

# **BENEFIT PLAN**

**Prepared Exclusively For  
Avaya Inc.**

**Freedom of Choice Comprehensive Dental**

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



## **Comprehensive Dental Plan**

### **Booklet**

#### **Prepared exclusively for**

<b>Employer:</b>	Avaya Inc.
<b>Contract number:</b>	ASA-0100462
<b>Booklet:</b>	3
<b>Plan effective date:</b>	January 1, 2022
<b>Plan issue date:</b>	January 14, 2022

**Third Party Administrative Services provided by Aetna Life Insurance Company**

# Welcome

---

Thank you for choosing **Aetna**.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded plan for dental coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It replaces all booklets describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible dental services** and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded plan.

# Table of Contents

---

	<b>Page</b>
<b>Welcome</b>	
<b>Let's get started!</b>	1
<b>Who the plan covers</b>	3
<b>Medical necessity requirements</b>	6
<b>What are your eligible dental services?</b>	7
<b>What rules and limits apply to dental care?</b>	8
<b>What your plan doesn't cover - some eligible dental service exclusions</b>	11
<b>Who provides the care</b>	14
<b>What the plan pays and what you pay</b>	15
<b>Claim decisions and appeals procedures</b>	17
<b>Coordination of benefits (COB)</b>	20
<b>When coverage ends</b>	23
<b>Special coverage options after your plan coverage ends</b>	26
<b>General provisions – other things you should know</b>	31
<b>Glossary</b>	34
<b>Discount programs</b>	37
<b>Schedule of benefits</b>	<b>Issued with your booklet</b>

# Let's get started!

---

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

## Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna** when we are describing administrative services provided by **Aetna** as Third Party Administrator.
- Some words appear in **bold** type and we define them in the *Glossary* section.

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

## What your plan does – providing covered benefits

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

## How your plan works – starting and stopping coverage

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

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

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

## How your plan works while you are covered

Your coverage helps you get and pay for a lot of – but not all – dental care services. These are called **eligible dental services**.

Your dental plan has two plan options:

- The first option is a Managed dental plan. You must live or work inside the service area to be eligible for this plan. The service area is the geographic location of providers for the Managed dental plan.
- The second option is a Comprehensive dental plan.

You may choose either plan option, but you cannot be covered for both at the same time.

The choice you make for your coverage also applies to your covered dependents. You may request to switch from one plan to the other. You can call us at 1-877-238-6200 to make a change. The change will be effective as follows:

If we receive request	Change will be effective on
On or before the 15 <sup>th</sup> day of the month	The 1 <sup>st</sup> day of the next month
After the 15 <sup>th</sup> day of the month	The 1 <sup>st</sup> day of the month following the next month
Once the change is effective your <b>eligible dental services</b> are based on your current plan not your prior plan. Payments, services and supplies you received under the prior plan will be applied to coverage under the current plan.	

**Important note:**

See the schedule of benefits for any **deductibles, payment percentage,** and maximum age or visit limits that may apply.

**Eligible dental services**

**Eligible dental services** meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in the *What your plan doesn't cover – some eligible dental service exclusions* section. (We refer to this section as the “Exclusions” section.)
- They are not beyond any limits in the schedule of benefits.

**Dental providers**

You may choose any **dental provider** for the care you need.

For more information about the role of your **dental provider**, see the *Who provides the care* section.

**Paying for dental services– the general requirement**

The general requirement for the plan to pay any part of the expense for an **eligible dental service** is that the **dental service** is **medically necessary**.

You will find details on **medical necessity** requirements in the *Medical necessity* section.

**Paying for eligible dental services– sharing the expense**

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

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

**How to contact us for help**

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at [www.aetna.com](http://www.aetna.com)
- Registering for our secure Internet access to reliable dental information, tools and resources

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Aetna Member Services** at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

**Your member ID card**

You don't need to show an ID card. When visiting a **dentist**, just provide your name, date of birth and either your member ID or social security number. The dental office can use that information to verify your eligibility and benefits. Your member ID is located on the front of your digital ID card which you can view or print by going to the secure member website at [www.aetna.com](http://www.aetna.com). If you don't have internet access, call us at 1-877-238-6200. You can also access your ID card when you're on the go. To learn more, visit us at [www.aetna.com/mobile](http://www.aetna.com/mobile).

## Who the plan covers

---

You will find information in this section about:

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

### Who is eligible

Your Employer decides and tells us who is eligible for dental care coverage.

### When you can join the plan

As an employee you can enroll yourself and your dependents:

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

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

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet as your “dependents”.)

- Your legal spouse
- Your domestic partner who meets the rules set by the employer and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
  - Under age 26, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody

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

### Adding new dependents

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

- A spouse - if you marry, you can put your spouse on your plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your Employer when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date your Employer receives your completed enrollment information and

- Within 31 days of the date of your marriage.
- A domestic partner - if you enter a domestic partnership, you can enroll your domestic partner on your dental plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your Employer.
  - Ask your Employer when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.
- A newborn child – Your newborn child is covered on your dental plan for the first 31 days after birth.
  - To keep your newborn covered, your Employer must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- An adopted child – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to your Employer within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask your Employer when benefits for your stepchild will begin. It will be either on the date of your marriage, the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.

### **Notification of change in status**

It is important that you notify your Employer of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

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

### **Late entrant rule**

Your Employer’s plan does not cover services or supplies given to a person age 5 or older if that person did not enroll in the Employer’s plan during one of the following:

- The first 31 days the person is eligible for this coverage or
- Any period of open enrollment agreed to by your Employer

This does not apply to charges incurred for any of the following:

- After the person had been covered by your Employer’s plan for 12 months
- As a result of **injuries** sustained while covered by your Employer’s plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included).



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

You can enroll in these situations:

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

Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

## **Effective date of coverage**

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

## Medical necessity requirements

---

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

Your plan pays for its share of the expense for **eligible dental services** only if the **eligible dental service** is **medically necessary**.

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

### **Medically necessary / medical necessity**

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

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

## What are your eligible dental services?

---

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

Your plan covers many kinds of dental care services and supplies. Your **eligible dental services** are listed in the schedule of benefits. There you will find the detailed list of **eligible dental services**. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the *Exclusions* and the *What rules and limits apply to dental care* sections, and about the limitations in the schedule of benefits.

## What rules and limits apply to dental care?

---

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

### Alternate treatment rule

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

If a charge is made for a non-eligible dental service or supply and an **eligible dental service** that would provide an acceptable result, then your plan will pay a benefit for the **eligible dental service** or supply.

If a charge is made for an **eligible dental service** but another **eligible dental service** that would provide an acceptable result is less expensive, the benefit will be for the least expensive **eligible dental service**.

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

### Coverage for dental work begun before you are covered by the plan

Your 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
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

### Orthodontic treatment rule

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

This benefit does not cover charges for the following:

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

### Orthodontic limitation for late enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the 2 year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

## Reimbursement policies

We have the right to apply **Aetna** reimbursement policies. Those policies may reduce the **recognized charge**.

These policies take into account factors such as:

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

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

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of **providers** and **dentists** practicing in the relevant clinical areas

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

## Replacement rule

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

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

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

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - 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 items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

## What your plan doesn't cover – some eligible dental service exclusions

---

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

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

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

### Exclusions

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

- The *Eligible dental services under your plan* section of this booklet or
- A rider or amendment issued to you for use with this booklet:

#### Charges for services or supplies

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

#### Charges in excess of any benefit limits

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

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

- **Cosmetic** services and supplies including:
    - Plastic surgery
    - Reconstructive surgery
    - **Cosmetic** surgery
    - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
    - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons
- Facings on molar crowns and pontics will always be considered **cosmetic**

#### Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

## Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder**

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

- Under any other part of this plan
- Under any other plan of group benefits provided by the Customer

## Examinations

Any dental examinations needed:

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

## Experimental or investigational

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



### **Non-medically necessary services**

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

### **Other primary payer**

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

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

- Prescribed drugs, pre-medication or analgesia

### **Personal care, comfort or convenience items**

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

### **Providers and other health professionals**

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

### **Services paid under your medical plan**

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

### **Services provided by a family member**

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

### **Work related illness or injuries**

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

## Who provides the care

---

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

### Providers

When you need dental care, you can go to any **dental provider** to provide **eligible dental services** to you.

You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider**.

## What the plan pays and what you pay

---

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

- Your **deductible**
- Your **payment percentage**
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible dental service**.

### The general rule

When you get **eligible dental services**:

- You pay your **deductible**

And then

- Your plan and you share the expense up to any **Calendar Year** and **lifetime maximum**. The schedule of benefits lists how much you pay and how much your plan pays. The payment percentage may vary by the type of expense. Your share is called payment percentage.

And then

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

When we say “expense” in this general rule, we mean the **recognized charge**. See the *Glossary* section for what this term means.

### Important note – when you pay all

You pay the entire expense for an **eligible dental service** when you get a dental care service or supply that is not **medically necessary**. See the *Medical necessity requirements* section.

In all these cases, the **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **Calendar Year** or lifetime **maximum**.

### Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

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

### Where your schedule of benefits fits in

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

### How your deductible works

Your **deductible** is the amount you need to pay for **eligible dental services** per **Calendar Year** before your plan begins to pay for **eligible dental services**. Your schedule of benefits shows the **deductible** amounts for your plan.

### How your payment percentage works

Your **payment percentage** is the amount your plan pays for **eligible dental services** after you have paid your **deductible**. Your schedule of benefits shows you which **payment percentage** your plan will pay for specific **eligible dental services**.

#### **How your maximum works**

The maximum is the most your plan will pay for **eligible dental services** per **Calendar Year** and lifetime incurred by you or your covered dependent after any applicable **deductible** and **payment percentage**. You are responsible for any amounts above the **maximum**.

#### **Important note:**

See the schedule of benefits for any **deductibles, payment percentage**, maximum and maximum age, visit limits, and other limitations that may apply.

## Claim decisions and appeals procedures

---

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

When a claim comes in, your employer decides how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

### Claim procedures

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

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>You should notify get a claim from our self-service website or call us</li> <li>The claim form will provide instructions on how to complete and where to send the forms</li> </ul>	<ul style="list-style-type: none"> <li>You must send us notice and proof as soon as reasonably possible</li> <li>If you are unable to complete a claim form, you may send us:               <ul style="list-style-type: none"> <li>A description of services</li> <li>Bill of charges</li> <li>Any dental documentation you received from your <b>dental provider</b></li> </ul> </li> </ul>
<p>Proof of claim</p> <p>When you have received a service from an eligible <b>dental provider</b>, you will be charged.</p> <p>The information you receive for that service is your proof of loss.</p>	<ul style="list-style-type: none"> <li>A completed claim form and any additional information required by your employer</li> </ul>	<ul style="list-style-type: none"> <li>You must send us notice and proof as soon as reasonably possible</li> </ul>
Benefit payment	<ul style="list-style-type: none"> <li>Written proof must be provided for all benefits</li> <li>If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</li> </ul>	<ul style="list-style-type: none"> <li>Benefits will be paid as soon as the necessary proof to support the claim is received</li> </ul>

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

## Communicating our claim decisions

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

### Post-service claim

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

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

## Adverse benefit determinations

We pay many **provider** claims at the **recognized charge**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision".

If we make an adverse benefit determination, we will tell you in writing.

## The difference between a complaint and an appeal

### A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

### An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal by calling us.

## Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling us. You need to include:

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

### **Timeframes for deciding appeals**

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

<b>Type of notice</b>	<b>Post-service appeal</b>
Initial decision by us	30 days

### **Exhaustion of appeals process**

You must complete the appeal process with us before you can take these actions:

- Pursue arbitration, litigation or other type of administrative proceeding

### **Recordkeeping**

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

### **Fees and expenses**

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

## Coordination of benefits

---

Some people have dental coverage under more than one plan. If you do, we will work together with your other plans to decide how much each plan pays. This is called coordination of benefits (COB).

### Key terms

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

Allowable expense means:

- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

### Here’s how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

### Determining who pays

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

A plan that does not contain a COB provision is always the primary plan.



<b>If you are:</b>	<b>Primary plan</b>	<b>Secondary plan</b>
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent  You cannot be covered as an employee and dependent
<b>COB rules for dependent children</b>		
Child of: <ul style="list-style-type: none"> <li>Parents who are married or living together</li> </ul>	The "birthday rule" applies  The plan of the parent whose birthday* (month and day only) falls earlier in the <b>Calendar Year</b>  *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*  *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together</li> <li>With court-order</li> </ul>	The plan of the parent whom the court said is responsible for dental coverage  But if that parent has no coverage then their spouse's plan	The plan of the other parent  But if that parent has no coverage, then their spouse's plan is primary
Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</li> </ul>	Primary and secondary coverage is based on the birthday rule	
Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together and there is no court-order</li> </ul>	The order of benefit payments is: <ul style="list-style-type: none"> <li>The plan of the custodial parent pays first</li> <li>The plan of the spouse of the custodial parent (if any) pays second</li> <li>The plan of the noncustodial parents pays next</li> <li>The plan of the spouse of the noncustodial parent (if any) pays last</li> </ul>	
<ul style="list-style-type: none"> <li>Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)</li> </ul>	Treat the person the same as a parent when making the order of benefits determination:  See <i>Child of</i> content above	

Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)
-----------------------------	--	--

COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	

<b>How are benefits paid?</b>	
Primary plan	The primary plan pays your claims as if there is no other dental plan involved
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.  The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense

### **Other dental coverage updates – contact information**

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

### **Right to receive and release needed information**

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

### **Right to pay another carrier**

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

### **Right of recovery**

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules

## When coverage ends

---

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

### When will your coverage end?

Coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employer has notified us that your employment is ended
- You do not make any required contributions
- You become covered under another dental plan offered by your employer

## When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of <b>illness, injury</b>, sabbatical or other authorized leave as agreed to by your employer and us.</p>	<p>If required contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.</li> </ul>
<p>Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer.</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage will stop on the date that your employment ends.</li> </ul>
<p>Your employment ends because:</p> <ul style="list-style-type: none"> <li>Your job has been eliminated</li> <li>You have been placed on severance, or</li> <li>This plan allows former employees to continue their coverage.</li> </ul>	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid medical leave of absence</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue until stopped by your employer but not beyond 30 months from the start of the absence.</li> </ul>
<p>Your employment ends because of a leave of absence that is not a medical leave of absence</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.</li> </ul>
<p>Your employment ends because of a military leave of absence.</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue until stopped by your employer but not beyond 24 months from the start of the absence.</li> </ul>

It is your employer's responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees in writing to extend them.

## **When will coverage end for any dependents?**

Coverage for your dependent will end if:

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

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.

## **What happens to your covered dependents if you die?**

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

## **Why coverage could end for you and your dependents?**

Your employer may end your coverage for any number of reasons—for some reasons your employer will give you notice before terminating your coverage, for other reasons your employer may terminate your coverage immediately.

Your employer will give you 30 days advance written notice if your employer ends your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

## Special coverage options after your plan coverage ends

---

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

### Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

#### What are your COBRA rights?

COBRA gives some people the right to keep their dental coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to employer of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

<b>Qualifying event causing loss of coverage</b>	<b>Covered persons eligible for continued coverage</b>	<b>Length of continued coverage (starts from the day you lose current coverage)</b>
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree dental coverage and your former employer files for bankruptcy	You and your dependents	18 months

**When do I receive COBRA information?**

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

<b>Employer/Group dental plan notification requirements</b>		
<b>Notice</b>	<b>Requirement</b>	<b>Deadline</b>
General notice – employer or <b>Aetna</b>	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	<ul style="list-style-type: none"> <li>• Your active employment ends for reasons other than gross misconduct</li> <li>• Your working hours are reduced</li> <li>• You die</li> <li>• You are a retiree eligible for retiree dental coverage and your former employer files for bankruptcy</li> </ul>	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or <b>Aetna</b>	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – employer or <b>Aetna</b>	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – employer or <b>Aetna</b>	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

<b>You/your dependents notification requirements</b>		
Notice of qualifying event – qualified beneficiary	Notify the employer if: <ul style="list-style-type: none"> <li>You divorce or legally separate and are no longer responsible for dependent coverage</li> <li>Your covered dependent children no longer qualify as a dependent under the plan</li> </ul>	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: <ul style="list-style-type: none"> <li>The Social Security Administration determines that you or a covered dependent qualify for disability status</li> </ul>	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary’s status change to non-disabled	Notify the employer if: <ul style="list-style-type: none"> <li>The Social Security Administration decides that the beneficiary is no longer disabled</li> </ul>	Within 30 days of the Social Security Administration’s decision
Enrollment in COBRA	Notify the employer if: <ul style="list-style-type: none"> <li>You are electing COBRA</li> </ul>	60 days from the qualifying event. You will lose your right to elect, if you do not: <ul style="list-style-type: none"> <li>Respond within the 60 days</li> <li>And send back your application</li> </ul>

**How can you extend the length of your COBRA coverage?**

The chart below shows qualifying events after the start of COBRA (second qualifying events):

<b>Qualifying event</b>	<b>Person affected (qualifying beneficiary)</b>	<b>Total length of continued coverage</b>
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
<ul style="list-style-type: none"> <li>You die</li> <li>You divorce or legally separate and are no longer responsible for dependent coverage</li> <li>Your covered dependent children no longer qualify as dependent under the plan</li> </ul>	You and your dependents	Up to 36 months



### **How do you enroll in COBRA?**

You enroll by sending in an application and paying the **fee**. Your employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **fee**. If this is completed on time, you have enrolled in COBRA.

### **When is your first fee payment due?**

Your first **fee** payment must be made within 45 days after the date of the COBRA election.

### **How much will COBRA coverage cost?**

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

### **Can you add a dependent to your COBRA coverage?**

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required **fees**.

### **When does COBRA coverage end?**

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group dental plan.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

## **Continuation of coverage for other reasons**

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

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

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

Ordered means:

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

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

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

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support

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

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

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

Your disabled child's coverage will end:

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

### **How can you extend coverage for a child in college on medical leave?**

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**,
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to a serious **illness or injury**

We must receive documentation or certification of the **medical necessity** for a leave of absence:

- At least 30 days prior to the absence, if the medical reason for the absence and the absence are foreseeable, or
- 30 days after the start date of the medical leave of absence from school

The **physician** treating your child will be asked to keep us informed of any changes.

## General provisions – other things you should know

---

### Administrative provisions

#### How you and we will interpret this booklet

We prepared this booklet according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage, so long as we use reasonable discretion.

#### How we administer this plan

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

#### Who's responsible to you

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

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

### Coverage and services

#### Your coverage can change

Your coverage is defined by the **group contract**. This document may have amendments too. Under certain circumstances, employer or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person –the **provider** – can do this.

#### If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your employer any unearned **fee**.

#### Financial sanctions exclusions:

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

#### Legal action

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

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

#### Physical examinations and evaluations

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

#### Records of expenses

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

Things that would be important to keep are:

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

## **Honest mistakes and intentional deception**

### **Honest mistakes**

You or your employer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **fee** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

### **Intentional deception**

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

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

We also may report fraud to criminal authorities.

## **Some other money issues**

### **Assignment of benefits**

When you see a **provider** they will usually bill us directly. We may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to a **provider**.

### **Recovery of overpayments**

If a benefit payment is made by the Plan, to you 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. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

### **Payment of fees**

The first **fee** payment for this contract is due on or before your **effective date of coverage**. Your next **fee** payment will be due the 1<sup>st</sup> of each month ("**fee due date**"). Each **fee** payment is to be paid to us on or before the **fee due date**.

## Your dental information

We will protect your dental information. We will use it and share it with others to help us process your **providers'** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at 1-877-238-6200. When you accept coverage under this plan, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

## Effect of benefits under other plans

### Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the customer (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Dental coverage under this plan will continue uninterrupted for your dependent college student who takes a **medically necessary** leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend dental coverage for a child in college on medical leave?* section.

## Glossary

---

### **Aetna**

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

### **Calendar year**

A period of 12 months beginning on January 1<sup>st</sup> and ending on December 31<sup>st</sup>.

### **Contribution**

The amount you or the customer are required to pay to **Aetna** to continue coverage.

### **Cosmetic**

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

### **Covered benefits**

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

### **Deductible**

The amount you pay for **eligible dental services** per **Calendar Year** before your plan starts to pay.

### **Dental provider**

Any individual legally qualified to provide dental services or supplies.

### **Dentist**

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

### **Effective date of coverage**

The date you and your dependent's coverage begins under this booklet as noted in our records.

### **Eligible dental services**

The dental care services and supplies listed in the schedule of benefits and not listed or limited in the *What rules and limits apply to dental care* and *Exceptions* sections of this plan.

### **Experimental or investigational**

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

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

## Health professional

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

## Illness

Poor health resulting from disease of the teeth or gums.

## Injury or injuries

Physical damage done to the teeth or gums.

## Lifetime maximum

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

## Medically necessary/medical necessity

Dental care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that we determine are:

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

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:

- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

## Medicare

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

## Orthodontic treatment

This is any:

- Medical service or supply
- Dental service or supply

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer
- A surgical procedure to correct malocclusion

## Orthodontic treatment lifetime maximum

The most the plan will pay for **eligible dental services** for **orthodontic treatment** that you incur during your lifetime is called the **orthodontic treatment lifetime maximum**.

## Payment Percentage

The specific percentage we have to pay for **eligible dental services**.

## Physician

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

## Premium

The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

## Provider

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

## Recognized charge

Your plan's **recognized charge** applies to **eligible dental services**. In all cases, the **recognized charge** is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and 90% of the **prevailing charge rate**

Special terms used:

### Geographic area

The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

### Prevailing charge rate:

The 90<sup>th</sup> percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

### **Additional information:**

Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool to help decide whether to get care. **Aetna's** secure member website at [www.aetna.com](http://www.aetna.com) may contain additional information which may help you determine the cost of a service or supply. Log on to access the "Estimate the Cost of Care" feature. Within this feature, view our "Dental Cost of Care" tool.

## Temporomandibular joint dysfunction/disorder

This is:

- A **temporomandibular joint (TMJ) dysfunction/disorder** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves



## Discount programs

---

### Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

### Wellness and other incentives

We may encourage and incent you to access certain dental services, to use online tools that enhance your coverage and services and to continue participation as an **Aetna** member. You and your **provider** can talk about these dental services and decide if they are right for you. We may also encourage and incent you to participate in a wellness or health improvement program. Incentives may include but are not limited to:

- Modification to **deductible** or **payment percentage** amounts
- **Fee** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

# Additional Information Provided by

## Avaya Inc.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

**Name of Plan:**

The Avaya Inc. Dental Expense Plan

**Employer Identification Number:**

22-3713430

**Plan Number:**

550

**Type of Plan:**

Welfare

**Type of Administration:**

Administrative Services Contract with:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:**

Avaya Inc.  
350 Mount Kemble Avenue  
Morristown, NJ 07960  
Telephone Number: (908) 953-2385

**Agent For Service of Legal Process:**

Avaya Inc.  
350 Mount Kemble Avenue  
Morristown, NJ 07960

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

**End of Plan Year:**

December 31

**Source of Contributions:**

Employer and Employee

**Procedure for Amending the Plan:**

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

## **ERISA Rights**

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

### **Receive Information about Your Plan and Benefits**

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

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

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

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

### **Continue Group Health Plan Coverage**

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

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

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

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

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

person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Comprehensive Dental Expense Plan**

### **Schedule of benefits**

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

**Prepared exclusively for:**

<b>Employer:</b>	Avaya Inc.
<b>Contract number:</b>	ASA-0100462
<b>Schedule of Benefits:</b>	3A
<b>Plan effective date:</b>	January 1, 2022
<b>Plan issue date:</b>	January 14, 2022

**Third Party Administrative Services provided by Aetna Life Insurance Company**

## Schedule of benefits

---

This schedule of benefits lists the **eligible dental services, deductibles, payment percentage**, maximums, and any limits that apply to the services you get under this plan.

### How to read your schedule of benefits

- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflects the **deductibles** and **payment percentage** amounts under your plan.
- You must pay any **deductibles** and your part of the **payment percentage**.
- The **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the **payment percentage** amount the plan pays. You are responsible for paying any remaining **payment percentage**.
- You must pay the full amount of any dental care services you get that is not a **covered benefit** or that exceed your **Calendar Year** or **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits.

#### Important note:

All **covered benefits** are subject to a **Calendar Year deductible** and **payment percentage** unless otherwise noted in the schedule of benefits below.

### How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at [www.aetna.com](http://www.aetna.com).
- Call Member Services at 1-877-238-6200.

The coverage described in this schedule of benefits will be provided under the Customer's group plan. This schedule of benefits replaces any schedule of benefits previously in effect under the plan of benefits. Keep this schedule of benefits with your booklet.

## General coverage provisions

---

This section explains the:

- **Deductibles**
- **Payment percentage**
- **Maximums**

### Calendar Year deductible

#### Individual deductible

This is the amount you pay for **eligible dental services** each **Calendar Year** before the plan begins to pay. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. Once you have reached the **Calendar Year deductible**, this plan will begin to pay for **eligible dental services** for the rest of the **Calendar Year**.

#### Family deductible

When you and each of your covered dependents incur **eligible dental services** that apply towards the individual **Calendar Year deductibles**, these expenses will also count toward a family **deductible**.

To satisfy this family **deductible** for the rest of the **Calendar Year**, the following must happen:

- The combined **eligible dental services** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** in a **Calendar Year**.

When this happens in a **Calendar Year**, the individual **Calendar Year deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

### Payment percentage

Once any applicable **deductibles** have been met, the specific **payment percentage** the plan pays for **eligible dental services** is listed below.

### Orthodontic lifetime maximum

The most the plan will pay for orthodontic expenses incurred by any one covered person during their lifetime is called the orthodontic **lifetime maximum**.

### Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.



## Plan features

---

### Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

<b>Calendar Year deductible</b>	Individual \$50
The <b>Calendar Year deductible</b> applies to all <b>eligible dental services</b> except Type B expenses.	

### Lifetime orthodontic deductible

You have to meet your lifetime orthodontic **deductible** before this plan pays for benefits.

<b>Lifetime orthodontic deductible</b>	\$50
--	------

### Payment percentage

<b>Type B expenses</b>	100% of the <b>recognized charge</b>
<b>Type C expenses</b>	100% of the <b>scheduled amount</b>

### Orthodontic treatment payment percentage

<b>Orthodontic treatment payment percentage</b>	100% of the <b>scheduled amount</b>
---	-------------------------------------

### Calendar Year maximum

<b>Calendar Year maximum</b>	\$1,500
------------------------------	---------

### Orthodontic lifetime maximum

<b>Orthodontic lifetime maximum</b>	\$1,500
-------------------------------------	---------

## Eligible dental services

---

### **Type B expenses: Basic restorative care**

#### **Images and pathology**

- Periapical images
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue
- Bitewing images (2 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 36 months)

**Space maintainers** - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation and if you are under age 19.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

#### **Oral surgery**

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth
  - Soft tissue
  - Partially bony
  - Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Coronectomy

## **Type C expenses: Major restorative care**

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary 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. Coverage is limited to 1 per tooth every 5 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (excluding temporary crowns)
- Recementation
- Occlusal guard for bruxism
- Repairs – inlay, onlay, veneer, crown
- Repairs, full
- Repairs, partial denture
- Repairs, bridges
- Adding teeth and clasps to existing partial denture
- Adjustments, repair or relines of occlusal guard
- Core Build Up, including any pins

## **Periodontics**

- Clinical crown lengthening – hard tissue
- Periodontal maintenance (eligible if prior hx of eligible perio maintenance “or” hx of surgical periodontal procedures)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant
- Root planing and scaling, 4 or more teeth per quadrant
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant
- Gingival flap procedure, 1 to 3 teeth per quadrant
- Gingival flap procedure, 4 or more teeth per quadrant
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant
- Soft tissue graft procedure
- Distal wedge procedure

### **Visits and exams**

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit
- Oral evaluations, (2 visits per year or 2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of sodium fluoride (4 applications per year) or Topical application of stannous fluoride and Topical application of acid fluoride phosphate (1 application per year) and to employees and dependents.

### **Endodontics**

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment once per lifetime
  - Anterior
  - Bicuspid
  - Molar
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation
- Treatment of root canal obstruction
- Incomplete endodontic surgery
- Internal root repair of defect

**Prosthodontics** - The 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 5 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 5 years. (See the *Replacement rule*.)

- Bridge abutments
- 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 and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture

- Adjustment to denture more than 6 months after installation
- Cleaning and inspection of a removable appliance
- Implant

**General anesthesia and intravenous sedation**

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

**Type: Orthodontics treatment expenses**

- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Orthodontic retention
- Repair of orthodontic appliance

## **Additional eligible dental services**

---

We will provide additional **eligible dental services** if you and your covered dependent have at least one of the following conditions:

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

### **Additional eligible dental services:**

- Prophylaxis (cleaning) (one additional per **Calendar 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

### **Payment of benefits**

We will waive the **Calendar Year deductible** for the additional **eligible dental services** above. The **payment percentage** applied to the additional **eligible dental services** will be 100%.

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

## **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

## **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*









צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-888-982-3862. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)