions will apply.

Section 7. Dental Plan Coverage

In accordance with the terms and conditions of this Evidence of **Coverage** and Disclosure Form, **Members** shall be entitled to the **Covered Services** specified in the Dental Care Schedule, when such services are **Medically Necessary** and are:

- provided by the **PCD**; or
- provided by another **Dental Provider** in the case of **Out-of-Network Emergency Dental Care**; or
- provided by another **Participating Specialist Dentist** when authorized by Aetna for a dental condition requiring specialized care if the care is not available from the **Member's PCD**.

However, the next sentence applies if:

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

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

Section 8. Copayments

In addition to Prepayment Fees, if any, each **Member** must pay part of the cost of some of the services or supplies provided under the Dental Plan. This payment must be made to the **Participating Dental Provider** at the time the dental care is received. Section 9, Dental Care Schedule, shows those services for which a **Copayment** is required, and the amount that each **Copayment** will be.

Note that no **Copayment** is shown in the Dental Care Schedule for the Alternate Treatment Rule described in the "Special Provisions" section. If the Alternate Treatment Rule is applied to a service, an additional **Copayment** may apply.

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

The care meets the definition of **Out-of-Area Network Dental Care**.
The care is for the temporary relief of the Emergency Condition until the **Covered** person can be seen by the **PCD**.
The person provides an itemized bill to Aetna. It must describe the care given.

The dental service given is listed on the Dental Care Schedule that applies.

Section 9. Dental Care Schedule

The Dental Care Schedule is a list of dental expenses that are **Covered** by the plan. There are several categories of **Covered** expenses:

Preventive- These are procedures that aid in the prevention of dental disease. It may include prophylaxis (cleanings) and fluoride treatments.

Diagnostic- These are procedures that are needed to evaluate a Member's dental condition and identify a problem requiring treatment. It may include exams, x-rays and other tests.

Restorative- These are procedures used to repair and restore natural teeth to a healthy condition. It may include fillings, inlays, onlays, and crowns.

Endodontics- These are procedures used to treat diseases of the tooth pulp and root. It may include pulp capping, removal of the pulp and root canal therapy.

Periodontics- These are procedures to deal with the prevention, diagnosis and treatment of disease of the surrounding and supporting structures of the teeth. This may include planning and scaling of teeth, gingivectomy and osseous surgery.

Prosthodontics- These are procedures that replace missing natural teeth and other tissue and bone. It may include fixed or removable prostheses, including complete and partial dentures and bridges.

Oral Surgery- These are cutting procedures. It may include extractions of a tooth or tooth root, surgical exposure of an unerupted tooth and removal or tumors or cysts.

Orthodontics- These are procedures that correct the way that teeth fit together. This may include using braces or removable appliances to reposition teeth that are crowded, crooked or protruding.

Coverage is also provided for a **Dental Emergency**. For additional information, please refer to Understanding Emergency and Urgent Dental Care.

In-Network Benefits

This Dental Care Schedule applies to **Covered Services** provided by **PCDs** and other in-network providers. The Dental Plan covers only the services in the list below.

Please refer to the Glossary Section at the end of this document for additional dental terms

Primary Care Dentist Services

	Copayment Amount
VISITS AND EXAMS	
• Oral examination (limited to total of 4 visits per year) *	$ 0.00
• Emergency palliative treatment	10.00
• Prophylaxis (cleaning), (limited to 2 treatments per year) *	
Adult	0.00
Child	0.00
• Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16) *	0.00
• Oral hygiene instruction	0.00
• Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16) *	0.00
• Pulp vitality test	0.00
• Consultation	0.00
• Diagnostic casts	0.00

****This limit will not apply if needed more frequently due to medical necessity as determined by your Primary Care Dentist.***

X-RAYS AND PATHOLOGY	
• Bitewing X-rays (limited to 1 set per year) *	0.00
• Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years) *	0.00
• Vertical bitewing X-rays (limited to 1 set every 3 years) *	0.00
• Periapical X-ray	0.00
• Intraoral, occlusal view, maxillary or mandibular	0.00
• Extraoral upper or lower jaw	0.00
• Accession of oral tissue	0.00

****This limit will not apply if needed more frequently due to medical necessity as determined by your Primary Care Dentist.***

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*	
• Fixed	0.00
• Removable	0.00
• Recement space maintainer	12.00
• Removal of fixed space maintainer (by dentist who did not place appliance)	12.00

ENDODONTICS	
• Pulp cap	0.00
• Pulpotomy	0.00
• Root canal therapy, including necessary X-rays	
Anterior	50.00
Bicuspid	70.00

RESTORATIONS AND REPAIRS - (Copayments for crowns and pontic *are per unit.) There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.*

• Amalgam restoration	
Primary or permanent teeth	
1 surface	0.00
2 surfaces	0.00
3 surfaces	0.00
4 or more surfaces	0.00
• Resin-based composite restoration - anterior	

1 surface	0.00
2 surfaces	0.00
3 surfaces	0.00
4 or more surfaces or incisal angle	40.00
Resin-based composite crown – anterior	40.00
• Resin-based composite restoration – posterior	
1 surface	35.00
2 surfaces	45.00
3 surfaces	55.00
4 or more surfaces	70.00
• Retention pins	10.00
• Stainless steel crowns, prefabricated, primary tooth	0.00
• Stainless steel crowns, prefabricated, permanent tooth	40.00
• Recementing inlays or crowns	5.00
• Recementing bridges	15.00
• Sedative filling	0.00
• **Inlays Metallic***	190.00
• **Crowns**	
Porcelain	225.00
Porcelain with metal (includes abutments)*	225.00
Metallic (full cast) (includes abutments)*	225.00
Metallic (3/4 cast)*	225.00
Cast post and core*	80.00
Prefabricated post and core	70.00
Core buildup including pins	60.00
• **Pontics**	
Metallic (full cast)*	225.00
Porcelain with metal*	225.00
• **Full mouth rehabilitation, per unit** *(This means 6 or more covered units of crowns and/or pontics under one treatment plan.)*	125.00
• **Dentures and Partials** - *(Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)*	
Complete, upper or lower	275.00
Partial, upper or lower	
Resin base	275.00
Cast metal base	325.00
Immediate, upper or lower (does not include charge for reline)	325.00
Adjust complete denture, upper or lower	10.00
Adjust partial denture, upper or lower	10.00
Repair broken acrylic, complete denture, upper or lower	30.00
Replace one tooth on complete denture	35.00
Repair resin denture base, cast frame, broken clasp	35.00
Replace broken tooth, partial	35.00
Add tooth to existing partial denture	35.00
Add clasp to existing partial	40.00
Replace all teeth and acrylic on case metal framework	100.00
Rebase, complete denture, upper or lower	100.00
Rebase, partial denture, upper or lower	100.00
Reline, complete denture, upper or lower (chairside)	40.00
Reline, partial denture, upper or lower (chairside)	40.00
Reline, complete denture, upper or lower (laboratory)	90.00
Reline, partial denture, upper or lower (laboratory)	90.00
Interim partial denture, upper or lower (stayplate), anterior only	90.00
Tissue conditioning for dentures	40.00

PERIODONTICS

• Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years)	50.00
• Scaling and root planing, 1 to 3 teeth (limited to once per site every 2 years)	30.00
• Periodontal maintenance procedures following surgical therapy	

FOC - XXXX

(limited to 2 per year)	30.00
• Occlusal guard (for bruxism only), limited to 1 every 3 years	100.00
• Full mouth debridement, once per lifetime	60.00

ORAL SURGERY *- Includes local anesthetics and routine post-operative care.*

• Extraction, erupted teeth or exposed root	0.00
• Extraction, coronal remnants - deciduous tooth uncomplicated	0.00
• Surgical removal of erupted tooth	0.00
• Surgical removal of impacted tooth (soft tissue)	0.00
• Incision and drainage of intraoral abscess	10.00
• Mobilization of erupted or malpositioned tooth to aid eruption	30.00
• Biopsy of oral tissue	50.00

Specialty Services

	Copayment Amount
ENDODONTICS *- Includes local anesthetics where necessary.*	
• Apicoectomy/periradicular surgery	
Anterior	$ 65.00
Bicuspid, first root	65.00
Molar, first root	80.00
Each additional root	40.00
Retrograde filling, per root	20.00
Root amputation, per root	60.00
Molar root canal therapy	175.00
Retreatment of previous root canal therapy	
Anterior	150.00
Bicuspid	170.00
Molar	275.00

ORAL SURGERY *- Includes local anesthetics where necessary and post-operative care.*

• Surgical removal of residual tooth roots	15.00
• Frenectomy	24.00
• Alveoloplasty in conjunction with extractions - per quadrant	18.00
• Alveoloplasty not in conjunction with extractions - per quadrant	25.00
• Surgical removal of impacted tooth	
Partially bony	45.00
Completely bony	70.00
Completely bony with unusual surgical complications	70.00

PERIODONTICS

• Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years	100.00
• Gingivectomy or gingivoplasty - per tooth, limited to 1 per site, every 3 years	30.00
• Gingival flap procedure, including root planing - per quadrant	110.00
• Gingival flap procedure, including root planing – 1 to 3 teeth	66.00
• Occlusal adjustment (other than with an appliance or by restoration)	
Limited	20.00
Complete	80.00
• Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years	250.00
• Osseous surgery (including flap entry and closure) – 1 to 3 teeth, limited to once per site every 3 years	150.00
• Surgical revision procedure, per tooth	100.00
• Pedicle soft tissue graft	190.00
• Free soft tissue graft (including donor site surgery)	205.00
• Subepithelial connective tissue graft	115.00
• Soft tissue allograft	230.00
• Combined connective tissue and double pedicle graft	190.00
• Clinical crown lengthening - hard tissue	150.00

FOC - XXXX

ORTHODONTICS

• Orthodontic screening exam	30.00
• Orthodontic diagnostic records	150.00
• Comprehensive orthodontic treatment of adult or adolescent dentition	1545.00
• Orthodontic retention	275.00

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (only when provided in conjunction with a covered surgical procedure)

Deep sedation/General Anesthesia	
First 30 minutes	165.00
each additional 15 minutes	70.00
Intravenous conscious sedation/analgesia	
First 30 minutes	165.00
each additional 15 minutes	70.00

Additional Benefits

As to a **Covered** person who is:

is pregnant; or
has coronary artery disease/cardiovascular disease; or diabetes; and
is a covered person for medical coverage insured or administered by Aetna,

the Copayment will be waived for the following dental services and they will not be subject to any frequency limits except as shown above as to the following dental services:

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

Also, One additional prophylaxis (cleaning) per year will be payable the same as other prophylaxis under the plan.

Section 10. Rules and Limits That Apply to the Dental Plan

Members need to be aware of several rules that apply to the Dental Plan. Following these rules will help **Members** use the plan to their advantage, by avoiding expenses that aren't **Covered** by the Dental Plan.

Orthodontic Treatment Rule

Comprehensive **Orthodontic Treatment** is limited to a maximum of 24 months of active; usual and customary **Orthodontic Treatment** on permanent dentition, plus an extra 24 months of post-treatment retention.

The Dental Plan does not cover the following orthodontic services and supplies:

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

The Dental Plan will not cover, subject to the section of this EOC entitled Requesting Continuity of Care, the charges for an orthodontic procedure if an active appliance for that procedure was installed before **Members** were **Covered** by the Dental Plan.

The Dental Plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed within the two year-period before **Members** were **Covered** by the Dental Plan. This limit applies only if **Members** do not become enrolled in the plan within 31 days after **Members** first become eligible.

Replacement Rule

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

- **Member** had a tooth (or teeth) extracted after the existing denture or bridge was installed, and while **Member**s were **Covered** by the plan. As a result, **Members** need to replace or add teeth to your denture or bridge.
- The present crown, cast or processed restoration complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- **Member** had a tooth (or teeth) extracted while **Members** were **Covered** by the plan. **Members** 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.

Alternate Treatment Rule

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

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

Members should review the differences in the cost of alternate treatment with your **Dentist**. Of course, you and your **Dentist** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover. The following chart provides examples of alternate procedures that are subject to this rule.

Type of Service	How the Alternate Treatment Rule May Affect Your Coverage
Gold, baked porcelain restorations, crowns and jackets	If a tooth can be restored with an amalgam or similar material, but a more costly type of restoration (gold, for example) is selected by the patient and the **Dentist**, payment will be based on the amalgam procedure, not the more costly treatment chosen by the patient.
Reconstruction	When you or your **Covered Dependent** needs treatment to eliminate oral disease or to replace missing teeth, the plan will base **Coverage** on the applicable percentage of the **Reasonable Charge**.
Partial dentures	The plan limits **Coverage** to the charges for a cast chrome or acrylic denture, if this would restore an arch satisfactorily. The limitation applies even if you and your **Dentist** choose a more elaborate or precision appliance.
Complete dentures	The plan covers only the charges for a standard procedure, even if you and your **Dentist** choose personalized or specialized treatment.
Replacement of existing dentures	The plan will cover replacement only if the existing denture cannot be used or repaired. If it can be used or repaired, the plan will cover only the cost of making it usable.

Coverage for Dental Work That Began Before You Are Covered by the Plan

The plan does not cover dental work that began before you or your **Covered Dependent** was **Covered** by the plan. This means that the following dental work is not **Covered**:

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

Dental Work in Progress

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

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed bridgework; and
- Root canals.

"Ordered" means:

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

Late Entrant Rule

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

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

This exclusion does not apply to charges incurred:

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

Section 11. Dental Plan Exclusions

The Dental Plan does not cover every dental care service, even if prescribed, recommended, or approved by **Members** attending **Dentist**. The Dental Plan covers only those services and supplies that are listed in the What the Dental Plan Covers section. In addition, some services and supplies are specifically limited or excluded. This section describes the services and supplies that are not **Covered** or that are subject to special limitations.

The plan does not cover the following expenses, unless they are specifically listed as a **Covered** service or supply in What the Dental Plan Covers:

Dentures or fixed bridges. The plan does not cover expenses for the first installation of a denture or fixed bridge, or any inlay and crown if they function as an abutment to replace:

- Congenitally missing teeth; or
- Teeth that were lost while you or your **Covered Dependent** was not **Covered** by the plan.

Duplicate Coverage. The plan does not cover dental services and supplies that are **Covered**, in whole or in part:

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

Extra sets of dentures.

High noble metal (gold). The plan does not cover pontics, crowns, cast or processed restorations made with high noble metals

Impacted wisdom teeth. The plan does not cover surgical removal of impacted wisdom teeth when done for orthodontic reasons only.

Jaw treatment intended for non-surgical treatment of any **Jaw Joint Disorder**.

Non-Covered services. Services and supplies needed solely in connection with a non-**Covered** service.

Orthodontic treatment. Services or supplies which are for **Orthodontic Treatment.**

Out-of-network providers. Services furnished by an **out-of-network provider.**

Plastic, reconstructive and 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, except to the extent **Coverage** is specifically provided in the What the Plan Covers section except to the extent needed to:

- Improve the function of a part of the body that:
  - Is not a tooth or structure that support the teeth; and
  - Is malformed:
    - By reason of a congenital abnormality; or
    - As a direct result of disease or surgery performed to treat an illness or **injury**.
- Repair an injury. Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic.

Replacement of lost, missing, stolen, or damaged devices or appliances, including the replacement of appliances that have been damaged due to abuse, misuse or neglect.

Restorations. The plan does not cover a crown, cast, or processed restoration unless:

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

Services and supplies that are **not medically necessary**, as determined by Aetna, for the diagnosis, care or treatment of the illness or **injury** involved. This applies even if they are prescribed, recommended or approved by **Members Dentist**.

Services and supplies provided in connection with treatment of an **occupational illness** or **occupational injury**.

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

Treatment given by a provider who is not a Dentist. However, the plan covers the following services provided by a licensed dental hygienist under the supervision and guidance of a **Dentist**:

- Scaling of teeth.
- Cleaning of teeth.
- Topical application of fluoride.

Unlisted services, that are not included in the Dental Care Schedule.

Section 12. Relationship With Participating Dental Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

IN SOME CIRCUMSTANCES, CERTAIN DENTAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY THE AETNA

A. Choice of Dental Providers: Selecting a PCD

Aetna uses a network of independent Participating Providers throughout the **Service Area**.

At the time of enrollment, all **Subscribers** must select a **PCD** for themselves and any **Covered Dependents** from among those approved by Aetna to provide dental care. The choice of **PCD** is made solely by the Subscriber. If a **Member** fails to select a **PCD**, Aetna may elect one for the **Member**. Aetna will notify **Member** of the selection.

If a Subscriber needs assistance in selecting a **PCD**, or if, for any reason, a Subscriber is not satisfied with the initial choice of a **PCD**, the Subscriber must contact the Customer Service Department at 1-800-843-3661. They will assist in changing the Subscriber's selection.

A change in **PCD** will be effective as follows:

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

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

PCDs may be paid in any of the following ways; depending upon the type of contract they have with Aetna.

A fixed price per service.
A fee for each service set by a fee schedule.
A fixed monthly amount per **Member**.

Compensation arrangements are designed to encourage the provision of the most appropriate care for each **Member** and to discourage the provision of unnecessary, and potentially detrimental services. Such arrangements do not include any financial incentives in the form of bonuses related to patient care.

If a **Member** wishes to know more about Provider compensation issues, the **Member** may request additional information from Aetna or the **Member**'s PCD.

B. Liability of Subscriber for Payment

The **Covered Services** described in this Evidence of Coverage and Disclosure Form are provided only if and to the extent such services are rendered by a **Participating Dental Provider** (except for Dental Emergencies). The services of a **Participating Dental Provider** are not **Covered** unless the **Member** has obtained any required referrals from his or her **PCD**. If a **Member** self-refers to a Participating (other than his or her **PCD**) or non-**Participating Dental Provider**, the **Member** will be responsible for the costs of those services.

By statute, every contract between Aetna and its **Participating Dental Providers** provides that in the event Aetna fails to pay a **Participating Dental Provider** for **Covered Services**, the **Member** shall not be liable for sums owed by Aetna. However, in the event that Aetna fails to pay a non-**Participating Dental Provider**, the **Member** will be responsible for the costs of the services rendered.

C. Termination of Dental Providers' Participation

Aetna or **Participating Dental Providers** may terminate their contract or limit the number of **Member**s that the **Participating Dental Provider** will accept as patients during the term of the **Agreement**. Aetna does not promise that a specific **Participating Dental Provider** will be available to render services throughout the period that a **Member** is **Covered** by Aetna.

Aetna will notify a **Member** if his or her **PCD** no longer acts as a **PCD**, and will assign that **Member** to an interim **PCD**. The **Member** will cooperate with Aetna to select another **PCD**. Should a **Participating Dental Provider**, other than a **PCD**, terminate his or her contract with Aetna, **Member**s who are under the care of such provider may continue to receive **Covered Services** from such provider until Aetna makes reasonable and dentally appropriate provision for the assumption of treatment by another **Participating Dental Provider**.

The **Member** must cooperate with his or her **PCD** and Aetna to select another **Participating Dental Provider** to render **Covered Services**.

Aetna cannot guarantee the continued participation of any Provider with Aetna. For purposes of this section, Provider Group means a dental group, independent practice association, or other similar organization.

In the event Aetna terminates its contract with a **PCD**, Aetna shall provide notification to **Members** of the **PCD**'s termination in the following manner:

At least 30 days prior to the termination date Aetna will send written notification to **Members** who are currently enrolled in the **PCD's** office; or are receiving an Active Course of Treatment from other terminating Providers affiliated with the **PCD**.

Members must notify Aetna of their new choice of **PCD** prior to the date of the **PCD**'s termination or Aetna will assign a new **PCD** to the **Member**.

In the event Aetna terminates its contract with a Provider Group, or a Provider Group terminates its contract with Aetna, Aetna shall provide notification to **Members** in the following manner:

At least 60 days prior to the anticipated termination date Aetna will send written notification to **Members** whose **PCDs** are part of the terminating Dental Group. **Members** will be assigned to a new **PCD** and information regarding the new **PCD** assignment will be included in the notice.

If the Dental Group termination does not occur**, Members** will be notified and given the opportunity to return to their previous **PCD**.

Members undergoing an Active Course of Treatment may refer to the Procedure section, "Requesting Continuity of Care", for information about how to continue treatment with a terminated Provider for a limited time.

D. Second Opinions

If you are concerned about a **Participating Dental Provider's** recommended course of treatment, you may request Aetna to designate another **Participating Dental Provider** to render a second opinion. Aetna will authorize or deny a request for a second opinion within 72 hours of receipt of such request. If the first and second opinions do not agree, Aetna will designate another **Participating Dental Provider** to render a third opinion. However, if the second and third opinions confirm the recommendation of the first **Participating Dental Provider** and you refuse to follow the recommendation, or if the second and third **Participating Dental Provider** agree that there is no acceptable alternative method of treating your condition, then neither Aetna nor any **Participating Dental Provider** shall have any further responsibility to provide care for the condition being treated. If you elect to receive services not ordered or certified by your **PCD** to treat that condition, those services will not be **Covered** by Aetna.

Information regarding timeframe for decisions and notification of decisions is located in the Claim Procedures/Complaints and Appeals/Dispute Resolution section of the EOC.

Section 13. Rules For Coordination of Benefits of the Group Dental Care Coverage With Other Benefits

Under certain conditions, the benefits of the Group Dental Care Coverage that would be provided for your or your Qualified Dependent's dental care may be reduced so that the total benefits from this Program and all other Programs (defined below) will not be more than the total Allowable Expenses (defined below). That reduction will be made only if these rules so state. This coordination with other Programs helps to control the cost of benefits for everyone.

These rules for coordination apply to the Group Dental Care Coverage, but only with respect to services and supplies furnished, or expenses incurred, on or after the date these rules take effect. The terms used in these rules are defined in Section A. Section B describes the effect of other health care benefits on those of the Group Dental Care Coverage, subject to Sections C, D and E.

A. Definitions

(1) **Program:** Any of these that provide benefits or services for, or by reason of, dental care or treatment:

(a) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

(b) Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But this does not include school accident-type coverage for grammar school, high school, and college students.

For the purposes of these rules, a Dental Program is one that mainly provides benefits or services for, or because of, dental care or treatment.

Separate Programs:

Each contract or other arrangement for coverage under (a) or (b) is a separate Program. But each part of a contract or other arrangement for coverage that is a Dental Program is a Separate Program.

Also, rules for coordination of benefits may apply only to part of a Dental Program. If so, the part to which the rules apply is a separate Program from the part to which the rules do not apply.

(2) **This Program:** The Group Dental Care Coverage provided by DMO. The term "This Program" applies separately to each part of the Group Dental Care Coverage that is a Dental Program.

(3) **Allowable Expense:** The Reasonable Charge for a needed service or supply, when the charge, service or supply is covered at least in part by one or more Dental Programs covering the person for whom claim is made.

When a Program (including This Program) provides benefits in the form of services, the Reasonable Cash Value for each service rendered will be considered both an Allowable Expense and a benefit paid. When payment under a Program is based on a contracted fee, that fee or the dentist's usual charge, whichever is less, will be considered the Allowable Expense.

(4) **Claim Determination Period:** A Calendar Year, but, for a person, this does not include any part while the person has no coverage under This Program or any part before the date these or similar rules take effect.

B. Effect on Benefits

(1) **When this Section Applies:** This Section B applies when the sum of the benefits in (a) and (b) below for a person's Allowable Expenses in a Claim Determination Period would be more than those Allowable Expenses. In that case, the benefits of This Program will be reduced so that they and the benefits in (b) do not total more than those Allowable Expenses.

(a) The Reasonable Cash Value of the benefits that would be provided for the Allowable Expenses under This Program in the absence of this Section B.

(b) The benefits that would be payable for the Allowable Expenses under all other Programs of the same type as This Program, in the absence of rules with a purpose like that of these rules, whether or not claim is made. But this (b) does not include the benefits of a Program if:

(i) It has rules coordinating its benefits with those of This Program; and

(ii) Those rules have Claim Determination Period and Facility of Payment items similar to those in these rules; and

(iii) Its rules and This Program's rules both require This Program to determine benefits before it does.

(2) **This Program's Rules for the Order in which Benefits are Determined:** When a person's dental care is the basis for a claim:

(a) **Non-dependent/Dependent:** The benefits of a Program that covers the person other than as a dependent are determined before those of a Program that covers the person as a dependent.

(b) **Dependent Child/Parents Not Separated or Divorced:** Except as stated in subparagraph B.(2)(c) below, when This Program and another Program cover the same child as a dependent of different persons, called "parents":

(i) the benefits of the Program of the parent whose birthday falls earlier in a year are determined before those of the Program of the parent whose birthday falls later in that year; but

(ii) if both parents have the same birthday, the benefits of the Program that covered the parent longer are determined before those of the Program that covered the other parent for a shorter period of time.

However, if the other Program does not have the rule described in (i), immediately above, and if, as a result, the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

(c) **Dependent Child/Separated or Divorced Parents:** If two or more Programs cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) first, the Program of the parent with custody of the child;

(ii) then, the Program of the spouse of the parent with custody of the child; and

(iii) finally, the Program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Program of that parent has actual knowledge of those terms, the benefits of that Program are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, benefits for the child are determined in accordance with rule B.(2)(b) above.

(d) **Active/Inactive Employee:** The benefits of a Program that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Program that covers that person as a laid off or retired employee or as that employee's dependent. If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (d) is ignored.

(e) **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the benefits of the Program that covered a person longer are determined before those of the Program that covered that person for the shorter time.

(3) **Effect of Reduction in Benefits:** When these rules reduce This Program's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Program.

C. Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. DMO has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. DMO need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Program must give DMO any facts it needs to pay the claim.

D. Facility of Payment

A payment made under another Program may include an amount for a benefit that should have been provided under This Program. If it does, DMO may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit provided under This Program. DMO will have no further liability with respect to that amount. The term "payment made" includes providing benefits in the form of services. In that case, the payment made will be deemed to be the Reasonable Cash Value of any benefits provided in the form of services.

E. Right of Recovery

If the Reasonable Cash Value of the benefits provided by DMO is more than the Reasonable Cash Value of the benefits it should have provided under This Program, it may recover the excess. It may recover such excess from one or more of:

(1) the persons to whom or for whom it has provided such benefits;

(2) insurance companies; or

(3) other organizations.

Section 14. Termination of Benefits

A **Member's Coverage** under this EOC will terminate upon the earliest of any of the conditions listed below.

A. Termination of Subscriber Coverage.

A **Subscriber's Coverage** will terminate for any of the following reasons:

1. employment terminates;

2. the **Agreement** terminates for the following reasons;

   the Contract Holder notifies Aetna that they wish to terminate the **Agreement** if the Contract Holder no longer has any Subscribers who live or work in the **Service Area** upon 90 days' notice of continuation, if Aetna ceases to offer the product purchased through the **Agreement** upon 180' days notice of continuation if Aetna exits the California market entirely.

3. the Subscriber is no longer eligible as outlined on the Schedule of Benefits; or

4. the Subscriber becomes **Covered** under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the Contract Holder in lieu of **Coverage** under this EOC.

B. Termination of Dependent Coverage.

A **Covered Dependent's Coverage** will terminate for any of the following reasons:

1. a **Covered Dependen**t is no longer eligible, as outlined in the Eligibility and Enrollment section of the EOC or in the Schedule of Benefits;

2. the Agreement terminates; or

3. the Subscriber's **Coverage** terminates.

C. Termination For Cause.

Aetna may terminate **Coverage** for cause:

1. upon 15 days advance written notice of cancellation, if the **Member** has failed to make any required **Premium** payment which the **Member** is obligated to pay, as specified by Contract Holder. Only **Members Covered** under COBRA continuation **Coverage** are required to make **Premium** payments to Aetna. Please see the Continuation and Conversion section of this EOC for additional information regarding termination under COBRA continuation. **Member** will receive a notice of cancellation from Aetna stating the amount of such required **Premium** payment, the date and time when the **Member** will be terminated if the required **Premium** payment is not received within the time frame specified in the notice, and additional information regarding Conversion coverage or HIPAA Individual coverage. The date and time of termination will be no sooner than 15 days after the date the notice of cancellation was mailed to the **Member**. Upon the effective date of such termination, prepayments received by Aetna from **Member** on account of such terminated **Member** or **Member**s for periods after the effective date of termination shall be refunded to the sender of such prepayments.

2. immediately, upon written notice of cancellation, upon discovering a material misrepresentation by the **Member** in applying for or obtaining **Coverage** or benefits under this EOC or discovering that the **Member** has committed fraud against Aetna. This may include, but is not limited to, furnishing incorrect or misleading information to Aetna, or allowing or assisting a person other than the **Member** named on the identification card to obtain Aetna benefits. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for **Coverage** under this EOC will be deemed representations and not warranties. No statement made for the purpose of obtaining **Coverage** will result in the termination of benefits or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

3. upon 30 days advance written notice of cancellation if a **Member** threatens the safety of Aetna employees, Providers, **Members**, or other patients, or if the **Member's** repeated behavior has substantially impaired the Aetna's ability to furnish or arrange services for the **Member** or other **Members**, or substantially impaired a Provider's ability to provide services to other patients.

4. upon termination of the Agreement if the Contract Holder has failed to make any **Premium** payments within the grace period specified in the **Agreement**. Aetna will provide written notice of cancellation to Contract Holder 15 days prior to the date of termination of the **Agreement**. The notice will include the date and time of the termination, information regarding Conversion **Coverage** or HIPAA Individual **Coverage**, and notice that the **Member** may call **Member** Services at the number listed on their ID card to verify that the Contract Holder has, or has not paid the required **Premium**. Contract Holder will provide notice of cancellation to **Member** 15 days prior to the termination date which will include the date and time of the termination, information regarding Conversion **Coverage** or HIPAA Individual **Coverage**, and notice that the **Member** may call **Member** Services at the number listed on their ID card to verify that the Contract Holder has, or has not paid the required **Premium**. In addition**, Members** will receive a notice confirming termination of benefits if the Contract Holder fails to remit the **Premium** payments within the specified grace period.

5. immediately upon written notice to Contract Holder if Contract Holder has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the **Coverage** provided under the **Agreement**;

6. upon 30 days written notice of cancellation to Contract Holder if Contract Holder (i) breaches a provision of the **Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet Aetna's requirements for an employer group or association; (iii) fails to meet Aetna's contribution or participation requirements applicable to the **Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by the **Agreement** within a reasonable period of time specified by Aetna; or (v) changes its eligibility or participation requirements without Aetna's consent;

D. Disenrollment by Member

If **Member** elects **Coverage** under an alternative health benefits plan offered by or through Contract Holder as an option to **Coverage** under Aetna, **Member's Coverage** terminates automatically at the time and date the alternate **Coverage** becomes effective. **Member** and Contract Holder agree to notify Aetna immediately that **Coverage** has been elected elsewhere.

Members may voluntarily disenroll from Aetna. **Member** may disenroll by notifying Contract Holder and/or Aetna in writing of **Member's** intent to cancel Membership. **Member's Coverage** terminates at midnight on the last day of the month during which Aetna receives notice of intent to disenroll, or at midnight on the last day of the month for which **Member** requested cancellation.

E. Effective Date of Termination

Coverage as a **Member** ceases on the following dates:

1. At midnight on the last day of the month in which **Member** was eligible for **Coverage** according to the eligibility requirements as specified in the Eligibility and Enrollment section of the EOC and in the Schedule of Benefits.
2. At midnight on the termination date specified in the written notice of cancellation;

3. On the termination date and time established by Aetna and Contract Holder as specified in the **Agreement** or as otherwise agreed by Contract Holder.

4. At the time replacement **Coverage**, as provided by the Contract Holder, or chosen by the **Member** takes effect.

Aetna shall have no further liability or responsibility under this EOC except for **Coverage** for **Covered** Benefits provided prior to the date of termination of benefits.

The fact that **Member**s are not notified by the Contract Holder of the termination of their **Coverage** due to the termination of the **Agreement** shall not deem the continuation of **Members' Coverage** beyond the date **Coverage** terminates.

F. Member's Right to Review

A **Member** may register a Complaint with Aetna, as described in the Claim Procedures/Complaints and Appeals section of this EOC, after receiving notice that Aetna has or will terminate the **Member's Coverage** as described in the Termination For Cause subsection of the EOC. HMO will continue the **Member's Coverage** in force until a final decision on the Complaint is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor because a **Member** has exercised the **Member**'s rights under the EOC's Claim Procedures/Complaints and Appeals section to register a Complaint with Aetna. If a **Member** believes their membership was terminated because of the **Member's** health status or requirements for health care services, the **Member** may request a review by the Director of the California Department of Managed Health Care. The Complaint process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this EOC.

Section 15. Coverage for Certain Handicapped Children

Handicapped Children

Coverage is available for a child of any age who is medically certified as disabled and Dependent upon the **Subscriber** for support and maintenance. In order to continue **Coverage** for a handicapped child, the **Subscriber** must provide proof of the child's incapacity and dependency to Aetna within 31 days of the date the child is medically certified as disabled or upon request by Aetna, whichever occurs first. Subsequent proof may be requested by Aetna, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such **Coverage**. This eligibility provision will no longer apply on the date the Dependent's incapacity ends.

Coverage will cease on the earliest to occur of:

Cessation of the handicap.

Failure to give proof that the handicap continues.

After attainment of the limiting age, Aetna will have the right to require proof of the continuation of the handicap. Such proof will not be required more often than once each year starting on the date the child reaches the limiting age.

Section 16. Continuation or Extension of Benefits

Members with questions concerning HIPAA may contact the Centers for **Medicare** & Medicaid Services (CMS) (formerly HCFA) at the following telephone number 1-800-633-4227. CMS has posted at its web site a publication entitled: "Commonly Asked Questions and Answers for Consumers about the Provisions of Health Insurance Portability and Accountability Act of 1996" at the following Internet address: http://www.hcfa.gov/regs/hipaacer.htm. CMS may be contacted directly, by mail, at : Centers for **Medicare** & Medicaid Services, Attention: HIPAA Unit, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105.

A. Continued Group Coverage (COBRA)

Members may continue group health **Coverage** under certain circumstances where **Coverage** would otherwise terminate ("continuation **Coverage**"). The Federal law pertaining to this **Coverage** is the Consolidated Omnibus Reconciliation Act ("COBRA"). COBRA applies to employers with twenty (20) or more eligible employees.

B. COBRA Continuation Coverage.

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and related amendments ("COBRA") The description of COBRA which follows is intended only to summarize the **Member's** rights under the law. **Coverage** provided under this EOC offers no greater COBRA rights than COBRA requires and should be construed accordingly. COBRA permits eligible **Members** or eligible **Covered Dependents** to elect to continue group **Coverage** as follows:

Employees and their **Covered Dependents** will not be eligible for the continuation of **Coverage** provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:

   The Contract Holder must have normally employed 20 or more employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees **Covered** by a health plan, and includes full-time and part-time employees.

2. Loss of **Coverage** due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue **Coverage** for 18 months after eligibility for **Coverage** under this EOC would otherwise cease.

3. Loss of **Coverage** due to:

   a. divorce or legal separation, or

   b. Subscriber's death, or

   c. Subscriber's entitlement to **Medicare** benefits, or,

   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this EOC:

      The **Member** may elect to continue **Coverage** for 36 months after eligibility for **Coverage** under this EOC would otherwise cease.

4. Continuation **Coverage** ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the **Premiums** section of the **Agreement**.

d. the first day on which the Contract Holder ceases to maintain any group health plan.

e. the first day, after the day COBRA **Coverage** has been elected, on which a **Member** is actually **Covered** by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied **Coverage** under the new plan for a preexisting condition, continuation **Coverage** will not be terminated until the last day of the continuation period, or the date upon which the **Member**'s preexisting condition becomes **Covered** under the new plan, whichever occurs first.

f. the date, after COBRA **Coverage** had been elected, when the **Member** is entitled to **Medicare**.

5. Extensions of **Coverage** Periods:

   a. The 18-month **Coverage** period may be extended if an event which would otherwise qualify the **Member** for the 36-month **Coverage** period occurs during the 18-month period, but in no event may **Coverage** be longer than 36 months from the event which qualified the **Member** for continuation **Coverage** initially.

   b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the Contract Holder within 60 days of the Social Security determination and before the end of the initial 18-month period, continuation **Coverage** for the **Member** and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The **Member** must have become disabled during the first 60 days of the COBRA continuation **Coverage**.

6. Responsibility of the Contract Holder to provide **Member** with notice of Continuation Rights:

   The Contract Holder is responsible for providing the necessary notification to **Members**, within the defined time period, as required by COBRA.

7. Responsibility to pay **Premiums** to Aetna:

   The Subscriber or **Member** will only have **Coverage** for the 60 day initial enrollment period if the Subscriber or **Member** pays the applicable **Premium** charges due within forty-five days of submitting the application to the Contract Holder.

8. **Premiums** due Aetna for the continuation of **Coverage** under this section shall be due in accordance with the procedures of the **Premiums** section of the **Agreement** and shall be calculated in accordance with applicable federal law and regulations.

Section 17. Inquiry and Grievance Procedure/Claim Procedures/Complaints and Appeals/Dispute Resolution

A. Inquiry and Grievance Procedure

Overview

The purpose of the Grievance process is to address matters causing Members to be dissatisfied with their Plan coverage. We recognize that misunderstandings between Members, providers and the Plan may occur. Therefore, every effort is made to efficiently resolve grievances. Information about this process is also available in more detail in your member handbook and, as always, our Customer Services representatives are available to assist you.

Grievance Process

Any expression of dissatisfaction received by the Plan in writing, verbally and/or via the Aetna Navigator website will be considered a grievance. The Plan's Grievance Coordinator will coordinate grievances that concern administrative issues. The Plan's Dental Director coordinates grievances involving quality of care, access and continuity of care, with the assistance of the Grievance Coordinator. You can call our Customer Services Department at 1-800-843-3661 with any questions, problems, or concerns. To express a grievance, you can contact us by telephone, online at www.aetna.com or by mailing a written complaint to:

Aetna Dental of California Inc.
Customer Resolution Team
P.O. Box 10462
Van Nuys, CA 91410

The Plan shall not discriminate against a Member (including cancellation of the contract) on the grounds that the complainant filed a grievance.

The Plan's grievance process shall allow Members to file grievances for at least 180 calendar days following any incident or action that is the subject of the member's dissatisfaction.

The Plan will provide Members with written acknowledgement of the grievance within 5 calendar days of the Plan's receipt of the grievance. The Plan will provide the name of the Plan Representative, including, his or her telephone number and address which the Member may use to contact the Plan representative directly regarding the grievance documented in the acknowledgement letter. The Plan will resolve the grievance within 30 calendar days from the Plan's receipt.

The Plan has a process in place to inform Members of the pending status of his or her grievance if the resolution date is set to exceed 30 calendar days. If additional time is required by the Plan in order to properly investigate and resolve the grievance, the Plan will provide the Member with a written notice every 15 calendar days after the grievance exceeds 30 calendar days until resolution of the grievance has been reached.

A grievance involving an imminent and serious threat to the member's health, including but not limited to severe pain, swelling, fever, bleeding or the potential loss of life, will be characterized as a dental condition requiring urgent attention. A Plan representative receiving this type of grievance would assist the Member in receiving emergency care, which would be rendered in order to alleviate pain and or prevent worsening of a condition that would be caused by delay. The Plan will immediately notify the Member of his or her right to contact the Department of Managed Health Care (DMHC) regarding the urgent grievance. The Plan will provide the Member with a written statement as to the disposition or pending status of an urgent grievance no later than 3 calendar days from the date the grievance was received by the Plan. The Member's dental condition will be considered when determining the length of the Plan's response time.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at 1-800-843-3661 and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

B. Claim Procedures

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from Aetna, a **Referral** as required by the plan from a **Participating Dental Provider** or requests payment for services or treatment received. As an Aetna **Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered** benefits, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card.

Aetna will make a decision on the **Member's** claim**.** For urgent care claims, Aetna will send the **Member** written notification of the determination, whether adverse or not adverse. For other types of claims, the **Member** may only receive notice if Aetna makes an adverse benefit determination.

Adverse benefit determinations are decisions made by Aetna that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review**. Aetna determines that the service or supply is not **Medically Necessary** or are **Experimental or Investigational** procedures;
- **No Coverage**. Aetna determines that a service or supply is not **Covered** by the plan. A service or supply is not **Covered** if it is not included in the list of **Covered Services**;
- it is excluded from **Coverage**;
- a Aetna limitation has been reached; or
- **Eligibility**. Aetna determines that the **Subscriber** or **Subscriber's Covered Dependents** are not eligible to be **Covered** by Aetna.

Written notice of an adverse benefit determination will be provided to the **Member** and/or **Member's** provider within the time frames provided below. The times are measured from Aetna's receipt of the information reasonably necessary and requested by Aetna to make the determination. These time frames may be extended, if Aetna has requested information which has not been received or, consistent with good dental practice, has requested consultation with an expert reviewer, or requested an additional examination or additional tests. In these cases Aetna will notify the provider and the enrollee in writing of the reasons why a decision cannot be made within the required timeframes and the anticipated date the decision can be made. The notice of adverse benefit determination will provide the information required by California law that will assist the **Member** in making an Appeal of the adverse benefit determination, if the **Member** wishes to do so.

California laws and rules regulate adverse benefit determinations as Disputed Health Care Services or **Coverage** Determinations. Please see the Complaints and Appeals section of this EOC for more information about Complaints and Appeals.

Aetna Timeframe for Decision and Notification		
Type of Claim	**Aetna Time Frame for Decision**	**Aetna Time Frame for Notification of an Adverse Benefit Determination**
Dental Emergency Urgent Care Claim. A claim for dental care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function, or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	In a timely fashion appropriate to the nature of the condition not to exceed 72 hours of Aetna's receipt of the information reasonably necessary to make decision.	1. If Aetna is in receipt of the information reasonably necessary to make a decision when claim is submitted, as soon as possible but not later than 72 hours. 2. Aetna will request any additional information necessary within 24 hours of receipt of claim. If information is received within 48 hours, within 48 hours of receipt of information. 3. If information not received within 48 hours, within 72 hours of the receipt of the initial request. If notification of decision is provided orally, written or electronic notification provided within 3 calendar days after initial oral notification.
Aetna Timeframe for Decision and Notification (cont)		
Type of Claim	**Aetna Time Frame for Decision**	**Aetna Time Frame for Notification of an Adverse Benefit Determination**
Pre-Service Claim. A claim for a benefit that requires approval pre-authorization of the benefit in advance of obtaining dental care.	In a timely fashion appropriate to the nature of the condition not to exceed 5 business days of Aetna's receipt of the information reasonably necessary to make decision.	Provider notified within 24 hours of decision: **Member** notified of decision in writing within 2 business days.
Concurrent Care Claim Extension, Reduction or Termination. A request to extend, reduce or terminate a course of treatment previously pre-authorization by Aetna.	In a timely fashion appropriate to the nature of the condition not to exceed 5 business days of Aetna's receipt of the information reasonably necessary to make decision.	Provider notification within 24 hours of decision: **Member** notified in writing within 2 business days. In the case of decisions to terminate or reduce treatment, **Member** must be notified with adequate time for the **Member** to appeal, which time may be shorter than described above.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 days of Aetna's receipt of the information reasonably necessary to make decision.	Within 30 calendar days in writing.

COMPLAINTS AND APPEALS

Aetna has procedures for **Members** to use if they are dissatisfied with a decision that Aetna has made or with the operation of Aetna. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An Appeal is a request to Aetna to reconsider an adverse benefit determination. The Appeal procedure for an adverse benefit determination has one level. An Appeal is a type of Complaint. If the Member is appealing a Disputed Health Care Service, the **Member** has the right to a Disputed Resolution in addition to the processes described in the Complaints and Appeals Section.
- **Complaint.** A Complaint is a written or oral expression of dissatisfaction regarding Aetna or the operation of Aetna and/or a **Dental Provider** including quality of care concerns, and includes a grievance, dispute, request for reconsideration or Appeal made by an enrollee or the enrollee’s representative.

A. Complaints.

If the **Member** is dissatisfied with the administrative services the **Member** receives from Aetna, or wants to complain about a **Participating Dental Provider**, call or write **Member** Services within 180 calendar days of the incident. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. Aetna will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the Complaint. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. Appeals of Adverse Benefit Determinations.

The **Member** will receive written notice of an adverse benefit determination (including **Coverage** Decisions and Disputed Health Care Service decisions) from Aetna. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to Appeal. The notice will also identify the **Member's** rights to receive additional information that may be relevant to an Appeal. Requests for an Appeal must be made in writing within 180 calendar days from the date of the notice.

A **Member** may also choose to have another person (an authorized representative) make the Appeal on the **Member's** behalf by providing Aetna with written consent. However, in case of a **Dental Emergency** urgent care claim or a pre-service claim, a **Dentist** may represent the **Member** in the Appeal.

The following chart summarizes some information about how the Appeals are handled for different types of claims.

Aetna Timeframe for Responding to an Adverse Benefit Determination Appeal	
Type of Claim	**Aetna Response Time from Receipt of Appeal**
Dental Emergency Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function, or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by personnel not involved in making the adverse benefit determination.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days. Review provided by personnel not involved in making the adverse benefit determination.
Concurrent Care Claim Extension. a request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-Service Claim. any claim for a benefit that is not a pre-service claim.	Within 30 calendar days. Review provided by personnel not involved in making the adverse benefit determination.

C. Exhaustion of Process.

The foregoing procedures and process are mandatory and must be exhausted prior to: the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Agreement** or EOC by Aetna, or any matter within the scope of the Complaints and Appeals process.

D. Record Retention.

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

E. Fees and Costs.

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a Complaint or Appeal.

DISPUTE RESOLUTION

Any controversy, dispute or claim between Aetna on the one hand and one or more Interested Parties on the other hand arising out of or relating to the **Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. Aetna and Interested Parties hereby give up their rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Dental Providers** shall not include Aetna. A **Member** must exhaust all Complaint, Appeal and dispute resolution review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or **Coverage** beyond payment of or **Coverage** for the benefit or **Coverage** where (i) Aetna has made available dispute resolution and (ii) Aetna has followed the reviewer's decision. Punitive damages may not be **Covered** as part of a Claim under any circumstances. No Interested Party may participate in a representative capacity or as a **Member** of any class in any proceeding arising out of or related to the **Agreement**. This **agreement** to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

Section 18. Reimbursement Provisions

Members are financially responsible for the cost of any services received from **Non-Participating Dental Providers** unless those services were arranged by the **Member's PCD** or were required to treat a **Dental Emergency**.

When a **Member** receives **Covered Services** or supplies from a **Non-Participating Dental Provider** for a **Dental Emergency**, the **Member** should request that the **Non-Participating Dental Provider** bill Aetna. If he or she refuses to bill Aetna but agrees to bill the **Member**, the **Member** should immediately submit any such bills to Aetna.

When a **Member** is required to pay **Non-Participating Dental Provider**s for **Covered Services**, at the time they are rendered, the **Member** should submit a request for reimbursement for such services in writing to Aetna within 60 days of the date those services were rendered. Proof of payment acceptable to Aetna must accompany all requests for reimbursement. Failure to request reimbursement within the required time shall not invalidate or reduce any claim if it was not reasonably possible to provide such proof within such time; provided that the required information is provided to Aetna as soon as reasonably possible. However, in no event shall Aetna be liable for claims or reimbursement requests for which proof of payment is submitted to Aetna more than 90 days following the date care was rendered, unless the **Member** is legally incapacitated. The **Member** should send itemized bills upon receipt to:

Claims Department
Aetna Dental of California Inc.
P.O. Box 10462
Van Nuys, CA 91410

Requests for reimbursement are processed within 30 days of receipt. A **Member**'s failure to submit required documentation may serve to delay reimbursement. Aetna may require a **Member** to provide additional dental and other information or documentation to prove that services rendered were **Covered Services** before paying health care providers or reimbursing the **Member** for such services; subject to the applicable requirements established by state or federal law.

Members may dispute any of Aetna's benefit determinations as explained in the Inquiry and Grievance Complaint Procedure section of this Evidence of Coverage and Disclosure Form.

Section 19. Medicare and Other Federal or State Government Programs

The benefits under this Evidence of Coverage and Disclosure Form are not intended to duplicate any benefits for which **Members** are, or could be eligible for, **Medicare** or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this Evidence of Coverage and Disclosure Form shall be payable to and retained by Aetna. Each **Member** shall complete and submit to Aetna such consents, releases, assignments and other documents as may be requested by Aetna in order to obtain or assure reimbursement under **Medicare** or any other government programs for which **Members** are eligible.

Aetna also reserves the right to reduce benefits for any dental expenses **Covered** under this Evidence of Coverage and Disclosure Form by the amount of any **Medicare** benefits available for such expenses. This will be done before the benefits under this Evidence of Coverage and Disclosure Form are calculated. Charges for services used to satisfy a **Member's Medicare** Part B deductible will be applied under this Evidence of Coverage and Disclosure Form in the order received by Aetna. Two or more charges for services received at the same time will be applied starting with the largest first.

Medicare benefits will be taken into account for any **Member** who is eligible for **Medicare**. This will be done whether or not the **Member** is enrolled in **Medicare**.

Members are considered eligible for **Medicare** or other government programs if they:

A. Are **Covered** under a program;
B. Have refused to be **Covered** under a program for which they are eligible;
C. Have terminated **Coverage** under a program; or
D. Have failed to make proper request for **Coverage** under a program.

The provisions of this Section will apply to the maximum extent permitted by federal or state law. Aetna will not reduce the benefits due any **Member** due to that **Member's** eligibility for **Medicare** where federal law requires that Aetna determines its benefits for that **Member** without regard to the benefits available under **Medicare**.

Section 20. Limitations

A. All services must be received from **Participating Dental Providers** or other **Health Professionals** as approved or authorized by the **Member's PCD**, and when required, certified in advance by Aetna; except as otherwise expressly specified herein.

B. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or other emergency or event not within the control of Aetna results in the offices, personnel, or financial resources of Dental Plan being unable to provide or arrange for the provision of **Covered Services**, Dental Plan shall have no liability or obligation for any delay in the provision of or failure to provide such services; except that Aetna shall make a good faith effort to provide such services, taking into account the impact of the event.

C. Certain **Covered Services** are subject to benefit maximum limitations as described in the Dental Care Schedule.

D. Certain **Members** may, for personal reasons, refuse to accept procedures or treatment recommended by **Participating Dental Provider**s. **Participating Dental Providers** may regard such refusal as incompatible with the continuance of the provider-patient relationship and as obstructing the provision of proper dental care. If a **Member** refuses to accept such a recommended treatment or procedure, and the **Participating Dental Provider** believes that no professionally acceptable alternative exists, such **Member** shall be so advised. If the **Member** still refuses to accept the recommended procedure or treatment, then after giving written notice to the **Member**, neither Aetna nor any **Participating Dental Provider** shall have any responsibility to provide care or **Coverage** for the condition with respect to which the **Member** has refused to accept procedures or treatment.

Section 21. General Provisions

Independent Contractors: Aetna does not itself undertake to directly furnish any dental care services under the **Agreement**. The obligations of Aetna are limited to arranging for the provision of dental care services to **Members**. Dental care providers are solely responsible for exercising independent dental judgments. Aetna is solely responsible for making benefit determinations in accordance with the **Agreement** and its contracts with **Participating Dental Providers**, but it expressly disclaims any right or responsibility to make medical treatment decisions. Such decisions may only be made by dental care providers in consultation with the **Member**. Such dental care providers and the **Member** may elect to continue dental treatments despite Aetna's denial of **Coverage** for such treatments, and the **Member** will be responsible for the cost of such treatments. **Members** and dental care providers may appeal any of Aetna's benefit decisions in accordance with Aetna's Inquiry and Grievance Complaint Procedure.

Second Opinions: If you are concerned about a **Participating Dental Provider's** recommended course of treatment, you may request Aetna to designate another **Participating Dental Provider** to render a second opinion. Aetna will authorize or deny a request for a second opinion within 72 hours of receipt of such request. If the first and second opinions do not agree, Aetna will designate another **Participating Dental Provider** to render a third opinion. However, if the second and third opinions confirm the recommendation of the first **Participating Dental Provider**, and you refuse to follow the recommendation, or if the second and third **Participating Dental Provider**s agree that there is no acceptable alternative method of treating your condition, then neither Aetna nor any **Participating Dental Provider** shall have any further responsibility to provide care for the condition being treated. If you elect to receive services not ordered or certified by your **PCD** to treat that condition, those services will not be **Covered** by Aetna.

Incontestability Clause: In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties and that no statement shall be the basis for voiding **Coverage** or denying a claim after the **Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

Entire Agreement: The Agreement, including the Evidence of **Coverage** and Disclosure Form, Dental Care Schedule, any Riders, and any amendments or attachments, constitutes the entire **Agreement** between Group and Aetna, and on the effective date of **Coverage**, supersedes all other agreements for health care services and benefits between the parties.

Third Party Liability and Workers' Compensation: In case of injuries caused by an act or omission of a third party, and complications incident thereto, and injuries and illnesses which are work-related, **Covered Services** required as a result of such injuries or illnesses shall be **Covered** by Aetna. However, by executing an enrollment form, each **Member** agrees to notify Aetna when there is any possibility that a third party may be liable for the injuries, or that an injury or illness could be work-related. Aetna shall have a first party lien against any settlement awarded to **Member**, even if the settlement does not specifically include payment for dental costs. Upon settlement, Aetna shall be reimbursed at the prevailing rates for the cost of all such services and benefits provided on account of such injury or illness. In the event the third party is unable to fulfill Aetna's lien by direct payment, **Member** nonetheless agrees to reimburse Aetna at prevailing rates upon obtaining the monetary recovery, but not to exceed the amount of recovery. Group also agrees to cooperate in protecting the interests of Aetna under this provision and to execute and deliver to Aetna or its designee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of Aetna or its designee. Failure to so cooperate is a basis for termination of Group's rights by Aetna.

Organ and Tissue Donation: Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Arbitration: All disputes arising pursuant to the **Agreement** between Group and Aetna will be resolved through arbitration conducted pursuant to the Commercial Rules of the American Arbitration Association, but not necessarily before the American Arbitration Association.

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

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

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

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

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

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

Any **Coverage** being continued for a Dependent will not be continued beyond the date it would otherwise terminate.

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

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

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

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

Section 22. Definitions

Defined terms are capitalized when used in this Evidence of Coverage and Disclosure Form.

Agreement: The Agreement between Aetna and Group, including this Evidence of Coverage and Disclosure Form, any Riders, any amendments, and any attachments.

Annual Enrollment Period: A period of time established by Group and Aetna during which eligible employees and their eligible Dependents may be enrolled as **Members**.

Copayment: The additional amount which is approved by the Commissioner of Corporations, which a **Member** is required to pay directly to a provider of **Covered Services**. Copayments are specified in the Dental Care Schedule in this Evidence of Coverage and Disclosure Form. Copayments must be paid at the time of delivery of services or supplies. Copayments may be changed by Aetna upon 30 days written notice to Group.

Covered Services, Coverage or Covered: Those services and supplies provided to a **Member**, while the **Member** is a Covered person. Those expenses are subject to the limitations and exclusions of the **Dental Care Plan**.

Covered Dependent: Dependents of the Subscriber who: (a) meet the eligibility requirements as set forth in the Eligibility section of this Evidence of Coverage and Disclosure Form and the **Agreement**; (b) have been enrolled in accordance with this Evidence of Coverage and Disclosure Form; and (c) for whom Aetna has received applicable **Premiums**.

Dental Care Plan(s): The plan(s) of benefits provided under the **Dental Care Plan Coverage**.

Dental Emergency: Any traumatic injury or condition which occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and has symptoms such as severe pain and bleeding, which could lead a prudent layperson who possesses an average knowledge of health or medicine, to result in:

placing the **Member**'s health in serious jeopardy; or
serious impairment of bodily function; or
serious dysfunction of any body organ or part.

Dental Provider: Any **Dentist**, group, organization, dental facility or other institution or person legally qualified to provide dental services or supplies.

Dentist: A legally qualified dentist or a legally qualified physician authorized by his or her license to perform, at the time and place involved, the particular dental procedure rendered by him or her.

Experimental or Investigational: A dental care procedure or treatment, or drug, is deemed to be experimental or investigational if it is not generally accepted by the dental profession in California due to a lack of clinical or other valid evidence as to its proven efficacy, or if it is still under review, test or investigation by dental or **health professionals**.

Health Professional: A health care provider which is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law.

Jaw Joint Disorder: A Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint, or a Myofacial Pain Dysfunction (MPD) or any similar disorder in the relationship between the jaw joint and related muscles and nerves.

Medicare: Title XVIII of the Social Security Act as amended.

Member: Any person enrolled in Dental Plan as a Subscriber or **Covered Dependent**.

Medically Necessary: The services or supplies necessary for the diagnosis, care or treatment of the **Member's** dental condition as determined by Aetna. All such **Covered Services** will be provided in accordance with professionally recognized standards of dental practice.

Non-Participating (Non-Par) Dental Provider: A **Dental Provider** who has not entered into a written agreement with Aetna to provide **Covered Services** to **Members**.

Orthodontic Treatment: Any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, bite, or jaws or jaw joint relationships, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care: Dental Care that is given to **Members** by a Non-Par **Dental Provider** for the palliative (pain relieving; stabilizing) treatment of a **Dental Emergency**. The emergency care is rendered outside of the 50 mile radius of the **Covered** person's home address. **Coverage** for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this **Dental Care Plan**.

Participating Dental Provider: Any **Dental Provider** who has entered into a written agreement with Aetna to provide **Coverage** to **Members**.

Participating (Par) Specialist Dentist: Any **Dentist** who, by virtue of advanced training, is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry, and who has entered into a written agreement with Aetna to provide **Coverage** to **Members**.

Premium: The total payment from Group to Aetna for **Coverage**.

Primary Care Dentist ("PCD"): The **Participating Dental Provider** chosen by the **Member**, in writing, to provide his or her dental care. If a **Member** fails to select a Primary Care **Dentist**, Aetna may select one for that **Member**. Aetna will notify **Member** of selection. The **Member** may later change Primary Care Dentists as explained in Section 6 of this Evidence of **Coverage** and Disclosure Form.

Reasonable Charge: The charge for a **Covered Service** which is the lower of: (a) the provider's usual charge for furnishing it; and (b) the charge Aetna determines to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account factors such as: the complexity; degree of skill needed; type or specialty of the provider; range of services provided by a facility; and the prevailing charge in other areas.

Service Area: The geographical service area of the Plan, designated by Aetna and approved by the California Department of Managed Health Care Corporations, in which an individual must live or work in order to be eligible to be a **Member**. Precise Service Area boundaries are published from time to time and disseminated to all Groups.

Subscriber: An employee of Group who: (a) meets all applicable eligibility requirements of this **Agreement**; (b) has enrolled for **Coverage**; and (c) on whose behalf Group has paid any applicable **Premium** payments to Aetna in accordance with the **Agreement**.

Section 23. Glossary

The following dental terms have the meanings indicated.

Abrasion – The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

Alveoloplasty – A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

Amalgam – A metal alloy used in filling teeth.

Apicoectomy – The surgical removal of the root tip.

Attrition – The normal loss of tooth substance resulting from friction during chewing.

Banding – Application of preformed stainless steel rings that are fitted around the teeth and cemented inplace for orthodontic purposes.

Cleft palate – A birth defect resulting in an incomplete closure or formation of the palate.

Endodontics – The diagnosis, prevention and treatment of disease or injuries of the pulp chamber or the apical area of a tooth root.

Erosion – Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

Frenum – The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

Frenectomy – Surgical removal or loosening of the frenum.

Gingiva – The soft tissue which covers a tooth or the gum surrounding a tooth.

Gingivectomy – The surgical removal of the unsupported gingiva to the level where it is attached.

Gingivoplasty – Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

Implant – A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

Macrognathia – A definite overgrowth of the mandible and maxilla.

Mandible – The lower jaw.

Mandibular – Pertaining to the lower jaw.

Maxilla – The upper jaw.

Maxillary – Pertaining to the upper jaw.

Micrognathia – An abnormal smallness of the jaws, especially the mandible.

Occlusal – The chewing surfaces of the posterior teeth.

Occlusion – The contact between the upper and lower teeth when in a closed position.

Orthodontics – Diagnosis and treatment of malocclusion of teeth and their surrounding structures.

Palate – The roof of the mouth.

Palatal – Pertaining to the roof of the mouth.

Palliative – Action that relieves pain but does not cure the cause of the pain.

Panoramic film – An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

Periapical – The area surrounding or enclosing the root tip of a tooth.

Periodontitis – Treatment of diseases of the supporting tissues of the teeth. Gingival changes that occur due to infection and loss of attachment between the tooth and gums.

Periradicular – Around the root.

Pontic – The term used for the artificial tooth on a bridge.

Prophylaxis – The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

Prosthodontics – The restoration of function by restoration or replacement of natural teeth.

Pulp cap – The covering of an exposed dental nerve with material that protects it from foreign irritants.

Quadrant – One of the four equal sections into which the dental arches can be divided, begins at the middle of the arch and goes to the last tooth on either side.

Rebase – Process of refitting a denture by replacing the acrylic base material.

Resin – Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.

Restorative –Treatment to restore the contours and function of teeth. Often refers to fillings, inlays, crowns and bridgework.

Retainer – An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

Retrograde filling – A method of sealing the root canal by preparing and filling it from the root tip.

Root planning – A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as “deep cleaning”.

Sealant – Application of a resin material to the biting surfaces of permanent molars to seal the surface crevices to prevent the formation of decay.

Scaling – The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

Study model – A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

Temporomandibular joint – The joint formed by the connection of the lower jaw to the skull.

Vertical dimension - The vertical height of the face with teeth in occlusion.

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.

Employer Identification Number:
13-3719008

Plan Number:
501

Type of Plan:
Health & Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Dental of California Inc.
6303 Owensmouth Avenue
Woodland Hills, CA 91367
1-800-238-6200

Plan Administrator:
TW Ventures Inc.
3500 West Olive Avenue
Suite 1000
Burbank, CA 91505
Telephone Number: (818) 972-0787

Agent For Service of Legal Process:
TW Ventures Inc.
3500 West Olive Avenue
Suite 1000
Burbank, CA 91505

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

End of Plan Year:
July 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 Board of Directors.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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.