BENEFIT PLAN

Prepared Exclusively for
County of El Paso

PPO Dental

What Your Plan Covers and How Benefits are Paid

Integration with Medical Benefits
In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses and only up to the excess amount.

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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

The dental benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** but will be paid from the Employer's funds. **Aetna** will provide certain administrative services under the **Aetna** dental benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** dental benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** dental benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supersedes all **Aetna** *Booklets* describing coverage for the dental benefits plan described in this *Booklet* that you may previously have received.

Employer:	County Of EL Paso
Customer Number:	866233
Effective Date:	Restated January 1, 2023~~3~~4
Booklet Number:	4~~3~~

Coverage for You and Your Dependents

Dental Expense Coverage

Benefits are payable for covered Dental care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a dental care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of Dental services and therefore is not responsible for and does not guarantee any results or outcomes of the covered dental care services and supplies you receive.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class (Retirement eligible)

You are in an eligible class if:

- You are a retired employee or are eligible to retire from an employer participating in this plan, and you:
  - ~~(1)~~ were covered under this plan or another plan offered by your employer~~;~~ and ~~(2)~~ were eligible to retire under the County's retirement system and~~;~~ ~~(3)~~ decease prior to your retirement effective date (the Retiree Election Time Period)~~;~~ and ~~(4)~~ you are a surviving dependent (or dependents) who were covered under this plan and retire under your employer's IRS-qualified retirement plan; or
  - ~~on or after January 1, 2017, during the Retiree Election Time Period, then you are eligible for enrollment in retiree coverage effective July 1, 2023 on the same basis as if the employee had not deceased prior to his or her retirement date; or~~
- You are a retired employee or are eligible to retire from an employer participating in this plan, and you:
- ~~You are a retired employee of an employer participating in this plan, and you:~~
  - Retired before the effective date of this plan and were covered under the prior plan for dental care coverage on the day before you retired and retire under your employer's IRS-qualified retirement plan; or
- You are a retired employee or are eligible to retire from an employer participating in this plan, and you:
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired~~;~~ and ~~R~~retire under your employer's IRS-qualified retirement plan.

Determining if You Are in an Eligible Class (Active employee)

You are in an eligible class if:

- You are a full or part-time non- collectively bargained employee, as defined by your employer.
- ~~Effective January 1, 2024, you are a part-time employee, as defined by your employer.~~
- ~~You are a District Judge who is enrolled in the medical plan as of 1/1/2018. Eligibility will end upon waiver of continued coverage and you will not be able to re-enroll.~~

Service Waiting Period

Eligibility for Individual Coverage

Each full or part-time employee non- collectively bargained who was covered under the prior Plan, if any, will be eligible on the Effective Date of this Plan. If you are a full or part time employee hired after the effective date of this plan, your coverage eligibility date will occur on the first of the month following 60 days from your date of hire. If the 60th day falls on the first of any month, the effective date shall be that date. If a Participant separates from employment and the Participant is reinstated pursuant to the timeframes outlined in the County of El Paso policies the service waiting period will be waived.

Commissioners Court, in its discretion, may waive the date pursuant to an interlocal agreement where: 1) such employees are current employees of another government agency that will become County employees under the terms of an agreement; 2) Commissioners Court concludes that such waiver will facilitate the implementation of the agreement; and, 3) such employees provide proof of coverage under the "sending " government agency's health plan' or as permitted by law. Any **Service Waiting Period** or portion thereof satisfied under the "sending" government agency's plan may be applied toward satisfaction of the County's **Service Waiting Period.**

Reinstatement

If you separate employment or lose coverage under this plan and are rehired or reinstated in the eligible class within 13 weeks of your separation date, the coverage eligibility date does not apply to you. If you are reinstated as a result of a civil service hearing or a reduction in force and hired in the eligible class within 6 months of your termination date, the coverage eligibility date does not apply to you. Coverage will be effective on the date of reinstatement if proper enrollment is completed within 31 days of reinstatement.

~~If you separate employment on good terms and are rehired in the eligible class within 30 days of your separation date, the service waiting period does not apply to you. If you are reinstated as a result of a civil service hearing or a reduction in force and hired in the eligible class within 6 months of your termination date, the service waiting period does not apply to you.~~

~~**Determining When You Become Eligible**~~

~~You become eligible for the plan on your eligibility date, which is determined as follows.~~

~~**On the Effective Date of the Plan**~~

~~If you are in an eligible class on the effective date of this plan, and you had previously satisfied the plan's service waiting period, your coverage eligibility date is the effective date of this plan. If you are in an eligible class on the effective date of this plan, but you have not yet satisfied the plan's service waiting period, your coverage eligibility date is the date you complete the service waiting period. If you had already satisfied the service waiting period before you entered the eligible class, your eligibility date is the date you enter the eligible class.~~

~~If an eligible employee separates from employment and the employee is reinstated pursuant to the timeframes outlined in the County of El Paso policies, the service waiting period will be waived. Commissioners Court, in its discretion, may waive the service waiting period pursuant to an interlocal agreement where: 1.) such employees are current employees of another government agency that will become County employees under the terms of an agreement; 2.) Commissioners Court concludes that such waiver will facilitate the implementation of the agreement; and, 3.) such employees provide proof of coverage under the "sending" government agency's dental plan. Any service waiting period or portion thereof satisfied under the "sending" government agency's dental plan may be applied toward satisfaction of the County's service waiting period.~~

~~**After the Effective Date of the Plan**~~

~~If you are in an eligible class on the date of hire, your eligibility date is the date you complete the service waiting period.~~

~~If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you complete the service waiting period. If you had already satisfied the service waiting period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.~~

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents: if you are covered under the County of El Paso's Medical Plan.

- Your spouse.
- Your dependent children.
- Your Plus One Qualified Dependent who meets the rules set by your employer.
- Dependent children of your Plus One Qualified Dependent.
- For retirees: your dependents that were enrolled on the Plan, as dependents, prior to your date of retirement

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Plus One Qualified Dependent

A Plus One Qualified Dependent is a person who certifies the following as of the date of enrollment:

"Plus One Qualifying Adult"

Plus One Qualifying Adult eligibility is extended to an individual who meets all of the following criteria:

1. The Employee and Plus One Qualifying Adult must have resided together in the same residence for at least twelve consecutive months and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Employee and Plus One Qualifying Adult's Driver's License or Government issued Identification Card listing a common address must be provided to the Plan Administrator;
2. The Plus One Qualifying Adult must be eighteen years of age or older; and
3. The Plus One Qualifying Adult must be financially interdependent with the Employee, sharing common financial obligations, as evidenced by three or more of the following documents (Financial Interdependence Documents), and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Financial Interdependence Documents must be provided to the Plan Administrator:
    a. Joint deed or mortgage agreement to demonstrate common ownership or real property or a common leasehold interest in real property;
    b. A Title or Vehicle Registration showing common ownership of a motor vehicle;
    c. Proof of joint bank accounts or credit accounts;
    d. Proof of designation as the primary beneficiary for life insurance or retirements benefits;
    e. Assignment of a durable property power of attorney or health care power of attorney.

Loss of Eligibility; Changes to Common Address or Financial Interdependence Documents. If the Employee and Plus One Qualifying Adult cease to reside together, or cease to share common financial obligations described in the Financial Interdependence Documents, the Plus One Qualifying Adult is no longer eligible to be a Dependent of the Employee. The Employee has an affirmative duty to inform the Plan Administrator of the change in status within 31 days. If the information on the Financial Interdependence Documents or Driver's license or Government issued Identification Card changes, the Employee must notify the Plan Administrator within 31 days and provide copies of the new documents, or risk loss of eligibility for the Plus One Qualifying Adult.

Note: Federal and/or State tax implications may arise when enrolling a Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.

Ineligible Individuals

The following individuals are not eligible for designation as a Plus One Qualifying Adult:
Parents;
Parents' other descendants (siblings, nieces, nephews);
Grandparents and descendants (aunts, uncles, cousins);
Step relatives; or
Renters, boarders, tenants, employees of the County Employee.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- 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 and any Plus One Qualifying Dependent.

Coverage for a disabled child may be continued past the age limits shown above. See *Disabled Dependent Children* for more information.

Benefits for the Survivors of Certain Public Servants

Eligible survivors of certain public servants who died as a result of personal injury sustained in the line of duty in the individual's position, as described, are entitled to purchase or continue to purchase health insurance benefits under Chapter 1551, Texas Insurance Code, as provided in this section.
A survivor is eligible if he or she is the surviving spouse of the individual or surviving dependent of the individual.

Certain Public Servants

This entitlement is available to eligible survivors of individuals who served in the following positions:
1. an individual elected, appointed, or employed as a peace officer by the state or a political subdivision of the state under Article 2.12, Code of Criminal Procedure, or other law;

2. a member of the class of employees of the correctional institutions division formally designated as custodial personnel under section 615.006 by the Texas Board of Criminal Justice or its predecessor in function;
3. a jailer or guard of a county jail who is appointed by the sheriff and who:
(a) performs a security, custodial, or supervisory function over the admittance, confinement, or discharge of prisoners; and
(b) is certified by the Commission on Law Enforcement Officer Standards and Education
4. an individual who is employed by the state or a political or legal subdivision and is subject to certification by the Texas Commission on Fire Protection or an individual employed by the state or a political or legal subdivision whose principal duties are aircraft crash and rescue fire fighting who is employed by a political subdivision of the state; or
5. an individual who is employed by the state or a political subdivision of the state and who is considered by the governmental employer to be a trainee and is employed as a trainee for a position otherwise described in section 615.071 of the Texas Government Code.

Eligible Surviving Spouse

An eligible surviving spouse of a deceased individual who was employed by a political subdivision of the state is entitled to purchase or continue to purchase health insurance benefits from the political subdivision that employed the deceased individual, including health coverage:
1. provided by or through a political subdivision under:
a. a health insurance policy or health benefit plan written by a health insurer; or

b. a self-insured health benefits plan.
2. under Chapter 172, Local Government Code.

The surviving spouse is entitled to purchase or continue to purchase health insurance coverage until the date the surviving spouse becomes eligible for federal Medicare benefits.

Eligible Surviving Dependent
An eligible surviving dependent who is a minor child is entitled to purchase or continue to purchase health insurance coverage until the date the dependent reaches the age of 26 or a later date to the extent required by state or federal law.
An eligible surviving dependent who is not a minor child is entitled to purchase or continue to purchase health insurance coverage until the earlier or:
1. the date the dependent becomes eligible for group health insurance through another employer; or
2. the date the dependent becomes eligible for federal Medicare benefits.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Open Enrollment

During the open enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this open enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins

Your Effective Date of Coverage

Your coverage takes effect on the date you are eligible for coverage

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to your employer within 31 days because they may affect your contributions.

Requirements For Coverage

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating a non-occupational **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

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

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

Important Note

- Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain dental services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

How Your Aetna Dental Plan Works

Understanding Your Aetna Dental Plan

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

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

Important Notes:
Unless otherwise indicated, "you" refers to you and your covered dependents.

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

Store this Booklet in a safe place for future reference.

Getting Started: Common Terms

Many terms throughout this Booklet are defined in the *Glossary* Section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About the PPO Dental Plan

The plan is a Preferred Provider Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more if you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice is Yours
You have a choice each time you need dental care:

Using Network Providers
- Your out-of-pocket expenses will be lower when your care is provided by a **network provider**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). **Network provider**s have agreed to provide covered services and supplies at a **negotiated charge**. Your **payment percentage** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of pocket expenses when the plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **payment percentage** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **copayment, payment percentage** or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Availability of Providers
Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

Using Out-of-Network Providers
You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**).

If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a covered expense from an **out-of-network provider**.

You must file a claim to receive reimbursement from the plan.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **copays**, **payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

Getting an Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note
The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $300. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See *Benefits When Alternate Procedures Are Available* for more information on alternate dental procedures.)

What is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

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

Important Reminder

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

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

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

The next sentence applies if:

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

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

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

PPO Dental Expense Coverage Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage and have at least one of the following conditions:

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

Additional Covered Dental Expenses

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

Payment of Benefits

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

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

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

Important Reminder

The **payment percentage** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the **network** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the out-of-network level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays
Office visit during regular office hours, for oral examination
Routine comprehensive or recall examination (limited to 2 visits every year)
Prophylaxis (cleaning) (limited to 2 treatments per year)
Adult
Child
Topical application of fluoride, (limited to one course of treatment per year and to children under age 19)
Sealants, per tooth (limited to one application every 3 years for permanent molars only)
Bitewing X-rays (limited to 2 set per year)

Type B Expenses: Basic Restorative Care

Visits and X-Rays
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit
Problem-focused examination (limited to 2 visits every year)

Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 per calendar year)
Vertical bitewing X-rays (limited to 1per calendar year)

X-Ray and Pathology
Periapical x-rays (single films up to 13)
Intra-oral, occlusal view, maxillary or mandibular
Upper or lower jaw, extra-oral
Biopsy and histopathologic examination of oral tissue

Oral Surgery
Extractions
Erupted tooth or exposed root
Coronal remnants
Surgical removal of erupted tooth/root tip
Impacted Teeth
Removal of tooth (soft tissue)
Odontogenic Cysts and Neoplasms
Incision and drainage of abscess
Removal of odontogenic cyst or tumor
Other Surgical Procedures
Alveoplasty, in conjunction with extractions - per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Excision of hyperplastic tissue
Removal of exostosis
Transplantation of tooth or tooth bud
Closure of oral fistula of maxillary sinus
Sequestrectomy
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

Surgical removal of impacted teeth
Removal of tooth (partially bony)
Removal of tooth (completely bony)

Periodontics
Occlusal adjustment (other than with an appliance or by restoration)
Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
Gingivectomy, per quadrant (limited to 1 per quadrant every 3 rolling years)
Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 rolling years
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
Periodontal maintenance procedures following active therapy (limited to 2 per year)
Localized delivery of antimicrobial agents
Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 rolling years
Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 rolling years
Clinical Crown lengthening, hard tissue

Endodontics
Pulp capping
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
Anterior
Bicuspid
Molar

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)

Pins
Pin retention—per tooth, in addition to amalgam or resin restoration
Prefabricated stainless steel
Prefabricated resin crown (excluding temporary crowns)
Recementation
Inlay

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

General Anesthesia and Intravenous Sedation (only when **medically necessary** and only when provided in conjunction with a covered surgical procedure)

Type C Expenses: Major Restorative Care

Periodontics
Soft tissue graft procedures

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years- see *Replacement Rule*).
Inlays/Onlays
Labial Veneers
Laminate-chairside
Resin laminate – laboratory
Porcelain laminate – laboratory
Crowns
Resin
Resin with noble metal
Resin with base metal
Porcelain/ceramic substrate
Porcelain with noble metal
Porcelain with base metal
Base metal (full cast)
Noble metal (full cast)
3/4 cast metallic or porcelain/ceramic
Crowns (when tooth cannot be restored with a filling material)
Crown exposure to aid eruption
Post and core
Core buildup, including any pins
Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See *Replacement Rule*.)
Bridge Abutments (See Inlays and Crowns)
Pontics
Base metal (full cast)
Noble metal (full cast)

Porcelain with noble metal
Porcelain with base metal
Resin with noble metal
Resin with base metal

Removable Bridge (unilateral)

One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

Complete upper denture
Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
Laboratory reline
Special tissue conditioning, per denture
Rebase, per denture

Adjustment to denture more than 6 months after installation

Adding teeth to existing partial denture

Each tooth
Each clasp

Repairs: crowns and bridges

Orthodontics

Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization
Removable appliance therapy to control harmful habits
Fixed appliance therapy to control harmful habits
Occlusal guard (for bruxism only), limited to 1 every 3 rolling years

Rules and Limits That Apply to the Dental Plan

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

Orthodontic Treatment Rule

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

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

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

Orthodontic Limitation

There is a one year waiting period for orthodontic services if you are a late entrant as defined herein.

Replacement Rule

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

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

Tooth Missing but Not Replaced Rule

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

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

Alternate Treatment Rule *(GR-9N-20-015-01)*

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

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

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

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

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

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

Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

Late Entrant Rule

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

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

This exclusion does not apply to charges incurred:

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

What The PPO Dental Plan Does Not Cover

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

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

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

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

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

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

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

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

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

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

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

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

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

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

Additional Items Not Covered By The Dental Plan

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

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

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

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

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

When Coverage Ends

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

When Coverage Ends for Employees

Your **Aetna** dental benefits coverage will end if:

- The **Aetna** dental benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer; or
- Your employer notifies **Aetna** that your employment is ended.

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

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees.;
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a **"Plus One Qualified Dependent"** will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for **Plus One Qualified Dependent**.
- The date of termination of the Plus One Qualifying Relationship. In that event, you should provide your Employer a completed and signed Declaration of Termination of **"Plus One Qualified Dependent"** form.

- If the Employee and Plus One Qualifying Adult cease to reside together, or cease to share common financial obligations described in the Financial Interdependence Documents, the Plus One Qualifying Adult is no longer eligible to be a Dependent of the Employee. The Employee has an affirmative duty to inform the Plan Administrator of the change in status within 31 days. If the information on the Financial Interdependence Documents or Driver's license or Government issued Identification Card changes, the Employee must notify the Plan Administrator within 31 days and provide copies of the new documents, or risk loss of eligibility for the Plus One Qualifying Adult.

Coverage for dependents may continue for a period after your death. Coverage for disabled dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage

Continuing Dental Care Benefits

Disabled Dependent Children

Dental Expense Coverage for your fully disabled dependent child may be continued past the maximum age for a dependent child.

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of mental retardation or a physical disability which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully disabled must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the disability. **Aetna** also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

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

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

Allowable Expense means a dental care service or expense, including, coinsurance and **copayments**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a dental care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

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

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

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

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

This Plan is any part of the contract that provides benefits for dental care expenses.

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

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

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

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

Which Plan Pays First

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one **plan** is:

   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      - The plan of the **custodial parent**;
      - The plan of the spouse of the **custodial parent**;
      - The plan of the non**custodial parent**; and then
      - The plan of the spouse of the non**custodial parent**.

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

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

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan**,** the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

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

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

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

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

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

When You Have Medicare Coverage

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

Medicare, when used in this Booklet, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes coverage that is an authorized alternative to Parts A and B of **Medicare**

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

- Covered under it by reason of age, disability, or
- End Stage Renal Disease

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

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

When Medicare is Primary

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

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

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total **allowable expense**.

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

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

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

Right to Receive and Release Required Information

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

General Provisions

Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Type of Coverage

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

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive dental care services that are not, or might not be, covered.
- You cannot receive multiple coverage as Both an employee and a dependent; or
- A dependent of more than one employee
- under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the **Aetna** medical benefits plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The **Aetna** dental benefits plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this **Aetna** medical benefits plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this **Aetna** medical benefits plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this **Aetna** medical benefits plan.

Recovery of Overpayments

Dental Coverage

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

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

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

Reporting of Claims

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for dental benefits will not be covered if they are filed more than 1 year after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered dental benefits are payable to you. However, **Aetna** has the right to pay any dental benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

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

Records of Expenses

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing verbal or written consent to Aetna.

The claimant's appeal must be addressed as follows:
Aetna
Attn: Appeals Coordinator
PO Box 14597
Lexington, KY 40512

Level One Appeal - Group Dental Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim**, **a Pre-Service Claim**, **or a Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process
You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Dental Claims – Voluntary Appeals

You may file a voluntary **appeal** to the Company of any final standard **appeal** determination. You must complete all of the levels of standard appeal described above before you can file a voluntary appeal. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes, described above.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Appeal to the Company

If you choose to **appeal** to the Company following an **adverse determination** at the final level of standard **appeals**, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with your Dental Plan (including any EOBs); and
- Any applicable information that you have not yet sent to your Dental Plan.

If you file a voluntary appeal, you will be deemed to authorize the Company to obtain information from your Dental Plan relevant to your claim.

Mail your written appeal directly to:

Name: County of El Paso
Address: 800 E. Overland, Suite 223
El Paso, TX 79901

The Company will review your appeal. The Company reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The Company reviewer will follow relevant internal rules maintained by the applicable Dental Plan to the extent they do not conflict with its own internal guidelines.

The Company reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by the Company with respect to your claim shall be final and binding.

Glossary

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

A

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

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

C

Covered Person
Includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan." Please refer to the section of the booklet "Determining if you are in an Eligible Class" for more information.

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

Cosmetic
Services or supplies that alter, improve or enhance appearance.

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

D

Dental Provider
This is:

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

legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

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

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

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

E

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

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

It also includes the written informed consent used by:

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

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

H

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

I

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

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

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

J

Jaw Joint Disorder
This is:

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

M

Medically Necessary or Medical Necessity

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

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

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

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

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

N

Negotiated Charge

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

Network Provider

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

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

Network Service(s) or Supply(ies)

Dental care service or supply that is:

- Furnished by a **network provider**

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

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

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

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

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

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

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

Orthodontic Treatment
This is any:

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

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

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

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)
Dental care service or supply that is:

- Furnished by an **out-of network provider**.

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

P

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

Physician
A duly licensed member of a medical profession who:

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

This also includes a dental professional who:

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

Plus One Qualifying Adult
Plus One Qualifying Dependent eligibility is extended to an individual who meets all of the following criteria1. The Employee and Plus One Qualifying Adult must have resided together in the same residence for at least twelve consecutive months and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Employee and Plus One Qualifying Adult's Driver's License or Government issued Identification Card listing a common address must be provided to the Plan Administrator;

2. The Plus One Qualifying Adult must be eighteen years of age or older; and

3. The Plus One Qualifying Adult must be financially interdependent with the Employee, sharing common financial obligations, as evidenced by three or more of the following documents (Financial Interdependence Documents), and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Financial Interdependence Documents must be provided to the Plan Administrator:
    a. Joint deed or mortgage agreement to demonstrate common ownership or real property or a common leasehold interest in real property;
    b. A Title or Vehicle Registration showing common ownership of a motor vehicle;
    c. Proof of joint bank accounts or credit accounts;
    d. Proof of designation as the primary beneficiary for life insurance or retirements benefits;
    e. Assignment of a durable property power of attorney or health care power of attorney.
    f. Loss of Eligibility; Changes to Common Address or Financial Interdependence Documents. If the Employee and Plus One Qualifying Adult cease to reside together, or cease to share common

financial obligations described in the Financial Interdependence Documents, the Plus One Qualifying Adult is no longer eligible to be a Dependent of the Employee. The Employee has an affirmative duty to inform the Plan Administrator of the change in status within 31 days. If the information on the Financial Interdependence Documents or Driver's license or Government issued Identification Card changes, the Employee must notify the Plan Administrator within 31 days and provide copies of the new documents, or risk loss of eligibility for the Plus One Qualifying Adult.

g. Note: Federal and/or State tax implications may arise when enrolling a Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.
h. Ineligible Individuals
i. The following individuals are not eligible for designation as a Plus One Qualifying Adult:
j. Parents;
k. Parents' other descendants (siblings, nieces, nephews);
l. Grandparents and descendants (aunts, uncles, cousins);
m. Step relatives; or
n. Renters, boarders, tenants, employees of the County Employee.

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

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

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

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

R

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

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

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

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

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

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

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

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

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.
What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

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

R.N.
A registered nurse.

S

Service Waiting Period
Service Waiting Period shall mean an interval of time an Employee must be employed prior to becoming eligible to enroll in the Plan. The waiting period shall be 60 days of continuous full-time employment.

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

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

Specialty Care
Dental care services or supplies that require the services of a **specialist**.

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 determined by 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.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

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

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

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

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan 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 this Plan 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 this Plan only if and when this Plan gives its written consent.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and dental claims records
- Correct your health and dental claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health and dental care treatment you receive
- Pay for your health and dental services
- Administer your health and dental plan
- Help with public health and dental safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health or dental information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health and dental information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health/dental care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health and dental information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health and dental information about you to develop better services for you.

Pay for your health and dental services

We can use and disclose your health information as we pay for your health and dental services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health and dental information to our health plan administrator for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health and dental information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health and dental research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health and dental information about you with organ procurement organizations.
- We can share health and dental information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health and dental information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health and dental oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health and dental information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.