BENEFIT PLAN

Prepared Exclusively For
Outten & Golden, LLP

PPO Dental

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™

This is your

PREFERRED PROVIDER ORGANIZATION CERTIFICATE OF COVERAGE

Issued by

Aetna Life Insurance Company

Prepared exclusively for

Policyholder:	Outten & Golden, LLP
Policyholder number:	GP-0149284-A
Certificate:	1
Group policy effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	November 10, 2021
Plan revision effective date:	January 1, 2022

This certificate of coverage ("**certificate**") explains the benefits available to you under a **group policy** between **Aetna Life Insurance Company** (hereinafter referred to as "we", "us", or "our") and the **group** listed in the **group policy**. This **certificate** is not a contract between you and us. Amendments, riders or endorsements may be delivered with the **certificate** or added thereafter.

This **certificate** offers you the option to receive covered **eligible dental services** on two benefit levels:

- **In-network benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when your care is provided by **participating providers** in-network. You should always consider receiving **eligible dental services** first through the in-network benefits portion of this **certificate**.
- **Out-of-network benefits.** The out-of-network benefits portion of this **certificate** provides coverage when you receive covered **eligible dental services** from **non-participating providers**. Your out-of-pocket expenses will be higher when you receive out-of-network benefits. You may have to pay for **eligible dental services** at the time that they are provided. You may 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**. In addition to **cost-sharing**, you will also be responsible for paying any difference between the **allowed amount** and the **non-participating provider's** charge.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This **certificate** is governed by the laws of New York State.

The insurance evidenced by this certificate provides DENTAL insurance ONLY.

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

- Logging onto your secure member website at 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.

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. 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.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Edward C. Lee

Vice President and Corporate Secretary

Table of Contents

SECTION I: Definitions

Defined terms will appear bolded throughout the **certificate**.

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

Allowed amount
The maximum amount on which our payment is based for covered **eligible dental services**. For **participating providers** this is based on a **negotiated charge** for a covered **eligible dental service**, or in the case of a **non-participating provider** on the **recognized charge**.

Appeal
A request for us to review a **utilization review** decision or a **grievance** again.

Balance billing
When a **non-participating provider** bills you for the difference between the **non-participating provider's** charge and the **allowed amount**. A **participating provider** may not **balance bill** you for **covered eligible dental services.**

Calendar year
A period of 12 months.

Calendar year maximum
This is the most this plan will pay for **eligible dental services** incurred by you during the **calendar year**.

Certificate
This **certificate** issued by Aetna Life Insurance Company, and any attached riders. The **certificate** explains the benefits available to you under the **group policy**.

Child, children
The **subscriber's children**, including any natural, adopted or step-children, unmarried disabled **children**, newborn **children**, or any other **children** as described in the *Who is Covered* section of this **certificate**.

Coinsurance
Your share of the costs of a covered **eligible dental service**, calculated as a percent of the **allowed amount** for the service that you are required to pay to a **provider**. The amount can vary by the type of covered **eligible service**.

Copayments
The specific dollar amount you have to pay for **eligible dental services**.

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

Cost-sharing
Amounts you must pay for covered **eligible dental services**, expressed as **copayments**, **deductibles** and/or **coinsurance**.

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

Deductible
The amount you owe before we begin to pay for covered **eligible dental services**. The **deductible** applies before any **copayments** or **coinsurance** are applied. The **deductible** may not apply to all covered **eligible dental services**. You may also have a **deductible** that applies to a specific covered **eligible dental service** that you owe before we begin to pay for a particular covered **eligible dental service**.

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

Dependents
The **subscriber's spouse** and **children.**

Directory
The list of **participating providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **Participating providers** may only be considered **participating providers** for certain **Aetna** plans.

Effective date of coverage
The date you and your **dependent's** coverage begins under this **certificate** as noted in our records.

Eligible dental services
The dental care services and supplies listed in the *Dental care* section and not listed or limited in the *Exclusions and rules* sections of this plan.

Emergency dental care
Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the *Dental care* section of this **certificate** for details.

Exclusions
Dental care services that we do not pay for or cover.

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 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.

External appeal agent

An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

General dentist

A **dentist** licensed under Title 8 of the New York State Education Law (or other comparable state law, if applicable) who is not a **specialist**.

Grievance

A complaint that you communicate to us that does not involve a **utilization review** determination.

Group

The employer or party that has entered into an agreement with us as a policyholder.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The **certificate**
- Any amendments to the **group policy** and the **certificate**

Health (care) 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.

Hospital
A short term, **acute**, general **hospital**, which:

- Is primarily engaged in providing, by or under the continuous supervision of **physicians**, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a **physician** or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a **hospitalization** review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such **hospitals**; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization
Care in a **hospita**l that requires admission as an inpatient and usually requires an overnight stay.

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

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

In-network coinsurance
Your share of the costs of a covered **eligible dental service**, calculated as a percent of the **allowed amount** for the covered **eligible dental service** that you are required to pay to a **participating provider**. The amount can vary by the type of covered **eligible dental service**.

In-network copayment
A fixed amount you pay directly to a **participating provider** for a covered **eligible dental service** when you receive the service. The amount can vary by the type of covered **eligible dental service**.

In-network deductible
The amount you owe before we begin to pay for covered **eligible dental services** received from **participating providers**. The **in-network deductible** applies before any **copayments** or **coinsurance** are applied. The **in-network deductible** may not apply to all covered **eligible dental services**. You may also have an **in-network deductible** that applies to a specific covered **eligible dental service** that you owe before we begin to pay for a particular covered **eligible dental service**.

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

Medically necessary
See the *How Your Coverage Works* section of this **certificate** for the definition.

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

Member
The subscriber or a covered **dependent** for whom required **premiums** have been paid. Whenever a **member** is required to provide a notice, "**member**" also means the **member's** authorized representative.

Negotiated charge
This is either:

- The amount an **participating provider** has agreed to accept
- The amount we agree to pay directly to an **participating provider** or third party vendor (including any administrative fee in the amount paid)

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

Non-participating provider
A **provider** who doesn't have a contract with us to provide services to you. You will pay more to see a **non-participating provider**.

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.

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** benefit.

Out-of-network coinsurance
Your share of the costs of a covered **eligible dental service** calculated as a percent of the **allowed amount** for the service that you are required to pay to a **non-participating provider**. The amount can vary by the type of covered **eligible dental service**.

Out-of-network deductible

The amount you owe before we begin to pay for covered **eligible dental services** received from **non-participating providers**. The **out-of-network deductible** applies before any **coinsurance** or **copayments** are applied. The **out-of-network deductible** may not apply to all covered **eligible dental services**. You may also have an **out-of-network deductible** that applies to a specific **covered eligible dental service** that you owe before we begin to pay for a particular covered **eligible dental service**.

Participating provider

A **provider** who has a contract with us to provide services to you. A list of **participating providers** and their locations is available on our website at www.aetna.com or upon your request to us. The list will be revised from time to time by us.

Physician or physician services

Health care services a licensed Medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan year

The 12-month period beginning on the effective date of the **certificate** or any anniversary date thereafter, during which the **certificate** is in effect.

Premium

The amount that must be paid for your dental insurance coverage.

Provider

An appropriately licensed, registered or certified **dentist**, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for covered **eligible dental services**. The **provider's** services must be rendered within the lawful scope of practice for that type of **provider** in order to be covered under this **certificate**.

Recognized charge

The amount of a **non-participating provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.

Your plan's **recognized charge** applies to all out-of-network **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**

The **recognized charge** for **providers** in the dental out-of-network savings program is the lesser of what the **provider** bills and the agreed upon rate for **providers**, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

Your out-of-network **cost-sharing** applies when you get care from dental out-of-network savings program **providers** except for **dental emergency services**.

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 90th 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 on www.aetna.com to help decide whether to get care in-network or out-of-network. **Aetna's** secure member website at 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.

Specialist
A **dentist** who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse
The person to whom the **subscriber** is legally married, including a same sex **spouse**. **Spouse** also includes a domestic partner.

Subscriber
The person whom this **certificate** is issued.

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

Utilization review
The review to determine whether services are or were **medically necessary** or **experimental or investigational** (including treatment for a rare disease or a clinical trial).

SECTION II: How your coverage works

Your coverage under this certificate

Your employer (referred to as the "**group**") has purchased a group dental insurance policy from us. We will provide the benefits described in this **certificate** to covered **members** of the **group**, that is, to employees of the **group** and/or their covered **dependents**. However, this **certificate** is not a contract between you and us. You should keep this **certificate** with your other important papers so that it is available for your future reference.

Covered eligible dental services

You will receive covered **eligible dental services** under the terms and conditions of this **certificate** only when the covered **eligible dental service** is:

- **Medically necessary**;
- Provided by a **participating provider** for in-network coverage;
- Provided by a **non-participating provider** for out-of-network coverage;
- Listed as a covered **eligible dental service**;
- Not in excess of any benefit limitations described in the *Dental care* section of this **certificate**; and
- Received while your **certificate** is in force.

Participating providers

We have contracted with dental **providers** to provide **eligible dental services** to you. These dental **providers** make up the network for your plan. For you to receive the network level of benefits you must use **participating providers** for **eligible dental services**.

The exceptions are:

- **Emergency dental care**
- An **participating providers** is not available to provide the service or supply that you need

To find out if a **provider** is a **participating provider**:

- Check your **provider directory**, available at your request;
- Call 1-877-238-6200; or
- Visit our website at www.aetna.com and search our online **directory**, DocFind®, for names and locations of **participating providers**.

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

Important note:
See the *Dental care* section for any **deductibles**, **coinsurance** and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Dental care* section.
- They are not carved out in the *Exclusions and rules* section. (We refer to this section as the "Exceptions" section.)
- They are not beyond any limits in the *Dental care* section.

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

Paying for dental services – the general requirement
There are general requirements for the plan to pay any part of the expense for an **eligible dental service** is that the **eligible 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 *Cost-sharing expenses and allowed amount* section, and see the *Dental care* section.

Access to providers and changing providers

Sometimes **providers** in our **provider directory** are not available. You should call the **provider** to make sure he or she is a **participating provider** and is accepting new patients.

To see a **provider**, call his or her office and tell the **provider** that you are an **Aetna member,** and explain the reason for your visit. The **provider's** office may ask you for your **group** or **Member** ID number.

If we do not have a participating provider for certain provider types in the county in which you live or in a bordering county that is within approved time and distance standards, we will approve a referral to a specific **non-participating provider** until you no longer need the care or we have a **participating provider** in our network that meets the time and distance standards and your care has been transitioned to that **participating provider**. Covered **eligible dental services** rendered by the **non-participating provider** will be paid as if they were provided by a **participating provider**. You will be responsible only for any applicable in-network **cost-sharing**.

Out-of-network services

We cover the services of **non-participating providers**. However, some services are only **covered** when you go to a **participating provider**. See the *Dental care* section of this **certificate** for the **non-participating provider** services that are covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

If you use a **non-participating provider** to receive **eligible dental services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

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
- Charges, expenses or costs in excess of the **negotiated charge** for in-network **covered benefits**

Services subject to preauthorization

Our preauthorization is not required before you receive certain covered **eligible dental services**.

Medical management

The benefits available to you under this **certificate** may be subject to retrospective reviews to determine when services should be covered by us. The purpose of these reviews is to promote the delivery of cost-effective dental care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered **eligible dental services** must be **medically necessary** for benefits to be provided.

Medical necessity

We **cover** benefits described in this **certificate** as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is **medically necessary**. The fact that a **provider** has furnished, prescribed, ordered, recommended, or approved the service does not make it **medically necessary** or mean that we have to cover it.

We may base our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of **health care professionals** in the generally-recognized health specialty involved;
- The opinion of the attending **providers**, which have credence but do not overrule contrary opinions.

Services will be deemed **medically necessary** only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of you, your family, or your **provider**;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results.

See the **utilization review** and external **appeal** sections of this **certificate** for your right to an internal **appeal** and external **appeal** of our determination that a service is not **medically necessary**.

Important telephone numbers and addresses

- Claims
  Aetna
  P.O. Box 14094
  Lexington, KY 40512-4094
  (Submit claim forms to this address)

- Complaints, grievances, and utilization review/appeals
  1-800-558-0860

- Member Services
  1-877-238-6200
  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 6:00 p.m.)

- Our website
  www.aetna.com

SECTION III: Cost-sharing expenses and allowed amount

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**. The *Dental care* section shows the **deductible** amounts for your plan.

How we count your deductible
When you see **participating providers**, we count the **negotiated charge** toward your in-network **deductible**. When you see a **non-participating provider**, we count the **recognized charge** toward your **out-of-network deductible**.

Calendar Year deductible
Eligible dental services applied to the out-of-network **deductibles** will be applied to satisfy the network **deductibles**. **Eligible dental services** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

Individual deductible
This is the amount you pay for in-network and out-of-network **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**.

Coinsurance
Your **coinsurance** is the percentage of the **allowed amount** your plan pays for **eligible dental services** after you have paid your **deductible**. The *Dental care* section shows you which **coinsurance** your plan will pay for specific **eligible dental services**.

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

Dental Emergency

Coverage is also provided for a **dental emergency**. **Eligible dental services** include dental services provided for a **dental emergency**. Services and supplies provided for a **dental emergency** will be covered even if services and supplies are provided by a **non-participating provider**.

If you have a **dental emergency**, you may get treatment from any **dentist**. You should consider calling your dental **participating providers** who may be more familiar with your dental needs. If you can't reach your dental **participating providers** or are away from home, you may get treatment from any **dentist**. You may also call Member Services for help in finding a **dentist**.

The care provided must be a covered eligible dental service or supply. If you get treatment from a **non-participating provider**, the plan pays a benefit at the network level of coverage up to the **dental emergency services maximum**. Any charges above the emergency maximum will be paid at the out-of-network level. For follow-up care to treat the **dental emergency**, services will be paid at the appropriate **coinsurance** level. To get the maximum level of benefits, services should be provided by your **participating providers**.

Allowed amount

When you get **eligible dental services**:

- You pay your **deductible**

  And then

- Your plan and you share the expense up to any **calendar** and **lifetime maximum**. The Dental *care* section lists how much your plan pays. The **coinsurance** percentage may vary by the type of expense. Your share is called **coinsurance** percentage.

  And then

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

When we say "expense" in the section above, we mean the **negotiated charge** for **participating providers**, and **recognized charge** for a **non-participating provider**.

SECTION IV: Who is covered

Who is covered under this certificate

You, the **subscriber** to whom this **certificate** is issued, are covered under this **certificate**. **Members** of your family may also be covered depending on the type of coverage you selected.

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

Types of coverage

We offer the following types of coverage:

- Individual - If you selected individual coverage, then you are covered.
- Individual and **spouse** - If you selected individual and **spouse** coverage, then you and your **Spouse** are covered.
- Parent and **child(ren)** - If you selected parent and **child(ren)** coverage, then you and your **child** or **children**, as described below, are covered.
- Family - If you selected family coverage, then you and your **spouse** and your **child** or **children**, as described below, are covered.

Coverage lasts until the end of the month in which the **child** turns 26 years of age.

Any unmarried **dependent child**, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the **child's** coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance, will remain covered while your insurance remains in force and your **child** remains in such condition.

You have 31 days from the date of your **child's** attainment of the termination age to submit an application to request that the **child** be included in your coverage and proof of the **child's** incapacity. We have the right to check whether a **child** is and continues to qualify under this section.

Coverage lasts until the end of the month in which the **child** turns 19 years of age. Any unmarried **child** who is a student at an accredited institution of learning is considered a **child** until age 26 and coverage will last until the end of the month in which the **child** turns 26 years of age.

Any unmarried **dependent child**, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the **child's** coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance, will remain covered while your insurance remains in force and your **child** remains in such condition.

You have 31 days from the date of your **child's** attainment of the termination age to submit an application to request that the **child** be included in your coverage and proof of the **child's** incapacity. We have the right to check whether a **child** is and continues to qualify under this section.

Coverage shall continue for a **child** who is a full-time student when the **child** takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the **child** is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, we may require that the leave be certified as medically necessary by the **child**'s physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered **subscriber** and all other prospective or covered **members** in relation to eligibility for coverage under this **certificate** at any time.

When coverage begins

Coverage under this **certificate** will begin as follows:

As a **subscribe**r you can enroll yourself and your **dependents**:

- At the end of any waiting period the policyholder requires
- At any time
- Once each **Calendar Year** during the annual enrollment period
- At other special times during the year (see the *Special enrollment period* section below)

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information 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.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child or adopted child - If you have a newborn or adopted child and we receive the notice of such birth within 31 days thereafter, coverage for your newborn starts at the moment of birth; otherwise coverage begins on the date on which we receive notice.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked.

- If you have individual or individual and spouse coverage, you must also notify us of your desire to switch to parent and child/children or family coverage and pay any additional Premium within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which we receive notice, provided that you pay any additional Premium when due.

- A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage, the date of your civil union partnership or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information. To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage, civil union or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have dental benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your stepchild's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.
- **Dependent** coverage due to a court order: If you must provide coverage to a **dependent** because of a court order, your **dependent** is covered on your dental plan for the first 31 days from the court order.
  - To keep your **dependent** covered, we must receive your completed enrollment information within 31 days of the court order.
  - You must still enroll the **dependent** within 31 days of the court order even when coverage does not require payment of an additional **premium** contribution for the **dependent.**
  - If you miss this deadline, your **dependent** will not have dental benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your **dependent's** coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Inform us of any changes

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

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

Late entrant rule

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

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

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

Special enrollment periods

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.

Domestic partner coverage

This **certificate** covers domestic partners of **subscribers** as **spouses**. If you selected family coverage, **children** covered under this **certificate** also includes the **children** of your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

- Registration as a domestic partnership indicating that neither individual has been registered as a **member** of another domestic partnership within the last six (6) months, where such registry exists; or:
- For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
  - The affidavit must be notarized and must contain the following:
    - The partners are both 18 years of age or older and are mentally competent to consent to contract;
    - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
    - The partners have been living together on a continuous basis prior to the date of the application;
    - Neither individual has been registered as a **member** of another domestic partnership within the last six (6) months; and
  - Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
  - Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
    - A joint bank account;
    - A joint credit card or charge card;
    - Joint obligation on a loan;
    - Status as an authorized signatory on the partner's bank account, credit card or charge card;
    - Joint ownership of holdings or investments;
    - Joint ownership of residence;
    - Joint ownership of real estate other than residence;
    - Listing of both partners as tenants on the lease of the shared residence;
    - Shared rental payments of residence (need not be shared 50/50);
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
    - Shared household budget for purposes of receiving government benefits;
    - Status of one (1) as representative payee for the other's government benefits;
    - Joint ownership of major items of personal property (e.g., appliances, furniture);
    - Joint ownership of a motor vehicle;
    - Joint responsibility for child care (e.g., school documents, guardianship);
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
    - Execution of wills naming each other as executor and/or beneficiary;
    - Designation as beneficiary under the other's life insurance policy;
    - Designation as beneficiary under the other's retirement benefits account;
    - Mutual grant of durable power of attorney;
    - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
    - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
    - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION V: Dental Care

Calendar Year deductible

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

	In-network coverage	**Out-of-network coverage**
Calendar Year deductible	Individual **$50** Family $150	Individual **$50** Family $150

The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses.

Coinsurance

The **coinsurance** listed below reflects your **coinsurance** percentage. This is the **coinsurance** amount that you pay. The plan is responsible for paying any remaining **coinsurance**.

	In-network coverage	**Out-of-network coverage**
Type A expenses	0% of the **negotiated charge**	0% of the **recognized charge**
Type B expenses	0% of the **negotiated charge**	20% of the **recognized charge**
Type C expenses	40% of the **negotiated charge**	50% of the **recognized charge**

Orthodontic treatment coinsurance

	In-network coverage	**Out-of-network coverage**
Orthodontic treatment coinsurance	50% of the **negotiated charge**	50% of the **recognized charge**

Calendar Year maximum benefit

	In-network coverage	**Out-of-network coverage**
Calendar Year maximum benefit	$2,250	$2,250

Dental emergency maximum benefit

	In-network coverage	**Out-of-network coverage**
Dental emergency maximum benefit	N/A	$75

Orthodontic lifetime maximum benefit

	In-network coverage	**Out-of-network coverage**
Orthodontic lifetime maximum benefit	$1,500	$1,500

Dental care

Type A expenses: Diagnostic & preventive care

Visits and exams

- Oral evaluations, (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 application per year)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)
- Scaling – moderate/severe inflammation, full mouth (2 treatments per year, frequency combined with prophylaxis)

Space maintainers - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

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

Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Type B expenses: Basic restorative care

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

Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative – Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- 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 (primary teeth only, excludes temporary crowns)
- Recementation

Oral surgery

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth – Soft tissue
- Removal of impacted tooth – Partially bony
- Removal of impacted tooth – 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
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Coronectomy

Periodontics

- Periodontal maintenance (following active therapy, 2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root 26lanning and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root 26lanning and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)

- 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 (1 per site every 3 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Clinical Crown Lengthening – Hard Tissue
- Full Mouth Debridement (limited to 1 per lifetime)

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid
  - Molar
- Pulpal regeneration
- Hemisection
- Retrograde filling
- Root amputation

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

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service - Only for impacted wisdom teeth procedure

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 8 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs – inlay, onlay, veneer, crown
- Core Buildup

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 8 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 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
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

Type: Orthodontics treatment expenses

- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**
- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Appliance therapy to control harmful habits
- 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 **coinsurance** applied to the additional **eligible dental services** will be 0% for in-network coverage and 0% for out-of-network coverage.

SECTION VI: Exclusions and rules

Exclusions

No coverage is available under this **certificate** for the following:

Cosmetic services

We do not **cover cosmetic** services or surgery unless otherwise specified, except that **cosmetic** surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered **child** which has resulted in a functional defect . **Cosmetic** surgery does not include surgery determined to be **medically necessary**. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the **utilization review** process in the **utilization review** and external **appeal** sections of this **certificate** unless medical information is submitted.

Experimental or investigational treatment

We do not **cover** any dental care service, procedure, treatment, or device that is **experimental or investigational**. However, we will cover **experimental or investigational** treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an **external appeal agent** certified by the State. However, for clinical trials, we will not **cover** the costs of any **investigational** drugs or devices, non-dental services required for you to receive the treatment, the costs of managing the research, or costs that would not be **covered** under this **certificate** for non-investigational treatments. See the *Utilization review* and *External appeal* sections of this **certificate** for a further explanation of your **appeal** rights.

Felony participation

We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.

Government facility

We do not cover care or treatment provided in a **hospital** that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

Medical services
We do not cover medical services or dental services that are medical in nature, including any **hospital** charges or prescription drug charges.

Medically necessary
In general, we will not cover any dental service, procedure, treatment, test or device that we determine is not **medically necessary**. If an **external appeal agent** certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise covered under the terms of this **certificate**.

Military service
We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

Services not listed
We do not cover services that are not listed in this **certificate** as being covered.

Services provided by a family member
We do not cover services performed by a member of the **member's** immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your **spouse**.

Workers' compensation
We do not **cover** services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Rules
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**.

The benefit will be based on the **participating provider's negotiated charge** for the e**ligible dental service** or, in the case of an **non-participating provider**, on the **recognized charge**.

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.

If we determine that an alternative procedure or treatment is more appropriate than the requested service, you may **appeal** our decision through an internal **appeal** or external **appeal**. See the **utilization review** and external **appeal** sections of this **certificate** for your right to an internal **appeal** and external **appeal**.

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”)

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

Orthodontic limitation 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 1 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 **negotiated charge** or **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:

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

relating to teeth that are part of the normal complement of 32.

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 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 8 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 8 years.
- And the tooth that was removed is part of the normal complement of 32.

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

Treatment of temporomandibular joint dysfunction/disorder

Treatment is covered as a Specialty Service. This includes treatments which alter the jaw, jaw joints, or bite relationships. The following are covered:

- Diagnosis
- Applicable therapy
- Non-invasive physical therapy
- Other surgical and non-surgical treatment

Not included are charges incurred for:

- **Orthodontic treatment**
- Crowns, bridges and dentures
- Treatment of periodontal disease
- Implants
- Root canal therapy

SECTION VII: Claim determinations

Claims

A claim is a request that benefits or services be provided or paid according to the terms of this **certificate**. When you receive services from a **participating provider**, you will not need to submit a claim form. However, if you receive services from a **non-participating provider**, either you or the **provider** must file a claim form with us. If the **non-participating provider** is not willing to file the claim form, you will need to file it with us. See the *Coordination of benefits* section of this **certificate** for information on how we coordinate benefit payments when you also have coverage with another plan.

Notice of claim

Claims for services must include all information designated by us as necessary to process the claim, including, but not limited to:

- **Member** identification number
- Name
- Date of birth
- Date of service
- Type of service
- The charge for each service
- Procedure code for the service as applicable
- Diagnosis code
- Name and address of the **provider** making the charge; and
- Supporting medical records, when necessary

A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from us by calling 1-877-238-6200, the number on your ID card or visiting our website at www.aetna.com. Completed claim forms should be sent to the address in the *How your coverage works* section of this **certificate**. You may also submit a claim to us electronically by visiting our website, www.aetna.com.

Timeframe for filing claims

Claims for services must be submitted to us for payment within 120 days after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, you must submit it as soon as reasonably possible.

Claims for prohibited referrals

We are not required to pay any claim, bill or other demand or request by a **provider** for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

Claim determinations

Our claim determination procedure applies to all claims that do not relate to a **medical necessity** or **experimental or investigational** determination. For example, our claim determination procedure applies to contractual benefit denials. If you disagree with our claim determination, you may submit a **grievance** pursuant to the *Grievance procedures* section of this **certificate**.

For a description of the **utilization review** procedures and **appeal** process for **medical necessity** or **experimental or investigational** determinations, see the *Utilization review and External appeal* sections of this **certificate**.

Pre-service claim determinations

A pre-service claim is a request that a service or treatment be approved before it has been received. If we have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), we will make a determination and provide notice to you (or your authorized representative) within 15 days from receipt of the claim.

If we need additional information, we will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If we receive the information within 45 days, we will make a determination and provide notice to you (or your authorized representative) in writing, within 15 days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

Urgent pre-service reviews

With respect to urgent pre-service requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your authorized representative) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If we need additional information, we will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your authorized representative) by telephone within 48 hours of the earlier of the earlier of our receipt of the information of the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

Post-service claim determinations

A post-service claim is a request for a service or treatment that you have already received. If we have all information necessary to make a determination regarding a post-service claim, we will make a determination and notify you (or your authorized representative) within 30 calendar days of the receipt of the claim if we deny the claim in whole or in part. If we need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information.

We will make a determination and provide notice to you (or your authorized representative) in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period if we deny the claim in whole or in part.

Payment of claims

Where our obligation to pay a claim is reasonably clear, we will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If we request additional information, we will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION VIII: Grievance procedures

Grievances

Our **grievance** procedure applies to any issue not relating to a **medical necessity** or **experimental or investigational** determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to **providers**.

Filing a grievance

You can contact us by phone at 1-877-238-6200; or in writing to file a **grievance**. You may submit an oral **grievance** in connection with a denial of a covered benefit determination. We may require that you sign a written acknowledgement of your oral **grievance**, prepared by us. You or your authorized representative has up to 180 calendar days from when you received the decision you are asking us to review to file the **grievance**.

When we receive your **grievance**, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your **grievance**, and indicate what additional information, if any, must be provided.
We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited **grievances**, depending on the nature of your inquiry.

Grievance determination

Qualified personnel will review your **grievance**, or if it is a clinical matter, a licensed, certified or registered **health care professional** will look into it. We will decide the **grievance** and notify you within the following timeframes:

Expedited/urgent **grievances**:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your **grievance**.
Pre-service **grievance**: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of your **grievance**.
Post-service **grievances**: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of your **grievance**.
All other **grievances**: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your **grievance**.

Grievance appeals

If you are not satisfied with the resolution of your **grievance**, you or your authorized representative may file an **appeal** by phone at 1-877-238-6200 or in writing. You have up to 60 business days from receipt of the **grievance** determination to file an **appeal**.

When we receive your **appeal**, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your **appeal** and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the **grievance** determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the **appeal** and notify you in writing within the following timeframes:

Expedited/urgent **grievances**:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of your **appeal**.
Pre-service **grievances**: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of your **appeal**.
Post-service **grievances**: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of your **appeal**.
All other **grievances**: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

Assistance

If you remain dissatisfied with our **appeal** determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If you need assistance filing a **grievance** or **appeal**, you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION IX: Utilization review

Utilization review

We review **eligible dental services** to determine whether the services are or were **medically necessary** or **experimental or investigational** ("**medically necessary**"). This process is called **utilization review**. **Utilization review** includes review of activities after the service id performed (retrospective). Under this **certificate**, we only review activities after the service is performed. If you have any questions about the **utilization review** process, please call 1-877-238-6200. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that **eligible dental services** are not **medically necessary** will be made by:

- Licensed **physicians**; or
- Licensed, certified, registered or credentialed **health care professionals** who are in the same profession and same or similar specialty as the **provider** who typically manages your dental condition or disease or provides the dental care service under review.

We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not **medically necessary**. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, call 1-877-238-6200 or visit our website at www.aetna.com.

Preauthorization Reviews

Non-Urgent Preauthorization Reviews: If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone and in writing, within three (3) business days of receipt of the request.

If we need additional information, we will request it within three (3) business days. You or your **provider** will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45- day period.

Urgent Preauthorization Reviews: With respect to urgent Preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or your **provider** will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your authorized representative) and your **provider** by telephone within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. Written notification will be provided within the earlier of three (3) business days of our receipt of the information or three (3) calendar days after the verbal notification.

Concurrent Reviews

Non-Urgent Concurrent Reviews: Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your authorized representative) and your **provider**, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your **provider** will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or your authorized representative) and your **provider**, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

Urgent Concurrent Reviews: For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you (or your authorized representative) and your **provider** by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and we have all the information necessary to make a determination, we will make a determination and provide written notice to you (or your authorized representative) and your **provider** within the earlier of 72 hours or of one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. You or your **provider** will then have 48 hours to submit the information. We will make a determination and provide written notice to you (or your authorized representative) and your **provider** within the earlier of one (1) business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your **provider** within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your **provider** will then have 45 calendar days to provide the information.

We will make a determination and provide notice to you and your **provider** in writing within 15 calendar days of the earlier of our receipt of all or part of the requested information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a **utilization review** determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal **appeal**.

Reconsideration

If we did not attempt to consult with your **provider** who recommended the **covered eligible dental service** before making an adverse determination, the **provider** may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. If the adverse determination is upheld, a notice of adverse determination will be given to you and your **provider**, by telephone and in writing.

Utilization review internal appeals

You, your authorized representative, and, in retrospective review cases, your **provider**, may request an internal **appeal** of an adverse determination, either by phone or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an **appeal**.

We will acknowledge your request for an internal **appeal** within 15 calendar days of receipt.
This acknowledgment will, if necessary, inform you of any additional information needed before a decision can be made. The **appeal** will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is:

- A **physician**; or
- A **health care professional** in the same or similar specialty as the **provider** who typically manages the disease or condition at issue.

Preauthorization appeal

- If your **appeal** relates to a preauthorization request, we will decide the **appeal** within 30 calendar days of receipt of the **appeal** request.
- Written notice of the determination will be provided to you (or your authorized representative), and where appropriate, your **provider**, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

Retrospective appeal

- If your **appeal** relates to a retrospective claim, we will decide the **appeal** within 60 calendar days of receipt of the **appeal** request.
- Written notice of the determination will be provided to you (or your authorized representative), and where appropriate, your **provider**, within 2 business days after the determination is made, but no later than 60 calendar days after receipt of the **appeal** request.

Expedited appeal

- An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.
- An expedited appeal is not available for retrospective reviews.
- For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax.
- An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

Full and fair review of an appeal

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appeal assistance

If you need assistance filing an **appeal**, you may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or email cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION X: External appeal

Your right to an external appeal

In some cases, you have a right to an external **appeal** of a denial of coverage. If we have denied coverage on the basis that a service is not **medically necessary** (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an **experimental or investigational** treatment (including clinical trials and treatments for rare diseases). You or your authorized representative may appeal that decision to an **external appeal agent**, an independent third party certified by the State to conduct these **appeals**.

In order for you to be eligible for an external **appeal** you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered **eligible dental service** under this **certificate**; and
- In general, you must have received a final adverse determination through our internal **appeal** process. But, you can file an external **appeal** even though you have not received a final adverse determination through our internal **appeal** process if:
  - We agree in writing to waive the internal **appeal**. We are not required to agree to your request to waive the internal **appeal**; or
  - We fail to adhere to **utilization review** claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your right to appeal a determination that an eligible dental service is not medically necessary

If we have denied coverage on the basis that the service is not **medically necessary**, you may **appeal** to an **external appeal agent** if you meet the requirements for an external **appeal** as described above.

Your right to appeal a determination that an eligible dental service is experimental or investigational

If we have denied coverage on the basis that the **eligible dental service** is an **experimental or investigational** treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external **appeal** as described above and your attending **physician** must certify that your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by us; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending **physician** must have recommended one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered **eligible dental service** (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending **physician** certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending **physician** must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending **physician** must be a licensed, board-certified or board eligible **physician** qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending **physician** may not be your treating **physician**.

The external appeal process

You have 4 months from receipt of a final adverse determination or from receipt of a waiver of the internal **appeal** process to file a written request for an external **appeal**. If you are filing an external **appeal** based on our failure to adhere to claim processing requirements, You have 4 months from such failure to file a written request for an external **appeal**.

We will provide an external **appeal** application with the final adverse determination issued through our internal **appeal** process or our written waiver of an internal **appeal**. You may also request an external **appeal** application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external **appeal**, the State will forward the request to a certified **external appeal agent**.

You can submit additional documentation with your external **appeal** request. If the **external appeal agent** determines that the information you submit represents a material change from the information on which we based our denial, the **external appeal agent** will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have 3 business days to amend or confirm our decision. Please note that in the case of an expedited external **appeal** (described below), we do not have a right to reconsider our decision.

In general, the **external appeal agent** must make a decision within 30 days of receipt of your completed application. The **external appeal agent** may request additional information from you, your **physician**, or us. If the **external appeal agent** requests additional information, it will have 5 additional business days to make its decision. The **external appeal agent** must notify you in writing of its decision within 2 business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external **appeal**. In that case, the **external appeal agent** must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and us by telephone or facsimile of that decision. The **external appeal agent** must also notify you in writing of its decision.

If the **external appeal agent** overturns our decision that a service is not **medically necessary** or approves coverage of an **experimental or investigational** treatment, we will provide coverage subject to the other terms and conditions of this **certificate**. Please note that if the **external appeal agent** approves coverage of an **experimental or investigational** treatment that is part of a clinical trial, we will only **cover** the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this **certificate** for non-investigational treatments provided in the clinical trial.

The **external appeal agent's** decision is binding on both you and us. The **external appeal agent's** decision is admissible in any court proceeding.

Your responsibilities

It is your responsibility to start the external **appeal** process. You may start the external **appeal** process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within 4 months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XI: Coordination of benefits (COB)

This section applies when you also have group coverage with another plan that offers dental benefits. When you receive a covered **eligible dental service**, we will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions

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

An "allowable expense" is:

- The necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

A "plan" is:

- Other group dental coverage with which we will coordinate benefits.
- The term "plan" includes:
  - Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
  - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
  - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

A "Primary plan" is:

- One whose benefits must be determined without taking the existence of any other plan into consideration.
- A plan is primary if either:
  - The plan has no order of benefits rules or its rules differ from those required by regulation; or
  - All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

A "secondary plan" is:

- One which is not a primary plan.
- If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to determine order of payment

The first of the rules listed in the paragraphs below that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the **subscriber** and is only covered as a **dependent** under the other plan, this **certificate** will be primary.
- If a **child** is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a **child** is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the **child's** dental care expenses:
  - The plan of the parent who has custody will be primary;
  - If the parent with custody has remarried, and the **child** is also covered as a **child** under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
  - If a court decree between the parents says which parent is responsible for the **child's** dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
- If the person receiving services is covered under one plan as an active employee or **member** (i.e., not laid-off or retired), or as the **spouse** or **child** of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the **spouse** or **child** of such a laid-off or retired employee, the plan that covers such person as an active employee or **spouse** or **child** of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed our maximum available benefit for each covered **eligible dental service**. Also, the amount we pay will not be more than the amount we would pay if we were primary. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to receive and release necessary information

We may release or receive information that we need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give us any needed information for coordination purposes, in the time frame requested.

Our right to recover overpayment

If we made a payment as a primary plan, you agree to pay us any amount by which we should have reduced our payment. Also, we may recover any overpayment from the primary plan or the **provider** receiving payment and you agree to sign all documents necessary to help us recover any overpayment.

Coordination with "always excess," "always secondary," or "non-complying" plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this **certificate** is primary, as defined in this section, we will pay benefits first.
- If this **certificate** is secondary, as defined in this section, we will pay only the amount we would pay as the secondary insurer.
- If we request information from a non-complying plan and do not receive it within 30 days, we will calculate the amount we should pay on the assumption that the non-complying plan and this **certificate** provide identical benefits. When the information is received, we will make any necessary adjustments.

SECTION XII: Termination of coverage

Coverage under this **certificate** will automatically be terminated on the first of the following to apply:

- The **group** and/or **subscriber** has failed to pay **premiums** within 30 days of when **premiums** are due. Coverage will terminate as of the last day for which **premiums** were paid.
- The date on which the **subscriber** ceases to meet the eligibility requirements as defined by the **group**.
- Upon the **subscriber's** death, coverage will terminate unless the **subscriber** has coverage for **dependents**. If the **subscriber** has coverage for **dependents**, then coverage will terminate as of the last day of the month for which the **premium** has been paid.
- For **spouses** in cases of divorce, the date of the divorce.
- For **children**, until the end of the month in which the **child** turns 26 years of age.
- For all other **dependents**, the day the **dependent** ceases to be eligible.
- The end of the month during which the **group** or **subscriber** provides written notice to us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If the **subscriber** has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by us to the **subscriber**. However, if the **subscriber** makes a misrepresentation of material fact in writing on his or her enrollment application we will rescind coverage if the facts misrepresented would have led us to refuse to issue the coverage. Rescission means that the termination of your coverage will have a retroactive effect of up to your enrollment under the **certificate**. If termination is a result of the **subscriber's** action, coverage will terminate for the **subscriber** and any **dependents**. If termination is a result of the **dependent's** action, coverage will terminate for the **dependent**.
- The date that the **group policy** is terminated. If we terminate and/or decide to stop offering a particular class of **group policies**, without regard to claims experience or health related status, to which this **certificate** belongs, we will provide the **group** and **subscribers** at least 30 days' prior written notice.
- The **group** has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
- The **group** has failed to comply with a material plan provision relating to **group** participation rules. We will provide written notice to the **group** and **subscriber** at least 30 days prior to when the coverage will cease.
- The **group** ceases to meet the statutory requirements to be defined as a **group** for the purposes of obtaining coverage. We will provide written notice to the **group** and **subscriber** at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the *Continuation of coverage* section of this **certificate** for your right to continuation of this coverage under COBRA or USERRA.

SECTION XIII: Extension of Benefits

Your dental coverage may end, whether due to termination of eligibility, or termination of the **certificate** 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-sustaining employment because of mental, physical, or developmental 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 *Termination of coverage* 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.

SECTION XIV: Continuation of coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your employer to find out if you are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying events

Pursuant to federal COBRA, you, the **subscriber**, your **spouse** and your **children** may be able to temporarily continue coverage under this **certificate** in certain situations when you would otherwise lose coverage, known as qualifying events.

If your coverage ends due to voluntary or involuntary termination of employment or a change in your employee class (e.g., a reduction in the number of hours of employment) you may continue coverage. Coverage may be continued for you, your **spouse** and any of your covered **children**.

If you are a covered **spouse**, you may continue coverage if your coverage ends due to:

- Voluntary or involuntary termination of the **subscriber's** employment;
- Reduction in the hours worked by the **subscriber** or other change in the **subscriber's** class;
- Divorce or legal separation from the **subscriber**;
- Death of the **subscriber**; or
- The covered employee becoming entitled to **Medicare**.

If you are a covered **child**, you may continue coverage if your coverage ends due to:

- Voluntary or involuntary termination of the **subscriber's** employment;
- Reduction in the hours worked by the **subscriber** or other change in the **subscriber's** class;
- Loss of covered **child** status under the plan rules;
- Death of the **subscriber**; or
- The covered employee becoming entitled to **Medicare**.

If you want to continue coverage you must request continuation from the **group** in writing and make the first **premium** payment within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date you are sent notice by first class mail of the right of continuation by the **group**.

The **group** may charge up to 102% of the **group premium** for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

- The date 18 months after the **subscriber's** coverage would have terminated because of termination of employment; provided that the **subscriber** or their **dependents** may continue for a total of 29 months if the **member** is determined to be disabled under the United States Social Security Act;
- If You are a covered **spouse** or **child** the date 36 months after coverage would have terminated due to the death of the **subscriber**, divorce or legal separation, the **subscriber's** eligibility for **Medicare**, or the failure to qualify under the definition of "**children**";
- The date you become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to **Medicare**;
- The date to which **premiums** are paid if you fail to make a timely payment; or
- The date the **group policy** terminates. However, if the **group policy** is replaced with similar coverage, you have the right to become covered under the new **group policy** for the balance of the period remaining for your continued coverage.

Continuation rights during active duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write your **group** to find out if you are entitled to temporary continuation of coverage under USERRA.

The **group** may charge up to 102% of the **group premium** for continued coverage. This does not apply if you or your **dependents** serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:

- The 24-month period beginning on the date on which the absence begins; or
- The day after the date on which you or your **dependent** fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

- This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
- If you or your **dependent's** coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their **dependents**, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if you or your **dependents** had become reemployed upon such termination of eligibility.

Continuation of coverage for other reasons

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 36 months from the start of your absence. • Your coverage will not continue beyond the end of the next month after the month in which your absence started.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder but not beyond 36 months from the start of the absence. • Your coverage will not continue beyond the end of the next month after the month beyond the end of the pay period in which your absence started.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Extension of benefits* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.

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

SECTION XV: General provisions

Agreements between us and participating providers

Any agreement between us and **participating providers** may only be terminated by us or the **providers**. This **certificate** does not require any **provider** to accept a **member** as a patient. We do not guarantee a **member's** admission to any **participating provider** or any dental benefits program.

Assignment

You cannot assign any benefits under this **certificate** to any person, corporation, or other organization. Any assignment of benefits by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this **certificate**. However, you may request us to make payment for services directly to your **provider** instead of you.

Changes in this certificate

We may unilaterally change this **certificate** upon renewal, if we give the **group** 30 days' prior written notice.

Choice of law

This **certificate** shall be governed by the laws of the State of New York.

Clerical error

Clerical error, whether by the **group** or us, with respect to this **certificate**, or any other documentation issued by us in connection with this **certificate**, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Conformity with law

Any term of this **certificate** which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

Continuation of benefit limitations

Some of the benefits in this **certificate** may be limited to a specific number of visits, a benefit maximum, and/or subject to a **deductible**. You will not be entitled to any additional benefits if your coverage status should change during the year. For example, if your coverage status changes from covered family **member** to **subscriber**, all benefits previously utilized when you were a covered family **member** will be applied toward your new status as a **subscriber**.

Enrollment ERISA

The **group** will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all **group members** covered under this **certificate**, and any other information required to confirm their eligibility for coverage.
The **group** will provide us with this information upon request. The **group** may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the **group**, or a third party appointed by the **group**. We are not the ERISA plan administrator.

The **group** will provide us with the enrollment form including your name, address, age, and social security number and advise us in writing when you are to be added to or subtracted from our list of **members**, on a monthly basis, on or before the same date of the month as the effective date of the **group's policy** with us. If the **group** fails to so advise us, the **group** will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

Entire agreement

This **certificate**, including any endorsements, riders and the attached applications, if any, constitutes the entire **certificate**.

Financial sanctions exclusions

If coverage provided under this booklet-certificate 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.

Fraud and abusive billing

We have processes to review claims before and after payment to detect fraud and abusive billing. **Members** seeking services from **non-participating providers** could be **balance billed** by the **non-participating provider** for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Furnishing information and audit

The **group** and all **members** under this **certificate** will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this **certificate**. You must provide us with certain information over the telephone for reasons such as the following:

- To determine the level of care you need;
- So that we may certify care authorized by your **provider**; or
- Make decisions regarding the **medical necessity** of your care

The **group** will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to **group** enrollment at the **group's** New York office.

Digital identification cards

Digital identification ("ID") cards are available to you for identification purposes only. Possession of any digital ID card confers no right to services or benefits under this **certificate**. To be entitled to such services or benefits, your **premiums** must be paid in full at the time that the services are sought to be received.

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 policyholder (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.

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

Incontestability

No statement made by you will be the basis for avoiding or reducing coverage unless it is in writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties.

Independent contractors

Participating providers are independent contractors. They are not our agents or employees. We and our employees are not the agent or employee of any **participating provider**. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you, your covered **spouse** or **children** while receiving care from any **participating provider** or in any **participating provider's** facility.

Material accessibility

We will give the **group**, and the **group** will give you, **certificates**, riders and other necessary materials.

More information about your dental plan

You can request additional information about your coverage under this **certificate**. Upon your request, we will provide the following information:

- A list of the names, business addresses and official positions of our board of directors, officers and members; and our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that we provide the State regarding our consumer complaints.
- A copy of our procedures for maintaining confidentiality of **member** information.
- A written description of our quality assurance program.
- A copy of our medical policy regarding an **experimental or investigational** drug, medical device or treatment in clinical trials.
- A copy of our clinical review criteria (e.g. **medical necessity** criteria), and where appropriate, other clinical information we may consider regarding a specific disease, course of treatment or **utilization review** guidelines.
- Written application procedures and minimum qualification requirements for **providers**.

Notice

Any notice that we give you under this **certificate** will be mailed to your address as it appears in our records. You agree to provide us with notice of any change of your address. If you have to give us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156.

Premium contribution

This plan requires the policyholder to make **premium** contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *Claims determination and Grievance procedure* section.

Payment of premiums

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

Premium refund

We will give any refund of **premiums**, if due, to the **group**.

Recovery of overpayments

On occasion a payment will be made to you when you are not **covered**, for a service that is not **covered**, or which is more than is proper. When this happens we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us. However, we shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or other intentional misconduct.

Renewal date

The renewal date for this **certificate** is the anniversary of the effective date of the **group policy** of each year. This **certificate** will automatically renew each year on the renewal date unless otherwise terminated by us, as permitted by this **certificate**, or by the **group** upon 30 days' prior written notice to us.

Right to develop guidelines and administrative rules

We may develop or adopt standards that describe in more detail when we will or will not make payments under this **certificate**. Those standards will not be contrary to the descriptions in this **certificate**. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this **certificate**.

We review and evaluate new technology according to technology evaluation criteria developed by our medical directors and reviewed by a designated committee, which consists of **health care professionals** from various dental specialties. Conclusions of the committee are incorporated into our dental policies to establish decision protocols for determining whether a service is **medically necessary**, **experimental or investigational**, or included as a covered benefit.

Right to offset

If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owe us. Except as otherwise required by law, if we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

Severability

The unenforceability or invalidity of any provision of this **certificate** shall not affect the validity and enforceability of the remainder of this **certificate**.

Significant change in circumstances

If we are unable to arrange for covered **eligible dental services** as provided under this **certificate** as the result of events outside of our control, we will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **participating providers'** personnel or similar causes. We will make reasonable attempts to arrange for covered **eligible dental services**. We and our **participating providers** will not be liable for delay, or failure to provide or arrange for covered **eligible dental services** if such failure or delay is caused by such an event.

Third party beneficiaries

No third party beneficiaries are intended to be created by this **certificate** and nothing in the **certificate** shall confer upon any person or entity other than you or us any right, benefit, or remedy of any nature whatsoever under or by reason of this **certificate**. No other party can enforce this **certificate's** provisions or seek any remedy arising out of either our or your performance or failure to perform any portion of this **certificate**, or to bring an action or pursuit for the breach of any terms of this **certificate**.

Time to sue

No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this **certificate**. You must start any lawsuit against us under this **certificate** within 2 years from the date the claim was required to be filed.

Translation services

Translation services are available under this **certificate** for non-English speaking **members**. Please contact us at 1-877-238-6200 to access these services.

Waiver

The waiver by any party of any breach of any provision of this **certificate** will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Who may change this certificate

This **certificate** may not be modified, amended, or changed, except in writing and signed by our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this **certificate** in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

Who receives payment under this certificate

Payments under this **certificate** for services provided by a **participating provider** will be made directly by us to the **provider**. If you receive services from a **non-participating provider**, We reserve the right to pay either the **subscriber** or the **provider** regardless of whether an assignment has been made.

Your dental records and reports

In order to provide your coverage under this **certificate**, it may be necessary for us to obtain your dental records and information from **providers** who treated you. Our actions to provide that coverage include processing your claims, reviewing **grievances**, **appeals**, or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this **certificate**, except as prohibited by state or federal law, You automatically give us or our designee permission to obtain and use your dental records for those purposes and you authorize each and every **provider** who renders services to you to:

- Disclose all facts pertaining to your care, treatment, and physical condition to us or to a dental professional that we may engage to assist us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to your care, treatment, and physical condition to us, or to a dental professional that we may engage to assist us in reviewing a treatment or claim; and
- Permit copying of your dental records by us.

We agree to maintain your dental information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, you automatically give us permission to share your information with the New York State Department of Health, quality oversight organizations, and third parties with which we contract to assist us in administering this **certificate**, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Aetna Life Insurance Company

Rider

Policyholder: Outten & Golden, LLP

Group policy number: 0149284-A

Rider effective date: January 1, 2022

This rider adds the following to the **group policy** issued to Outten & Golden, LLP and is effective on its issue date.

Section XVIII. Discount programs 2

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

Purpose

The purpose of this wellness program is to encourage you to take a more active role in managing your oral health and well-being.

Description

We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

- A health risk assessment tool, which may include completing an online health risk assessment
- Designated online wellness activities, which may include completing an educational course or quiz on dental health or watching videos on dental health topics
- Designated healthy activities, which may include visiting a dentist 1-2 times a year for cleanings and brushing and flossing your teeth
- Programs that promote preventive dental care, such as using an electronic toothbrush for 1-2 minutes a day, visiting a mobile dental clinic, or receiving care for routine dental check-ups

Eligibility
You, the subscriber, and the subscriber's covered spouse; each covered dependent can participate in the wellness program.

Participation
The preferred method for accessing the wellness program is through our website at www.aetna.com. You need to have access to a computer with internet access in order to participate in the website program. However, if you do not have access to a computer, please call us at 1-877-238-6200 and we will provide you with information regarding how to participate without internet access.

Rewards
Rewards for participation in a wellness program include:

- The waiver or reduction of copayments, deductibles or coinsurance.
- Contributions to a health reimbursement account ("HRA") or health savings account ("HSA").
- Monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good oral health, such as specialty toothbrushes, oral health supplies, or sugar-free gum.
- Merchandise, so long as the item is geared at promoting good oral health, such as specialty toothbrushes, oral health supplies, or sugar-free gum.

Aetna Life Insurance Company

Dental Amendment

Policyholder: Outten & Golden, LLP

Group policy number: 0149284-A

Amendment effective date: January 1, 2022

Your group dental policy has changed. The booklet-certificate is amended to reflect this. The change is effective on the date shown above.

- The **Coinsurance** table in the ***Dental care*** *section* of your certificate is amended to read as follows:

Coinsurance

The **coinsurance** listed below reflects your **coinsurance** percentage. This is the **coinsurance** amount that you pay. The plan is responsible for paying any remaining **coinsurance**.

	In-network coverage	**Out-of-network coverage**
Type A expenses	0% of the **negotiated charge**	0% of the **recognized charge**
Type B expenses	0% of the **negotiated charge**	20% of the **recognized charge**
Type C expenses	40% of the **negotiated charge**	50% of the **recognized charge**

- The following is deleted from the ***Exclusions and rules*** section of your certificate:

Treatment of temporomandibular joint dysfunction/disorder
Treatment is covered as a Specialty Service. This includes treatments which alter the jaw, jaw joints, or bite relationships. The following are covered:

- Diagnosis
- Applicable therapy
- Non-invasive physical therapy
- Other treatment

Not included are charges incurred for:

- **Orthodontic treatment**
- Crowns, bridges and dentures
- Treatment of periodontal disease
- Implants
- Root canal therapy

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Issue Date: November 10, 2021

Additional Information Provided by

Outten & Golden, LLP

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

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

Name of Plan:
Outten & Golden LLP Health and Welfare Plan

Employer Identification Number:
13-4014306

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Outten & Golden, LLP
685 Third Avenue 25th Floor
New York, NY 10017
Telephone Number: (917) 282-5176

Agent For Service of Legal Process:
Outten & Golden, LLP
685 Third Avenue 25th Floor
New York, NY 10017

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 Chief Operating Officer.

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

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

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

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

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

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

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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