

*Your  
Group  
Plan*

**Rice University**

## **ID Cards**

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

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

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

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

**Aetna Dental Inc.**  
Three Sugar Creek Center  
Sugar Land, TX 77478  
1-877-238-6200

### **CERTIFICATE OF COVERAGE**

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna Dental Inc., and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. The **Certificate** describes covered dental care benefits. Provisions of this **Certificate** include the Summary of Coverage, any riders, and any amendments, endorsements, inserts or attachments. Riders, amendments, endorsements, inserts or attachments may be delivered with the **Certificate** or added thereafter.

Aetna Dental Inc. agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

Coverage is not provided for any services received before coverage starts or after coverage ends except as shown in the Continuation section of this **Certificate**.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**. Clinical dental terms are defined in the Glossary section of this **Certificate**.

**Contract Holder:** Rice University  
**Contract Holder Number:** 878783  
**Contract Holder Group Effective Date:** July 1, 2014

**IMPORTANT NOTICE**

To obtain information or make a complaint:

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

**1-877-238-6200**

You may write to **Aetna Dental Inc.** at:

Aetna Dental Inc.

Three Sugar Creek Center

Sugar Land, TX 77478

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR POLICY:**

This notice is for information only and does not become a part or condition of the attached document.

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Usted puede llamar al siguiente número de teléfono gratuito de **Aetna Dental Inc.** para obtener información o para presentar una queja:

**1-877-238-6200**

Usted puede escribir a **Aetna Dental Inc.:**

Aetna Dental Inc

Three Sugar Creek Center

Sugar Land, TX 77478

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**UNA ESTE AVISO A SU POLIZA:**

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

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## ELIGIBILITY AND ENROLLMENT

### SUBSCRIBER ELIGIBILITY

You are eligible for coverage if you are in an Eligible Class shown on the Summary of Coverage.

### DEPENDENT ELIGIBILITY

You may cover:

Your wife or husband.

A dependent unmarried child under 25 years of age including a natural, foster, step, or legally adopted child, a proposed adoptive child, a child under court order, and a dependent of a dependent.

A child of any age who is medically certified as disabled and dependent on the **Subscriber** for support.

In addition:

1. the dependent's legal residence must be the same as the covered **Subscriber's**, or
2. if the dependent's legal residence is not the same as the covered **Subscriber's**, the dependent must live in the **Service Area** (except in the case of a qualified medical support order).

If you have completed and signed a "Declaration of Domestic Partnership" and the Declaration is acceptable to your Employer, you may also cover as your dependent the person who is the "domestic partner" named in your Declaration.

Of course, no person may be covered both as a **Subscriber** and a dependent or as a dependent of more than one **Subscriber**.

No person may be covered who does not work, live, or reside in the **Service Area**.

### SPECIAL RULES THAT APPLY TO A CHILD WHO MUST BE COVERED DUE TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child and is issued on or after the date the **Subscriber's** coverage becomes effective. The coverage shall be comparable to the coverage provided to other covered dependents. The child must meet all of the eligibility requirements of the Enrollment section of the **Group Agreement**, must have enrolled in the Dental Plan Coverage, and is subject to the premium requirements set forth in the Premium Rates section of the **Group Agreement**. If the **Subscriber** is the non-custodial parent, proof of claim for such child may be given by the custodial parent.

### ELIGIBILITY DATE

The Eligibility Date is shown on the Summary of Coverage.

### EFFECTIVE DATE OF SUBSCRIBER COVERAGE

#### Initial Enrollment Period

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date your enrollment is received.

### **Open Enrollment Period**

Eligible **Subscribers** who do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of completed enrollment information.

### **EFFECTIVE DATE OF DEPENDENT COVERAGE**

Coverage for your dependents which is non-contributory will become effective on the date your coverage becomes effective if, by then, you have requested dependent coverage.

Dependent coverage which is contributory becomes effective as shown below.

Also, in order to be sure coverage is in force for any new dependents you acquire, you should promptly report any change which will affect your contribution.

### **Initial Enrollment Period**

Dependent coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date your enrollment is received.

### **Open Enrollment Period**

Eligible dependents who do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of completed enrollment information.

### **Exception for Newborn Children**

Coverage for a newborn child will become effective on the date of birth. However, coverage will cease at the end of the 31 day period following the date of birth unless completed enrollment information is received within such 31 day period and agree to make the required contributions, if any. The terms of the foregoing "**Open Enrollment Period**" will then apply.

## **COVERAGE AFTER RETIREMENT**

If you retire and are in an Eligible Class, Dental Plan Coverage for yourself and your dependents will continue in force.

### **DENTAL PLAN COVERAGE (DPC) FOREWORD**

This Plan is designed to cover certain dental expenses, as described in the following pages:

- Coverage is non-occupational. Occupational injuries and disease are not covered.

An "occupational injury" is an accidental bodily injury that arises out of (or in the course of) any work for pay or profit, or in any way results from an injury which does.

An "occupational disease" is a disease that arises out of (or in the course of) any work for pay or profit, or in any way results from a disease which does. However, if proof is furnished that the person is covered under a workers' compensation law or similar law but is not covered for a particular disease under such law, that disease will be considered "non-occupational" regardless of cause.

- Coverage is provided only for services and supplies furnished to a **Member** while covered.
- Please note that certain limitations appear in the coverage descriptions. See also the Exclusions and Limitations section which apply to all dental plan coverage.



## **DENTAL PLAN COVERAGE (DPC) COVERED BENEFITS**

### **BENEFITS**

A **Member** shall be entitled to the covered benefits as specified below, in accordance with the terms and conditions of this **Certificate**. Not all services are covered. Some services are eligible only to a limited extent. There is no annual or lifetime maximum.

Aetna Dental Inc. has arranged for **Primary Care Dentists** and **Specialty Dentists** to furnish the necessary dental services under this coverage.

These services and supplies must be:

Given by the **Member's Primary Care Dentist** at the dental office location; or

Given by a **Specialty Dentist** for a dental condition requiring specialized care if the care is not available from the **Member's Primary Care Dentist**; and if the **Primary Care Dentist** has referred the **Member** to the **Specialty Dentist**; and provided Aetna Dental Inc. approves coverage for the treatment. If orthodontia is a covered benefit as shown in the Summary of Coverage, a **Primary Care Dentist** referral is not required for orthodontic services. This care is called "**Referral Care**"; or

Given by a **Non-Member Dental Provider** in the case of Out-Of-Area Emergency Dental Care.

Aetna Dental Inc. pays the benefits to **Primary Care Dentists** and **Specialty Dentists** as mutually agreed with them.  
**Copayment For Services Provided By Member Dental Providers:**

Each **Member** must pay part of the cost of the services or supplies for which coverage is provided under the **DPC Plan**. This is a copayment.

In addition to copayments for **Covered Dental Services**, **Members** may also be liable for the office visit copayment if specified in the Dental Care Schedule.

A copayment is separate from Aetna Dental Inc.'s compensation to **Member Dental Providers**. For certain dental services, the copayment may represent the full payment to the **Member Dental Provider**.

### **Dental Care Schedule for Services Provided by Member Dental Providers:**

The Dental Care Schedule shows:

Those services for which a **Copay** is required; and

The amount of each copayment; except that no copayment is shown in the Dental Care Schedule for the Alternate Treatment Rule described in the "limitations" section. If the Alternate Treatment Rule is applied to a service; an added copayment may apply.

The Dental Care Schedule is shown in the Summary of Coverage.

Please note: If, as specified in the **Member Dental Provider's** contract, their contract with Aetna Dental Inc. is terminated without cause or for breach, the provider shall remain obligated at Aetna Dental Inc.'s sole discretion to provide covered services to:

- (a) any **Member** receiving active treatment from the **Member Dental Provider** at the time of termination until the course of treatment is completed to Aetna Dental Inc.'s satisfaction or Aetna Dental Inc. transitions the **Member's** care to another **Member Dental Provider**;
- (b) any **Member**, upon request of such **Member** or the applicable Payor, until the anniversary date of the **Member's** Plan or for one (1) calendar year, whichever is less; and
- (c) any **Member** under the **Member Dental Provider's** care, who, as of the effective date of termination is under treatment by the **Member Dental Provider** for a disability, acute condition or a life-threatening illness, where the treating **Member Dental Provider** reasonably believes that discontinuing care by **Member Dental Provider** could cause harm to the patient.

### **How To Obtain Services: Emergencies**

**Members** needing **Emergency Care** should proceed as follows:

- (1) Whenever possible, the **Member** should telephone his or her **Primary Care Dentist** to arrange an emergency appointment.
- (2) If it is not possible to contact his or her **Primary Care Dentist**, the **Member** should contact the nearest **Dental Provider**. Coverage is subject to the terms which follow:

When care for an emergency condition is received from a **Member Dental Provider**, the **Member** will be responsible for the **Member Copay** indicated in the Dental Care Schedule.

When care for an emergency condition is received from a **Dental Provider** other than a **Member Dental Provider**, a benefit will be paid and will be based on the **Reasonable Charge** for such care. The **Member** will be responsible for the **Member Copay** indicated in the Dental Care Schedule.

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

The care given is for the temporary relief of an emergency condition; until the covered **Member** can be seen by the **Primary Care Dentist**.

An itemized bill is submitted to Aetna Dental Inc. It must describe the care involved. Depending on whether or not benefits are assigned to the provider, the bill may be submitted by either the provider or the **Member**.

The dental service given is listed in the Dental Care Schedule.

### **Out-of-Network Services**

If the **Member's Primary Care Dentist** is part of a practice group or association of **Dental Providers** and covered **Necessary Services and Supplies** are not available within the **Primary Care Dentist's** limited provider network, the **Member** has the right to a referral to a **Member Dental Provider** outside the **Primary Care Dentist's** limited provider network. If covered **Necessary Services and Supplies** are not available from **Member Dental Providers**, Aetna Dental Inc. will allow a referral to a **Non-Member Dental Provider**. The following apply:

1. The request must be from a **Member Dental Provider** or the **Member**.
2. Reasonably requested documentation must be received by Aetna Dental Inc.
3. Before Aetna Dental Inc. denies a referral, a review will be conducted by a specialist of the same or similar specialty as the type of **Dental Provider** to whom a referral is requested.

4. The referral will be provided within an appropriate time, not to exceed five business days, based on the circumstances and the **Member's** condition.
5. The **Member** shall not be required to change his or her **Primary Care Dentist** or **Specialty Dentist** to receive covered **Necessary Services and Supplies** that are not available from **Member Dental Providers**.
6. Aetna Dental Inc. will reimburse the **Non-Member Dental Provider** at the usual and customary or an agreed upon rate, less the applicable **Copay**.

## EXCLUSIONS AND LIMITATIONS

1. The following are not covered benefits except as described in rider(s) or amendments(s) attached to this **Certificate**:  

Services or supplies that are covered in whole or in part by any other part of this Dental Plan Coverage, or by any other plan of group benefits that is provided by or through your Employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:  

A non-occupational disease; or  
A non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies; unless otherwise specified in the **Certificate**.
4. Replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
5. Plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons are not covered, except (a) to the extent needed to repair an injury which occurs while the person is covered under the contract, and (b) for dental services or supplies provided in connection with a congenital defect. Facings on molar crowns and pontics will always be considered cosmetic.
6. Services, procedures, drugs, or other supplies that are determined by Aetna Dental Inc. to be experimental, or still under clinical investigation by health professionals.
7. Any appliances or services that are used only for the purpose of splinting (stabilization or immobilization of periodontally involved teeth), altering vertical dimension (the degree of jaw separation when the teeth are in contact), restoring occlusion (the contact relationship of the teeth in the upper and lower jaw), or correcting attrition; abrasion, or erosion (grinding or wearing away of teeth by mechanical or chemical means). This would include the use of dentures, crowns, inlays, onlays, bridgework, or any other appliance or service if they are used only for the purposes mentioned above.
8. Services that do not meet broadly accepted national standards of care, including but not limited to:
  - (i) more than two quadrants of scaling and root planing in a single office visit, unless necessary due to the need for pre-medication, significant travel distance or patient management difficulty;
  - (ii) services where diagnostic information does not support the proposed treatment;
  - (iii) services that will inadequately treat the **Member's** condition; and
  - (iv) prosthetic replacement dependent on severely compromised abutment teeth.
9. Services intended for medically necessary medical or surgical diagnosis or treatment of any **Jaw Joint Disorder**.
10. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
11. **Orthodontic Treatment**, unless otherwise specified in the **Certificate**.
12. General anesthesia and intravenous sedation; unless specifically covered and only when done in connection with another necessary covered service or supply.
13. Treatment by other than a **Dentist**; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **Dentist**.
14. A crown, cast, or processed restoration unless:
  - (i) it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - (ii) the tooth is an abutment to a covered partial denture or fixed bridge.

15. Pontics, crowns, cast or processed restorations made with high noble metals, unless otherwise specified in the **Certificate**.
16. Surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the **Certificate**.
17. Services needed solely in connection with non-covered services.
18. Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
19. Services given by a **Non-Member Dental Provider**, except if provided as Out-of-Area Emergency Dental Care.

Any exclusion above will not apply to the extent that coverage is required under any law that applies to the coverage.

To the extent allowed by Texas, those for services and supplies:

furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government.

furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid).

Benefits payable under Medicare will not have any effect on benefits payable under Dental Plan Coverage.

Benefits After Termination of Coverage: Dental services given after the **Member's** coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures; fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates. Ordered means that prior to the date coverage ends:

As to a denture:

impressions have been taken from which the denture will be prepared.

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

the teeth which will serve as retainers or support; or which are being restored; have been fully prepared to receive the item; and impressions have been taken from which the item will be prepared.

If a **Member's Primary Care Dentist's** contract with Aetna Dental Inc. terminates, the **Member** will be notified. The provider will continue to provide treatment to any **Member** who is receiving active treatment on the date of termination until the covered **Member** can either select another **Primary Care Dentist** or be assigned by Aetna Dental Inc. to another **Primary Care Dentist**, and be accepted by another **Primary Care Dentist**.

Dental Plan Coverage is subject to the following rules:

Replacement Rule: The replacement of, addition to, or modification of:

existing dentures;  
crowns;  
casts or processed restorations;  
removable bridges; or  
fixed bridgework

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

The existing denture, crown, cast or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Alternate Treatment Rule: If more than one service can be used to treat a **Member's** dental condition; Aetna Dental Inc. may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

The service must be listed on the Dental Care Schedule;

The service selected must be deemed by the dental profession to be an appropriate method of treatment; and

The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a **Member Dental Provider** and the **Member** asks for a more costly covered service than that for which coverage is approved; the specific copayment for such service will consist of:

- The copayment for the approved less costly service; plus
- The difference in cost between the approved less costly service and the more costly covered service.

Orthodontic Rule: Coverage for **Orthodontic Treatment** is limited to those services and supplies listed on the Dental Care Schedule that applies.

Aetna Dental Inc. has arranged for **Specialty Dentists** to furnish the orthodontic procedures. A copayment applies to the orthodontic procedures done on a **Member**.

Orthodontic services are covered on the date the **Orthodontic Treatment** begins.

Comprehensive **Orthodontic Treatment** is limited to a lifetime maximum of:

24 months of active, usual and customary **Orthodontic Treatment** on permanent dentition, plus an extra 24 months of post-treatment retention.

Coverage for services and supplies are not provided for any of 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;
- treatment of primary dentition;
- treatment of transitional dentition; or
- lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”).

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a **Member** for the benefits of the **Certificate**.

## TERMINATION OF COVERAGE

Coverage under this Plan terminates at the earliest to occur of the following, after written notice from Aetna Dental Inc. to you of at least 60 days, except as shown in 6. below.

1. Your employment terminates.
2. The **Group Agreement** discontinues as to the coverage.
3. You are no longer in an eligible class. This may apply to all or part of your coverage.
4. The date of your death, unless otherwise provided.
5. The date coverage terminates in accordance with the terms of the "Special Termination Provision".
6. If you fail to make any required contribution, at the later to occur of:

The end of the period for which contribution was made; and

30 days after written notice from Aetna Dental Inc.

Ceasing active work will be considered to be immediate termination of employment, except that if you are absent from active work because of sickness, injury, temporary layoff, or leave of absence, employment may be considered to continue for the purposes of this coverage up to the limits agreed to by Aetna Dental Inc. and your Employer. If the Certificate shows an eligible class of retired employees and you are in that class, your employment may be considered to continue for the purposes of this coverage up to the limits agreed to by Aetna Dental Inc. and your Employer. If you cease active work for any reason, you should find out immediately from your Employer if coverage can be continued in force so that you will be able to exercise any rights you may have under this Plan.

### Dependents Coverage Only

A dependent's coverage will terminate at the earliest to occur of the following:

1. Upon discontinuance of all dependents' coverage under the **Group Agreement**.
2. When a dependent becomes covered for employee coverage under this Plan.
3. When a domestic partner relationship ends, as indicated on the completed and signed Declaration of Termination of Domestic Partnership.
4. At the end of the month in which such person ceases to meet this Plan's definition of a dependent.
5. When your **Members** coverage terminates.
6. The date coverage terminated in accordance with the terms of the "Special Termination Provision".



## SPECIAL TERMINATION PROVISION

Coverage under this **Group Agreement** for a **Member** may be terminated, after notice described below, should any of the following circumstances occur:

- (a) The **Primary Care Dentist** and the **Member** are unable, after reasonable efforts, to establish and maintain a satisfactory provider-patient relationship, provided it is shown that:

Aetna Dental Inc. has, in good faith, given the **Subscriber** an opportunity to select an alternative plan **Dentist** for such **Member**. The **Subscriber** may change a **Member's Primary Care Dentist** at any time by written request to Aetna Dental Inc. Any such change will take effect no later than 30 days after the request is received by Aetna Dental Inc.

Aetna Dental Inc. has given the **Subscriber** 30 days advance written notice that Aetna Dental Inc. considers the provider-patient relationship unsatisfactory, has specified the changes necessary to avoid termination and the **Member** has failed to make such changes.

- (b) Fraud in the use of services or facilities is discovered (31 days advance written notice).

- (c) Misconduct detrimental to safe plan operations and the delivery of services is discovered. (No advance notice).

### Material Misrepresentation or Fraud Provision:

In the absence of fraud, all statements made by a **Subscriber** are considered representations and not warranties.

Aetna Dental Inc. may increase the premium to the appropriate level if it determines that the **Member** made a material misrepresentation or fraudulent statement in the written application (31 days advance written notice).

### Unearned Charges:

Aetna Dental Inc. will return to the **Contract Holder** the unearned portion, if any, of the charges paid on behalf of the terminated **Member**. The amount of the monies returned will be calculated on a pro rata basis.

## COVERAGE FOR CERTAIN HANDICAPPED CHILDREN

### Handicapped Children

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

Coverage will cease on the earliest to occur of:

Cessation of the handicap.

Failure to give proof that the handicap continues.

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

## CONTINUATION

### A. COBRA Continuation of Coverage

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, as amended (hereinafter referred to as COBRA), the **Contract Holder** may be required to provide **Members** with the right to continue Coverage under this **Certificate** upon the occurrence of certain qualifying events. For the purposes of this Section, any elections or payments required by minors or incapacitated **Members** may be made by the parents or legal guardian of such **Member**.

Subject to the payment of any required contribution, coverage may also be provided for any dependents acquired by the **Subscriber** while the coverage is being continued. The effective date of coverage for these dependents will be subject to the terms of the Agreement regarding the addition of new dependents.

#### (1) Eligibility

Covered persons who are covered by Aetna Dental Inc. at the time of a qualifying event may be eligible for continuation of coverage. The following are the qualifying events for continuation of coverage:

- (a) **Subscribers**. Loss of coverage due to termination of employment, except for gross misconduct as defined by the **Contract Holder**; or a reduction in the number of hours worked by the **Subscriber**.
- (b) Covered dependents. Loss of Coverage because of:
  - (i) Termination of the **Subscriber's** coverage as explained in subsection (a) above.
  - (ii) The death of the **Subscriber**.
  - (iii) Divorce or legal separation.
  - (iv) The **Subscriber** becoming entitled to Medicare.
  - (v) The **Subscriber's** loss of eligibility as a covered dependent.

#### (2) Duration and Termination of Continuation of Coverage

Coverage under this subsection A will terminate on the earliest to occur of the following:

- (a) The end of an 18 month period for coverage being continued because of the events described in subsection (1)(a) above;
- (b) The end of a 36 month period for coverage being continued because of the events described in subsection (1)(b) above;
- (c) Non-payment of required contribution for such coverage when due;
- (d) The **Member** becomes covered by another dental plan without limitation or exclusion of pre-existing conditions as either a **Subscriber** or dependent;
- (e) The Agreement with Aetna Dental Inc. is terminated. However, continuation of coverage may be available under another group dental plan sponsored by the employer;
- (f) The **Subscriber** becomes entitled to benefits under Medicare.

If coverage is being continued for up to 18 months under subsection (1)(a) and during this 18 month period one of the qualifying events under the above subsection (1)(b) occurs, this 18 month period may be increased. In no event will the total period of continuation provided under this section for any covered dependent be more than 36 months.

Such qualifying events, however, will not act to extend coverage beyond the original 18 month period under subsection (1)(a) for any dependents who were added after the date continued coverage began.

(3) **Special Rule For The Totally Disabled**

If a **Member** is determined to be disabled under Title II or Title XVI of the Social Security Act at the time of the qualifying event and would otherwise be limited to the 18 month period of continuation coverage, the **Member** may continue coverage up to a total of 29 months if the **Member** remains disabled during such 29 month period. The **Member** must provide to Aetna Dental Inc. evidence of disability prior to the end of the 18 month period. Coverage will terminate in the month that begins 31 days after the date of the final determination under Title II or Title XVI of the Social Security Act that the **Member** is no longer disabled, or if any of the events in subsection (2) above occur.

(4) **Notice Requirements**

If a **Member's** coverage is being continued for 18 months in accordance with the above subsection (1)(a), and it is determined under Title II or Title XVI of the Social Security Act that the **Member** was disabled on the date of the event in subsection (1)(a) which would have caused coverage to terminate, the **Member** must notify the **Contract Holder** of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that the **Member** is no longer disabled.

If coverage for a covered dependent would terminate because of:

- a) Divorce or legal separation; or
- b) The **Member's** loss of eligibility as a covered dependent.

The **Subscriber** or the covered dependent must provide notice to the **Contract Holder** of the occurrence of the event. This notice must be given within 60 days after the later to occur of the terminating event and the date coverage would terminate due to the occurrence of the terminating event. If notice is not provided within the above specified time periods, continuation under this section will not be available to the **Subscriber's** covered dependents.

(5) **Enrolling For Continuation of Coverage**

Covered persons have 60 days to enroll for continuation of coverage under this subsection A. from the later to occur of the date coverage would terminate and the date that they receive notification of their right to enroll. The **Contract Holder** will send the forms that should be used to enroll for continuation of coverage. If such **Members** do not submit the enrollment form to the **Contract Holder** within that 60 day period, they will lose their right to continuation of coverage under this Section.

If a **Member** who is eligible for continuation of coverage, receives covered services prior to electing such coverage and paying any required contributions for such coverage, the **Member** will be required to pay for those services. Aetna Dental Inc. will reimburse the **Member** the reasonable and customary charges for such services, less any required **Copays**, if, within said 60 day period, the **Member**: elects to continue coverage under this Section; pays any required contributions for coverage; and submits a claim for reimbursement of such charges.

(6) **Contributions**

A **Member** must pay to Aetna Dental Inc. through the **Contract Holder** any required contributions for continuation of coverage within 45 days after the date the **Member** elects to continue coverage.

Contributions for subsequent periods of continuation are due and payable on a regular monthly basis as required by the **Contract Holder**. If the contribution is not received by Aetna Dental Inc. on or before the due date, coverage will be terminated, upon 31 days written notice by Aetna Dental Inc., and effective as of the last day for which contributions were received.

If coverage would terminate for the reasons specified in subsection (1) above, **Members** may be required to pay up to 102% of the full cost of this continued coverage to Aetna Dental Inc.; or as to a **Member** whose coverage is being continued for 29 months in accordance with subsection (3) above, 150% of the full cost of this continued coverage to Aetna Dental Inc. for any month after the 18th month.

**B. Continuation of Coverage – State of Texas**

(1) Continuation for Certain Dependents.

A covered dependent who has been a **Member** of Aetna Dental Inc. for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Group Agreement** if coverage would otherwise terminate because of:

- a. the death of the **Subscriber**;
- b. the retirement of the **Subscriber**; or
- c. divorce or legal separation.

A **Member** must give written notice to the **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to the **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable premiums and administrative charges are paid.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;
- b. the end of the 3 year period after the date of the divorce or legal separation;
- c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital, or medical service **Subscriber** contract, medical practice or other prepayment plan, or by any other plan or program; or
- d. the end of the period for which the **Member** has paid any applicable premiums.

(2) Group Continuation Privilege

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the contract or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination, shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish premiums on a monthly basis in advance, must be given to the **Contract Holder** within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. six months after the date the election is made;
- b. the date on which failure to make timely payments would terminate coverage;
- c. the date on which the group coverage terminates in its entirety;
- d. the date on which the **Member** is or could be covered under Medicare;
- e. the date on which the **Member** is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;
- f. the date the **Member** is eligible for similar benefits whether or not covered therefore under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

## **RULES FOR COORDINATION OF BENEFITS OF THE DPC PLAN WITH OTHER BENEFITS**

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

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

### **A. DEFINITIONS**

- (1) Program: Any of these that provide benefits or services for, or by reason of, dental care or treatment:
  - (a) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
  - (b) Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But this does not include school accident-type coverage for grammar school, high school, and college students.

Separate Programs:

Each contract or other arrangement for coverage under (a) or (b) is a separate Program.

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

- (2) This Program: The **DPC Plan** provided by Aetna Dental Inc.
- (3) Allowable Expense: The usual and prevailing charge for a needed service or supply, when the charge, service or supply is covered at least in part by one or more Programs covering the person for whom claim is made.

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

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

### **B. EFFECT ON BENEFITS**

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

- (b) The benefits that would be payable for the Allowable Expenses under all other Programs of the same type as This Program, in the absence of rules with a purpose like that of these rules, whether or not claim is made. But this (b) does not include the benefits of a Program if:
    - (i) It has rules coordinating its benefits with those of This Program; and
    - (ii) Those rules have Claim Determination Period and Facility of Payment items similar to those in these rules; and
    - (iii) Its rules and This Program's rules both require This Program to determine benefits before it does.
- (2) This Program's Rules for the Order in which Benefits are Determined: When a person's dental care is the basis for a claim:
- (a) Non-dependent/Dependent: The benefits of a Program that covers the person other than as a dependent are determined before those of a Program that covers the person as a dependent.
  - (b) Dependent Child/Parents Not Separated or Divorced: Except as stated in subparagraph B.(2)(c) below, when This Program and another Program cover the same child as a dependent of different persons, called "parents":
    - (i) the benefits of the Program of the parent whose birthday falls earlier in a year are determined before those of the Program of the parent whose birthday falls later in that year; but
    - (ii) if both parents have the same birthday, the benefits of the Program that covered the parent longer are determined before those of the Program that covered the other parent for a shorter period of time.

However, if the other Program does not have the rule described in (i), immediately above, and if, as a result, the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.
  - (c) Dependent Child/Separated or Divorced Parents: If two or more Programs cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - (i) first, the Program of the parent with custody of the child;
    - (ii) then, the Program of the spouse of the parent with custody of the child; and
    - (iii) finally, the Program of the parent not having custody of the child.

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

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, benefits for the child are determined in accordance with rule B.(2)(b) above.
  - (d) Active/Inactive Employee: The benefits of a Program that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Program that covers that person as a laid off or retired employee or as that employee's dependent. If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (d) is ignored.
  - (e) Longer/Shorter Length of Coverage: If none of the above rules determine the order of benefits, the benefits of the Program that covered a person longer are determined before those of the Program that covered that person for the shorter time.
- (3) Effect of Reduction in Benefits: When these rules reduce This Program's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Program.

**C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

**D. FACILITY OF PAYMENT**

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

**E. RIGHT OF RECOVERY**

If the reasonable cash value of the benefits provided by Aetna Dental Inc. is more than the reasonable cash value of the benefits it should have provided under This Program, it may recover the excess. It may recover such excess from one or more of:

- (1) the persons to whom or for whom it has provided such benefits;
- (2) insurance companies; or
- (3) other organizations.



## GENERAL PROVISIONS

- A. Identification Card** - The identification card issued by Aetna Dental Inc. to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an Aetna Dental Inc. identification card confers no right to services or benefits under this **Certificate**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable premium charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.
- B. Reports and Records** - Aetna Dental Inc. is entitled to receive from any **Primary Care Dentist** or **Specialty Dentist** providing services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. The **Subscriber**, for himself or herself, and for all covered dependents, authorizes each and every provider who renders services to a **Member** hereunder to:
1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to Aetna Dental Inc., or a dental professional that Aetna Dental Inc. may engage to assist it in reviewing a treatment or claim;
  2. render reports pertaining to the care, treatment and physical condition of the **Member** to Aetna Dental Inc., or a dental professional that Aetna Dental Inc. may engage to assist it in reviewing a treatment or claim; and
  3. permit copying of the **Member's** records by Aetna Dental Inc.
- C. Assignment of Benefits** - All benefits may be assigned only with the consent of Aetna Dental Inc.
- D. Legal Action** - No action at law or in equity may be maintained against Aetna Dental Inc. for any expense or bill prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.
- E. Independent Contractor Relationship**
1. No **Member Dental Provider** or other provider, institution, facility or agency is an agent or employee of Aetna Dental Inc. Neither Aetna Dental Inc. nor any employee of Aetna Dental Inc. is an agent or employee of any **Member Dental Provider** or other provider, institution, facility or agency.
  2. Neither the **Contract Holder** nor a **Member** is the agent or representative of Aetna Dental Inc., its agents or employees, or an agent or representative of any **Member Dental Provider** or other person or organization with which Aetna Dental Inc. has made or hereafter shall make arrangements for services under this **Certificate**.
  3. **Member Dental Providers** maintain the dentist-patient relationship with **Members**.
  4. Aetna Dental Inc. cannot guarantee the continued participation of any provider or facility with Aetna Dental Inc. In the event a **Primary Care Dentist** terminates its contract or is terminated by Aetna Dental Inc., Aetna Dental Inc. shall provide notification to **Members** in the following manner:
    - a. within thirty days of the termination of a **Primary Care Dentist** contract to each affected **Subscriber**, if the **Subscriber** or any dependent of the **Subscriber** is currently enrolled in the **Primary Care Dentist's** office; and

- b. services rendered by a **Primary Care Dentist** or hospital to an enrollee after the date of termination of the Provider Agreement are covered benefits only if the services or supplies were furnished during a **Member's** confinement and the confinement began prior to the date of the termination.
- 5. **Restriction on Choice of Providers:** Unless otherwise approved by Aetna Dental Inc., **Members** must utilize **Member Dental Provider's** and facilities who have contracted with Aetna Dental Inc. to provide services.
- F. Inability to Provide Service** - In the event that due to circumstances not within the reasonable control of Aetna Dental Inc., including, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Member Dental Provider** Network, the rendition of dental benefits or other services provided under this **Certificate** is delayed or rendered impractical, Aetna Dental Inc. shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Aetna Dental Inc. on the date such event occurs. Aetna Dental Inc. is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
- G. Confidentiality.** Information contained in the dental records of **Members** and information received from **Dentist** incident to the physician-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide dental research and education as may be permitted by law, or reasonably necessary by Aetna Dental Inc. in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.
- H. Limitation on Services.** Except in cases of an **Emergency Care**, Urgent Care, and Emergency/Urgent follow-up care as provided under the Covered Benefits section of this **Certificate**, services are available only from participating **Member Dental Providers**. Aetna Dental Inc. shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Dentist**, facility, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by Aetna Dental Inc.
- I. Incontestability.** All statements made by the **Subscriber** on the enrollment application are considered representations and not warranties. The statements are considered to be truthful and are made to the best of the **Subscriber's** knowledge and belief. A statement may not be used to void, cancel or non-renew a **Member's** coverage or reduce benefits unless a signed copy of the written application is or has been furnished to the **Subscriber** or the **Subscriber's** personal representative.
- J.** This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive dental care benefits that are not, or might not be, covered benefits.
- K. Contract Holder** hereby makes Aetna Dental Inc. coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law. This can also be done by mutual written agreement between Aetna Dental Inc. and **Contract Holder** without the consent of **Members**. However, any and all amendments initiated by Aetna Dental Inc. will be done after 60 days written notice is provided to **Contract Holder**.
- L.** Aetna Dental Inc. may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.
- M.** This **Certificate**, including the Summary of Coverage, any Riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate**. The **Certificate** is part of the **Group Agreement**. The **Group Agreement** constitutes the entire agreement and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

- N. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.
- O. From time to time Aetna Dental Inc. may offer or provide **Members** access to discounts on health care related goods or services. While Aetna Dental Inc. has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the **Members** for the provision of such goods and/or services. Aetna Dental Inc. is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, Aetna Dental Inc. is not liable to the **Members** for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.
- P. **Refusal to Accept Procedures or Treatment** - It may occur that certain **Members**, for personal reasons, may decide to refuse to accept procedures or courses of treatment recommended by **Member Dental Providers**. Should this occur, the **Member Dental Provider** involved may regard such refusal as preventing him or her from continuing to provide dental care to that **Member**. If, in the judgment of the provider, no professionally acceptable alternative exists, the **Member** will be notified in writing. If after such notice, the **Member** still refuses to accept the **Member Dental Provider's** recommendation, neither Aetna Dental Inc. nor the **Member Dental Provider** involved shall have any further responsibility under the contract to provide or arrange for dental care for the condition under treatment. This decision is subject to the section entitled "Submitting Complaints" of this **Group Agreement**. Coverage for treatment of the condition involved will be resumed in the event the **Member** agrees to follow the recommended treatment or procedure.

**Q. Claims For Out-Of-Area Emergency Care**

Your claim must be submitted to Aetna Dental Inc. in writing and it must give proof of the nature and extent of the loss. Your Employer has claim forms.

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

If, through no fault of your own, you are unable to meet the deadline for filing the claim, your claim will still be accepted if you file as soon as reasonably possible, but no later than one year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

**R. Payments For Out-of-Area Emergency Care**

All benefits are payable to you. However, Aetna Dental Inc. has the right to pay any benefits directly to the provider providing services covered under this Plan unless you have specified otherwise by the time you file the claim.

Claims for out-of-area **Emergency Care** will be processed as follows:

1. Fifteen (15) days after receipt of the claim, Aetna Dental Inc. shall:
  - (a) Acknowledge receipt of the claim;
  - (b) Commence investigation of the claim;
  - (c) Request all information from claimant as deemed necessary by Aetna Dental Inc. Subsequent additional requests may be necessary.
2. No later than fifteen (15) business days after receipt of all items required by Aetna Dental Inc., Aetna Dental Inc. will:
  - (a) Notify claimant of acceptance or rejection of the claim;
  - (b) Notify claimant of the reasons Aetna Dental Inc. needs additional time.

If Aetna Dental Inc. notifies the claimant that the claim will be accepted, the claim will be paid no later than five (5) business days after the notice was made.

3. No later than forty-five (45) days after Aetna Dental Inc. has received documentation that is reasonably necessary to process the claim, Aetna Dental Inc. will either pay or reject the claim.

#### **S. Records of Expenses**

Keep careful, complete records of the expenses of each **Member**. They will be required when a claim is made.

Very important are:

1. Names of providers who furnish services.
2. Dates expenses are incurred.
3. Copies of all bills and receipts.

#### **T. Contract Changes**

The **Group Agreement** may be changed at any time by written agreement between Aetna Dental Inc. and the **Contract Holder**, without the consent of any **Subscriber** or other person. All agreements made by Aetna Dental Inc. are signed by one of its executive officers. No agent or other person can change or waive any of the contract terms or make any agreement binding Aetna Dental Inc. Formal acceptance of a change in contract by the **Contract Holder** shall not be required in any of the following instances:

The change has been negotiated by means of a request by the **Contract Holder** assented to by Aetna Dental Inc.

The change is required to bring the **Group Agreement** into conformance with any applicable law, regulation or ruling of

the State of Texas, or  
the Federal government.

The **Group Agreement**, application of the **Contract Holder**, Summary of Coverage, plus any riders, amendments, endorsements, inserts or attachments and this **Certificate** constitute the entire **Group Agreement**.

## SUBMITTING COMPLAINTS

### I. Purpose of Procedure

The purpose of this procedure is to address any matters, including certification, causing you to be dissatisfied with your coverage. You are encouraged to contact the Member Services Department if you have any questions or concerns related to your membership in the Aetna Dental Inc. dental plan.

### II. Definition

A complaint is any dissatisfaction, expressed by you orally or in writing, to Aetna Dental Inc. about any aspect of Aetna Dental Inc.'s operation, including plan administration; appeal of an adverse determination; denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions. A complaint is not a misunderstanding or misinformation that is resolved promptly to the satisfaction of the enrollee.

### III. Initial Oral/Written Complaint

All initial oral or written complaints will receive an acknowledgment letter within five (5) business days of receipt of the complaint which includes: a letter acknowledging the date of receipt of the complaint that includes a description of the organization's complaint procedures and time frames. If the complaint is received orally, Aetna Dental Inc. shall also enclose a one-page complaint form. The one-page complaint form does prominently and clearly state that the complaint form must be returned to Aetna Dental Inc. for prompt resolution of the complaint.

Aetna Dental Inc. will investigate each oral and written complaint received in accordance with its policies and in compliance with state mandates. The total time for acknowledgment, investigation, and resolution of the complaint by Aetna Dental Inc. will not exceed 30 calendar days after the date that Aetna Dental Inc. receives the written complaint or one-page complaint form from you.

### IV. Resolution And Response Obligation

All response letters shall include:

- a. Date of receipt of an oral or written request for appeal.
- b. A statement of the specific medical/dental and contractual reasons for the resolution.
- c. The specialization of any **Dentist** or other provider consulted.
- d. A full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.
- e. Texas Department of Insurance complaint address: Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091
- f. Texas Department of Insurance toll free telephone number: 1-800-252-3439

## V. Complaint Appeal Process

If the complaint is not resolved to your satisfaction, Aetna Dental Inc. shall provide for either an expedited or non-expedited appeals process.

### A. Non- expedited Appeals

You have the right either to appear in person before an Aetna Dental Inc. complaint appeal panel where you normally receive dental care services, unless another site is agreed to by you, or to address a written appeal to the complaint appeal panel. Aetna Dental Inc. shall complete the appeals process under this section no later than the 30<sup>th</sup> calendar day after the date of the receipt of the request for appeal. All appeals will receive an acknowledgment letter within five (5) business days of receipt of the appeal.

#### 1. Aetna Dental Inc. Complaint Appeal Panel:

You, or your designated representative, if you are a minor or disabled, are entitled to:

- a. appear in person before the complaint appeal panel;
- b. present alternative expert testimony; and
- c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

#### 2. Panel Composition:

Aetna Dental Inc. shall appoint members to the complaint appeal panel, which shall advise Aetna Dental Inc. on the resolution of the dispute. The complaint appeal panel shall be composed of:

- a. Equal numbers of Aetna Dental Inc. staff, **Dentists** or other providers, and enrollees.
- b. A member of the complaint appeal panel may not have been previously involved in the disputed decision.
- c. The **Dentists** or other providers must have experience in the area of care that is in dispute.
- d. If specialty care is involved in the complaint, the appeal panel must include an additional person who is a specialist in the field of care to which the appeal relates.
- e. The enrollees may not be employees of Aetna Dental Inc.

#### 3. Panel Response:

No later than the fifth business day before the scheduled meeting of the panel, unless you agree otherwise, Aetna Dental Inc. shall provide to you or your designated representative:

- a. Any documentation to be presented to the panel by Aetna Dental Inc. staff.
- b. Specialization of any **Dentists** or providers consulted during the investigation; and
- c. Name and affiliation of all Aetna Dental Inc. representatives on the panel.

You may respond to documentation in person or in writing. The response must be considered in panel deliberations if received prior to or during the hearing. A record of the proceeding must be kept for three (3) years. You will be given a copy within 30 days of request.

**4. Final response letter shall include:**

- a. Date of receipt of oral or written request for appeal.
- b. Contractual criteria used to reach a final resolution.
- c. Specialization of any **Dentist** or other provider consulted.
- d. Texas Department of Insurance complaint address: Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091
- e. Texas Department of Insurance toll free telephone number: 1-800-252-3439

**B. Expedited Appeals:**

Investigation and resolution of appeals relating to ongoing emergencies shall be concluded in accordance with the medical/dental immediacy of the case but in no event to exceed one business day after your request for appeal. Due to the ongoing emergency, and at your request, Aetna Dental Inc. shall provide, in lieu of a complaint appeal panel, a review by a **Dental Provider** who has not previously reviewed the case and is of the same or similar specialty as typically manages the dental condition, procedure, or treatment under discussion for review of the appeal. The **Dental Provider** reviewing the appeal may interview the patient or the patient's designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three days. Investigation and resolution of appeals after **Emergency Care** has been provided shall be conducted in accordance with the process established under this section, including the right to a review by an appeal panel.

The appeal procedures described above do not prohibit the **Member** from pursuing other appropriate remedies available under law, if the **Member** believes that the requirement of completing the appeal and review process places the **Member's** health in serious jeopardy.

**VI. Record Retention**

Aetna Dental Inc. will maintain a record of each complaint and any complaint proceeding and any actions taken on a complaint for three (3) years from the date of the receipt of the complaint. You are entitled to a copy of the record on the applicable complaint and any complaint proceeding. Aetna Dental Inc. will maintain documentation on each complaint received and the action taken on the complaint until the third anniversary of the date of the receipt of the complaint.

## PRESENTACIÓN DE QUEJAS

### I. Propósito del procedimiento

El propósito de este procedimiento es intentar solucionar cualquier problema o insatisfacción con la cobertura, incluida la certificación. En caso de tener alguna pregunta o inquietud relacionada con su calidad de miembro del plan dental de Aetna Dental Inc., le recomendamos comunicarse con el Departamento de Servicios al Cliente.

### II. Definición

Una queja es la expresión oral o escrita dirigida a Aetna Dental Inc. sobre algún aspecto de la operación de Aetna Dental Inc., por ejemplo, la administración del plan; la apelación de una determinación adversa; la negación, la reducción o la terminación de un servicio; la forma en que se brinda un servicio o las decisiones de baja. Una queja no es un malentendido ni una información errónea, que se resuelven de inmediato para satisfacción de la persona inscrita.

### III. Queja inicial oral o por escrito

Dentro de los cinco (5) días hábiles de haber recibido una queja inicial expresada en forma oral o escrita, Aetna Dental Inc. enviará una carta de acuse de recibo, esto es, una carta que contiene la fecha de recepción de la queja y la descripción de los plazos y procedimientos de queja de la organización. Si la queja se expresa en forma oral, Aetna Dental Inc. también adjuntará un formulario de queja de una página. Allí se destaca claramente que el formulario debe enviarse a Aetna Dental Inc. para la rápida resolución de la queja.

Aetna Dental Inc. investigará cada queja oral y escrita recibida de acuerdo con sus políticas y con los mandatos estatales. El tiempo total que comprende el acuse de recibo, la investigación y la resolución de la queja por parte de Aetna Dental Inc. no excederá los 30 días calendario contados a partir de la fecha en la que Aetna Dental Inc. reciba la queja escrita o el formulario de queja de una página.

### IV. Obligación de respuesta y resolución

Todas las cartas de respuesta incluirán:

- a. La fecha de recepción de una solicitud de apelación realizada en forma oral o escrita.
- b. La descripción de los motivos contractuales y médicos/dentales específicos de la resolución.
- c. La especialidad de todo dentista u otro proveedor que haya sido consultado.
- d. Una descripción completa del proceso de apelación, incluidos sus plazos y los que se aplican a la decisión definitiva sobre la apelación.
- e. La dirección para enviar quejas al Departamento de Seguros de Texas:  
Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091
- f. El número telefónico gratuito del Departamento: 1-800-252-3439

### V. Proceso de apelación de quejas

Si la queja no se resuelve de manera satisfactoria, Aetna Dental Inc. dispondrá un proceso de apelación acelerada o no acelerada.



## **A. Apelaciones no aceleradas**

Usted tiene derecho a comparecer en persona ante el panel de apelación de quejas de Aetna Dental Inc. donde habitualmente recibe atención dental, a menos que acceda a presentarse en otro lugar, o a dirigir una apelación por escrito a dicho panel. Aetna Dental Inc. completará el proceso de apelación previsto en este apartado antes del 30º día calendario a partir de la fecha de recepción de la solicitud de apelación. Se enviará una carta de acuse de recibo por cada apelación dentro de los cinco (5) días hábiles de haberla recibido.

### **1. Panel de apelación de quejas de Aetna Dental Inc.:**

Usted, o el representante que haya designado en caso de ser menor o discapacitado, tiene derecho a:

- a. comparecer en persona ante el panel de apelación de quejas;
- b. presentar el testimonio de otros expertos; y
- c. solicitar la presencia de cualquier persona responsable de haber tomado la determinación que motivó la apelación e interrogarla.

### **2. Composición del panel:**

Aetna Dental Inc. designará a los integrantes del panel de apelación de quejas que aconsejará a Aetna Dental Inc. con respecto a la resolución de la disputa. El panel de apelación de quejas estará compuesto por:

- a. Igual cantidad de miembros del personal de Aetna Dental Inc., dentistas u otros proveedores, y personas inscritas.
- b. Los miembros del panel de apelación de quejas deberán ser ajenos a la decisión que motivó la disputa.
- c. Los dentistas u otros proveedores deben tener experiencia en el área de atención en cuestión.
- d. Si la queja se relaciona con la atención de especialistas, el panel de apelación incluirá una persona más que sea especialista en el área con la que está vinculada la apelación.
- e. Las personas inscritas no podrán ser empleados de Aetna Dental Inc.

### **3. Respuesta del panel:**

Al menos cinco días hábiles antes de la reunión prevista del panel, salvo que se convenga de otro modo y usted acepte, Aetna Dental Inc. le proporcionará a usted o al representante que haya designado:

- a. La documentación que presentará el personal de Aetna Dental Inc. ante el panel.
- b. La especialidad de los dentistas o proveedores que hayan sido consultados durante la investigación; y
- c. El nombre y la afiliación de todos los representantes de Aetna Dental Inc. que integrarán el panel.

Podrá expresar su opinión respecto de la documentación en persona o por escrito. Esta opinión se considerará en las deliberaciones del panel si se recibe antes de la audiencia o durante su transcurso. Se conservará un acta del procedimiento durante tres (3) años. Usted recibirá una copia dentro de los 30 días a partir de su solicitud.

**4. La carta de respuesta definitiva incluirá:**

- a. La fecha de recepción de la solicitud de apelación realizada en forma oral o escrita.
- b. Los criterios contractuales aplicados para alcanzar la resolución definitiva.
- c. La especialidad de los dentistas u otros proveedores que hayan sido consultados.
- d. La dirección para enviar quejas al Departamento de Seguros de Texas:

Texas Department of Insurance  
P.O. Box 149091

Austin, TX 78714-9091

- e. El número telefónico gratuito del Departamento: 1-800-252-3439

**B. Apelaciones aceleradas:**

La investigación y la resolución de apelaciones relacionadas con emergencias existentes contemplarán la urgencia médica/dental del caso, pero no podrá excederse el plazo de un día hábil a partir de la solicitud de apelación. Debido a la emergencia existente, y cuando usted lo solicite, Aetna Dental Inc. dispondrá, en lugar de la reunión de un panel de apelación de quejas, la revisión de la apelación por parte de un proveedor dental que no haya revisado el caso con anterioridad y que pertenezca a la misma o similar especialidad que suele encargarse del tratamiento, del procedimiento o de la condición dental objeto de discusión. El proveedor dental que revise la apelación puede entrevistar al paciente o al representante que este haya designado y decidirá sobre la apelación. La primera notificación de la decisión podrá realizarse en forma oral si dentro de los tres días posteriores se envía por escrito. La investigación y la resolución de las apelaciones después de que se haya brindado atención de emergencia se llevarán a cabo de acuerdo con el proceso establecido en esta sección, incluido el derecho a la revisión por parte de un panel de apelación.

Los procedimientos de apelación descritos no prohíben al miembro hacer uso de otros recursos legales que puedan corresponder, si el miembro considera que la obligación de completar la apelación y el proceso de revisión pone en grave peligro su salud.

**VI. Comité de apelaciones de Aetna Dental Inc.**

En caso de no estar satisfecho con la decisión del panel de apelación de quejas, podrá apelar la decisión ante el Comité de apelaciones de Aetna Dental Inc. Deberá apelar por escrito ante Aetna Dental Inc. dentro de los quince (15) días hábiles desde que se le notifica la decisión del panel. El Comité de apelaciones revisará la decisión del panel de apelación de quejas, la correspondencia o cualquier documento relacionado con la disputa y emitirá su decisión por escrito dentro de los quince (15) días hábiles posteriores a la reunión del Comité.

**VII. Conservación de registros**

Aetna Dental Inc. conservará un registro de las quejas, de los procedimientos de queja y de las medidas tomadas al respecto durante tres (3) años a partir de la fecha de recepción de la queja. Tiene derecho a recibir una copia del registro de la queja y de los procedimientos de queja correspondientes. Aetna Dental Inc. conservará la documentación sobre cada queja recibida y sobre las medidas tomadas al respecto hasta el tercer aniversario de la fecha de recepción de la queja.

## DEFINITIONS

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply.

**Certificate:** This Certificate of Coverage, including the Summary of Coverage, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and dependent according to the **Group Agreement**.

**Contract Holder:** An Employer or organization who agrees to remit the premiums for coverage under the **Group Agreement** payable to Aetna Dental Inc. The Contract Holder shall act only as an agent of **Members** in the Contract Holder's group, and shall not be the agent of Aetna Dental Inc. for any purpose.

**Copay:** The amount shown for some services in the Dental Care Schedule that a covered dependent must pay to his or her **Primary Care Dentist** as part of the cost of the service.

**Covered Dental Services:** Dental services and supplies set forth in this **Certificate**, provided to a **Member**, while the person is a **Member**. Those services and supplies are subject to the limitations and exclusions of the **DPC Plan**.

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

**Dentist:** An individual licensed to practice dentistry by the Texas State Board of Dental Examiners.

**DPC Plan:** The plan of benefits provided under the section "Dental Plan Coverage".

**Emergency Care:** The dental services administered in a **Dentist's** office, dental clinic, or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson, possessing average knowledge of dentistry to believe that immediate care is needed.

**Group Agreement:** The Group Agreement between Aetna Dental Inc. and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Summary of Coverage, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

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

**Member:** A **Subscriber** or dependent as defined in this **Certificate**.

**Member Dental Provider:** Any **Dental Provider** who has entered into a written agreement with Aetna Dental Inc. to provide to **Members**, the dental care described herein.

**Necessary Service or Supply:** Coverage is only provided for a service or supply which is necessary for the diagnosis, care, or treatment of the dental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based on recognized standards of the health care specialty involved.

In no event will the following be considered to be necessary:

Those services rendered by a **Dental Provider** that do not require the technical skills of such a provider.

That part of the cost which exceeds that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the person's dental condition, except in the application of the Alternate Treatment Rule.

**Non-Member Dental Provider:** Any **Dental Provider** who has not entered into a written agreement with Aetna Dental Inc. to provide dental plan coverage covered services to **Members**.

**Open Enrollment Period:** A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in the **DPC Plan** without a waiting period or limitation, or if already enrolled in the **DPC Plan**, may transfer to an alternate dental plan offered by the **Contract Holder**.

**Orthodontic Treatment:** This is any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, bite, or jaws or jaw joint relationships, whether or not for the purpose of relieving pain.

Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Primary Care Dentist:** A **Member Dental Provider** currently chosen, by telephone or in writing, by the **Member**, to provide dental care.

A **Primary Care Dentist** chosen by the **Member** takes effect as a covered dependent's **Member Dental Provider** on the effective date of that dependent's coverage.

If the **Member** does not choose a Primary Care Dentist, Aetna Dental Inc. will have the right to make a selection for such **Member**. The **Member** will be notified of the selection.

A **Member** may change their Primary Care Dentist by notifying Aetna Dental Inc. by telephone or in writing.

The change will be effective as follows:

If Aetna Dental Inc. receives a request on or before the 15<sup>th</sup> day of the month, the change will be effective on the first day of the next month.

If Aetna Dental Inc. receives a request after the 15<sup>th</sup> day of the month, the change will be effective on the first day of the month following the next month.

In the event a **Member Dental Provider** discontinues an agreement to act as such under this Contract:

Aetna Dental Inc. will be liable for the services and supplies described herein being provided to a **Member** by such **Member Dental Provider** at the time of such discontinuance; but only until the provision of such services and supplies is complete, unless Aetna Dental Inc. makes a reasonably and medically appropriate provision for the assumption of such services by another **Member Dental Provider**.

Affected **Members** will be notified within 30 days of the date that Aetna Dental Inc. was notified of termination of their **Member Dental Provider**. In no event will the **Member** have less than 30 days actual notice of the termination of the **Member's Primary Care Dentist**. The **Member** will be provided with a current listing of participating providers and asked to select another **Member Dental Provider**.

The **Member** may choose a new **Primary Care Dentist** for the dependent. If the **Member** does not make a selection, Aetna Dental Inc. will have the right to make the selection and will notify the **Member**.

If a **Member's Primary Care Dentist** contract with Aetna Dental Inc. terminates, the **Member** will be notified. The provider will continue to provide treatment to any **Member** who is receiving active treatment on the date of termination until the covered **Member** can either select another **Member Dental Provider** or be assigned by Aetna Dental Inc. to another **Member Dental Provider**, and be accepted by another **Member Dental Provider**.

**Reasonable Charge:** The Reasonable Charge for a service or supply is the lower of:

the **Dental Provider's** usual fee charged to patients in general for furnishing it; and

the prevailing fee charged by other providers to patients in general in the geographic area in which it is furnished, as determined by Aetna Dental Inc.

In determining the Reasonable Charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna Dental Inc. may take into account certain relevant factors, such as:

the complexity involved;  
the degree of skill needed;  
the provider's specialty;  
the range of services or supplies provided; and  
the prevailing fee in other areas.

**Referral Care:** Covered services given to a **Member** by a **Specialty Dentist** after referral by the **Member's Primary Care Dentist** and provided Aetna Dental Inc. approves coverage for the treatment. A referral by the **Primary Care Dentist** is not required for any orthodontic services.

**Service Area:** The area consisting of the counties located in the State of Texas which are shown on the Summary of Coverage.

**Specialty Dentist:** Any **Dental Provider** who, by virtue of advanced training, is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry. In addition, this **Dental Provider** has entered into a written agreement with Aetna Dental Inc. to provide dental care described under the **DPC Plan to Members**.

**Subscriber:** A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Summary of Coverage, has enrolled, and is subject to any premium requirements as set forth in the premiums section of the **Group Agreement**.

## GLOSSARY

The following dental terms have the meanings indicated.

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

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

**Amalgam** – A metal alloy used in filling teeth.

**Apicoectomy** – The surgical removal of the root tip.

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

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

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

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

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

**Frenectomy** – Surgical removal or loosening of the frenum.

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

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

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

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

**Macrognathia** – A definite overgrowth of the mandible and maxilla.

**Mandible** – The lower jaw.

**Mandibular** – Pertaining to the lower jaw.

**Maxilla** – The upper jaw.

**Maxillary** – Pertaining to the upper jaw.

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

**Myofunctional therapy** – Training to curb or eliminate abnormal muscle function of the oral cavity.

**Occlusal** – The chewing surfaces of the posterior teeth.

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

**Orthodontic appliance** – Any appliance used to apply forces for tooth movement during orthodontic treatment.

**Palate** – The roof of the mouth.

**Palatal** – Pertaining to the roof of the mouth.

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

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

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

**Periodontitis** – Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

**Periradicular** – Around the root.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Trigeminal nerve** – The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

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

## 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](http://www.aetna.com).



## **Continuation Coverage Rights Under COBRA**

### **Introduction**

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

## **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

## **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### ***Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

### ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## **CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW**

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

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

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

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

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

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

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

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

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

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

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

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

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

**Employer Identification Number:**

74-1109620

**Plan Number:**

501

**Type of Plan:**

Welfare

**Type of Administration:**

Group Insurance Policy with:

Aetna Dental Inc.  
Three Sugar Creek Center  
Sugar Land, TX 77478  
(877) 238-6200

**Plan Administrator:**

Rice University  
6100 Main Street MS 92  
Houston, TX 77005

**Agent For Service of Legal Process:**

Rice University  
6100 Main Street MS 92  
Houston, TX 77005

**End of Plan Year:**

June 30

**Source of Contributions:**

Employer & Employee

**Procedure for Amending the Plan:**

The Employer may amend the Plan from time to time by a written instrument signed by the Assistant Director of Human Resources, Benefits or the Associate Vice President of Human Resources.

## ERISA RIGHTS

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

### Receive Information about Your Plan and Benefits

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

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

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

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

### Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

### Prudent Actions by Plan Fiduciaries

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

## ENFORCE YOUR RIGHTS

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

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

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

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

### **ASSISTANCE WITH YOUR QUESTIONS**

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

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

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

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

### **ADDITIONAL INFORMATION**

#### Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at **[www.aetna.com](http://www.aetna.com)**.

**AETNA DENTAL INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date July 1, 2014

**Aetna Dental Inc.**, (“Aetna”) and **Contract Holder** agree to the following provisions:

1. The following language is hereby deleted from the “Termination of Coverage” section of the **Certificate of Coverage**:

6. If you fail to make any required contribution, at the later to occur of:

The end of the period for which contribution was made; and

30 days after written notice from Aetna Dental Inc.

2. The following language is added to the “Termination of Coverage” section of the **Certificate of Coverage**:

6. **End of Coverage Date**

Unless otherwise specified above, your end of coverage date will be the end of the month in which you are no longer eligible under the plan.

For the purposes of this section, “month” means the period from a date in a calendar month to the corresponding date in the succeeding calendar month. If the succeeding calendar month does not have a corresponding date, the period ends on the last day of the succeeding calendar month.

Examples:

- For calendar months with succeeding corresponding dates: May 5<sup>th</sup> to June 5<sup>th</sup> would equal one “month”.
- For calendar months without succeeding corresponding dates: January 31<sup>st</sup> to February 28<sup>th</sup> would equal one “month”.

The monthly premium required by Aetna for your coverage will be the applicable rate in effect on the date the coverage ends. The **Contract Holder** is obligated to pay premium until the end of the month in which you are no longer eligible under the plan.

# Aetna Dental Inc.

Hartford, Connecticut 06156

## Amendment to the Certificate of Coverage

**Contract Holder:** Rice University  
**Group Policy No.:** 878783  
**Issue Date:** August 28, 2014  
**Effective Date:** July 1, 2014

The Certificate of Coverage is amended as described below. This amendment is effective on the date shown above. The changes set forth apply to covered persons residing in Texas.

### The “Dependent Eligibility” section of the Certificate is hereby deleted and replaced by the following:

For Dependents and Domestic Partners -- To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers** and the dependent must be:

- a. the spouse of a **Subscriber** under this **Certificate**; or
- b. If your employer chooses to include coverage for domestic partners, then domestic partners as described below; or
- c. a dependent unmarried child under age 26 including a natural, foster, step, or legally adopted child, a proposed adoptive child, or a child for whom the **Subscriber** is a party in a suit in which the adoption of the child by the **Subscriber** is sought, and a child under court order or any such child who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits; or
- d. a dependent unmarried grandchild who is living with and in the household of the **Subscriber**.

In addition,

- the dependent’s legal residence must be the same as the **Subscriber’s**; or
- if the dependent’s legal residence is not the same as the **Subscriber’s**, the dependent must live in the **Service Area** (except in the case of a qualified medical support order). A dependent unmarried grandchild must have the same legal residence as the **Subscriber**.

If your employer chooses to include coverage for domestic partners, then a domestic partner under this plan is an individual who:

- is at least 18 years old; or is the age of majority in Texas or is legally emancipated; and
- is mentally competent to consent to a contract; and
- has for a period of at least six (6) months prior to applying for coverage shared a common permanent residence with you; and
- does not share a permanent residence with another person who has obtained the age of majority and who has the competency to consent to a contract for a permanent residence;
- is jointly responsible with you for financial assets.



Aetna may require evidence that these requirements are met, both at the time the Application is submitted and at future times while coverage remains in effect. Evidence may include a domestic partnership registration where available, or documents showing:

- i) common residence;
- ii) common ownership of a home, automobile or other financial assets;
- iii) joint responsibility for a mortgage, long-term loan or other financial liability; or
- iv) other evidence of financial interdependence acceptable to Aetna.

The effective date of coverage for a domestic partner, if other than at the time you are first eligible to enroll will be as stated in the plan rules once the evidence of domestic partnership requirements listed above have been submitted to Aetna.

**AETNA DENTAL INC.  
TEXAS**

**DENTAL CARE RIDER**

**Contract Holder Group Agreement** Effective Date: **July 1, 2014**

The Aetna Dental Inc. **Certificates of Coverage** are hereby modified as follows:

The following exclusion is hereby deleted from the *Exclusions and Limitations* section(s) of the **Certificate**:

Services, procedures, drugs, or other supplies that are determined by Aetna Dental Inc. to be experimental, or still under clinical investigation by health professionals.

This plan rider shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.