MILA

YOUR DENTAL PLAN

THE FREEDOM

As a member of the MILA National Health Plan, you are eligible to receive comprehensive dental benefits, administered by Aetna, beginning January 1, 2011.

What's Inside

The goal of the MILA Dental Plan is to make good dental care available and affordable for you and your family. The plan includes generous coverage for a wide range of services:

- preventive and diagnostic care, such as routine check-ups, x-rays and cleanings;
- basic services, such as fillings and root canals;
- major services, such as bridges, crowns and dentures; and
- orthodontic treatment for eligible dependent children.

Terms to Know

Annual Benefit Maximum: The maximum amount of money the dental plan will pay for covered expenses in a plan year. There is a separate lifetime maximum for orthodontic services.

Coinsurance: The percentage of covered expenses that you and the plan each pay. For example, the plan pays 85% of the cost of basic services, and your coinsurance is 15%.

Covered Services: Services for which the plan provides a benefit. There are four categories: Preventive, Basic, Major and Orthodontic.

Deductible: The amount of covered expenses you pay each year for Basic or Major services before the dental plan starts to pay benefits. The deductible does not apply to Preventive or Orthodontic services.

Maximum Allowable Charge (MAX): The maximum amount that the plan will pay for services provided by an out-of-network provider, which is equal to the amount it would have paid a network provider in the same geographic area with the same credentials.

Network Provider: Providers within Aetna's Dental PPO/PDN with PPO II network who are contracted to provide services at a negotiated rate and file claim forms on your behalf.

Out-of-Network Provider: Providers who are not contracted with Aetna's network. When you visit an out-of-network provider, you will be responsible for the difference in cost between the provider's bill and Aetna's maximum allowable charge (MAX) for the service. You may also be responsible for submitting claim forms.

Preferred Provider Organization (PPO): A plan in which members may visit any qualified provider they choose. However, if the member visits a network provider, plan benefits will result in a lower out-of-pocket expense to the member.

TO SEE ANY DENTIST YOU CHOOSE

Introducing the Aetna PPO Network

Here's How the Plan Works

MILA's Dental Plan, using the Aetna PPO Network, works much like a traditional dental plan:

- You can visit the provider of your choice when you need care — no referrals are necessary and you do not have to designate a primary care dentist.
- You'll save time and money when you use a provider who participates in the Aetna PPO II network. Network providers are contracted to provide their services at a negotiated rate.
- When you visit your dentist, you will not pay a copay for an office visit, although you do have a deductible to satisfy before the plan pays a percentage of covered dental expenses (called coinsurance). The deductible does not apply to preventive services, which are 100% covered when you visit a network provider.
- The amount the plan pays varies by the type of service.
- The plan will pay up to $2,500 per person each year for covered services.
- Benefits for orthodontic services are available only for eligible dependent children. They do not count toward the annual benefit maximum, but are subject to a separate lifetime maximum of $1,500 per child.

Benefit Highlights

Plan Features	Amount
Annual Deductible*	
Individual	$25
Family	$75
Orthodontic Deductible	None
Annual Benefit Maximum	$2,500
Orthodontic Lifetime Maximum	$1,500

Covered Services	The Plan Pays
Preventive Services	100%
Basic Services*	85%
Major Services*	85%
Orthodontic Services**	85%

** The deductible applies to Basic & Major services only.*

*** Available only for eligible dependent children (appliance must be placed prior to age 20).*

The Network Difference

The MILA Dental Plan allows you the freedom to visit any licensed dentist. However, there are advantages to visiting a network dentist instead of an out-of-network dentist. When you visit an Aetna PPO II network provider, you'll save on your overall cost of dental care and your claim form will be filed for you. If you visit an out-of-network provider, your benefits will be limited to a maximum allowable charge (MAX) that will be the basis for the plan's payment. The MAX is based on the contracted fee that would have been payable to a participating network provider for the same service in the same geographic area.

Comparison of Coverage for Network and Out-of-Network Providers

Network	Out-of-Network
You will usually pay the lowest amount for services as network providers agree to accept a reduced fee.	You are responsible for the difference between the amount the plan pays and the amount your out-of-network provider charges for the product or service. You will usually have higher out-of-pocket costs when you visit an out-of-network provider.
You will be charged for only your share of the treatment cost at the time the service is rendered. Aetna will pay its portion directly to the network provider.	**Your out-of-network provider may require that you pay the entire bill at the time of service, and you will wait for reimbursement.**
Network providers will complete claim forms and submit them at no charge.	You may have to complete and submit your own claim forms or pay your out-of-network dentist a service fee to submit them on your behalf.

Network providers can be found on DocFind®, Aetna's online provider directory, at www.aetna.com. DocFind can also be accessed from Aetna Navigator™, Aetna's self-service website that offers personalized plan information and links to other health information. Or, you can call Aetna Member Services at 1-877-295-3719 for provider information.

Network Savings Example

Here's an example of how using a network provider can result in lower out-of-pocket costs. Let's say Bill visits the dentist and finds he needs two fillings. He's already satisfied his deductible for the year and has not yet met his annual benefit maximum. The dentist charges $180 for these services. Luckily, Bill has visited a network dentist that has contracted with the plan to provide both fillings for only $90. The plan then pays 85% of this cost, and Bill's share is just $13.50. Had he visited an out-of-network dentist not contracted to provide discounted services, his share of the cost would have been $103.50. **Bill saved $90 by visiting a network provider!**

	Network	Out-of-Network
Dentist bills	$180.00	$180.00
Amount dentist will accept as payment in full	$90.00 (Network discount)	$180.00 (No fee agreement)
Aetna's payment – 85%	$76.50	$76.50
Bill's share	$13.50	$103.50
Bill's savings	**$90**	$0

Covered Services

The MILA Dental Plan has four categories of covered expenses: Preventive, Basic, Major and Orthodontic. Some have limitations based on your age or how often they are used. Refer to your Summary Plan Description for details on benefit levels and covered services.

Preventive — Covered 100%

- Cleanings — 2 per year
- Exams — Routine: 2 per year
- Exams — Problem-focused: 2 per year
- Fluoride treatment — 1 per year for children under age 16
- Bitewing X-rays — 1 set per year
- Full mouth X-rays — 1 set every 3 rolling years
- Sealants — 1 per tooth every 3 rolling years under age 16; permanent molars only
- Space maintainers — no age limit (covered for premature loss of primary teeth only)

Basic — Covered 85%

- Root canal therapy
- Scaling and root planing — 4 separate quadrants every 2 rolling years
- Gingivectomy — 1 per quadrant or site every 3 rolling years
- Amalgam (silver) fillings
- Composite fillings (anterior teeth only)
- Stainless steel crowns
- Incision and drainage of abscess*
- Uncomplicated extractions
- Surgical removal of erupted tooth*
- Surgical removal of impacted tooth (soft tissue)*
- Osseous surgery — 1 per quadrant every 3 rolling years
- Surgical removal of impacted tooth (partial bony/full bony)*
- Crown lengthening

Major — Covered 85%

- Inlays
- Onlays
- Crowns
- Full and partial dentures
- Pontics
- General anesthesia/intravenous sedation*
- Denture repairs
- Crown build-ups

Orthodontic Services — Covered 85% up to a Lifetime Maximum of $1,500

Benefits for orthodontic treatment are available only for eligible dependent children. These services do not count toward the calendar year maximum, but are subject to a lifetime maximum.

* *Certain services may be covered under your MILA Medical Plan rather than under this Dental Plan. Contact Member Services at either CIGNA or Aetna for more information on a particular service.*

QUESTIONS

Contact MILA

- call: **212-766-5700**
- email: **info@milamhctf.com**

What's Not Covered

Here's a partial listing of charges and services this dental plan does not cover. For a complete list of the plan's exclusions and limitations, refer to your Summary Plan Description, which is available from MILA.

- Services or supplies that are covered under a MILA medical plan
- Replacement of lost, missing or stolen appliances and certain damaged appliances
- Dental services or supplies that are primarily used to alter, improve or enhance appearance
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder (TMJ)
- Treatment by other than a dentist, except cleaning of teeth or fluoride treatments that may be done by a licensed dental hygienist under the supervision and guidance of a licensed dentist
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition
- All other limitations and exclusions in your plan documents

How will I know if the treatment I need will be covered?

To find out your share of the cost for a service, ask your provider to submit an estimate to Aetna before care begins. This will let both you and the dentist know what the coverage would be if the service were done. You or your dentist may also call the Member Services number from your ID card for general information about your dental coverage.

Rules and Limitations

Replacement Rule

The replacement of, addition to, or modification of existing dentures, crowns, casts or processed restorations, removable denture, fixed bridgework or other prosthetic services 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. This coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown, cast or processed restoration, removable denture, bridgework, or other prosthetic service 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 extracted while the person is covered, 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.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures, fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures, fixed bridgework and other prosthetic services are:

- Needed to replace one or more natural teeth that were removed while the person was covered under this plan or a prior Port-sponsored Dental Plan; and
- Are not abutments to a partial denture, removable bridge or fixed bridge installed during the prior 8 years.

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna 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 practice.

If the treatment is being given by a participating dental provider and the covered person 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.

Continuation of Care

What will the MILA Dental Plan cover if a service started before my effective date?

If you were covered under a prior Port-sponsored Dental Plan in 2010 and started treatment for an ongoing service before January 1, 2011, your previous plan should cover the service under an extension of benefits provision. Contact your previous insurance provider for more information. If more than one service is needed to fix a problem, those services started after January 1, 2011 would be considered for benefits.

Continuing Orthodontic Treatment — What do I need to know?

If an eligible family member is enrolled in active orthodontic treatment, the plan does not require a change of orthodontist. Please include all of the following information with your first paper or electronic claims submission to help us make a benefit determination quickly and eliminate the need for additional claims submissions:

- Banding date
- Length of treatment
- Assignment information
- ADA code
- Total case fee
- Primary insurance provider explanation of benefits (if coordination of benefits is necessary)
- Previous insurance provider information, including deductible, coinsurance/copay, maximum and amount paid to date (if patient is continuing active treatment). This will help us determine your available orthodontic benefit.

Tools and Resources

It's Easy to Manage Your Benefits

Register at www.aetna.com to:

- Search for network dentists by name, specialty, zip code or miles using the DocFind® online directory and find maps and directions — Your dental network's formal name in the Aetna DocFind system is "Aetna Dental PPO/PDN with PPO II Network"
- Get average estimated costs for many services
- Review who is covered by your plan
- Check claims and review statements
- Print a temporary ID card and request a replacement card
- Contact Member Services

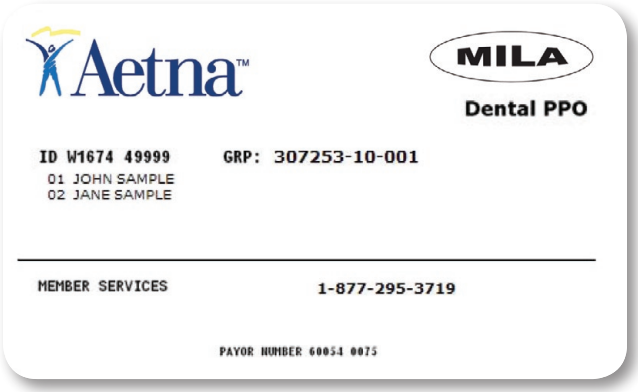
Dental Health Information at Your Fingertips

Visit the Aetna Simple Steps to Better Dental Health® website, www.simplestepsdental.com, for articles, illustrations, interactive tools, information on dental conditions, treatments, and more.

Identification Cards

In January, you'll receive an identification (ID) card and one additional family card for dependents that enroll. The ID card includes plan identification information, dependent coverage information, and the telephone number and website for contacting Aetna Member Services.

Sample card:



No computer? No problem! Call Member Services at the number on your ID card.

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