Dental

Dental insurance helps you and your covered dependents take good care of your dental health. That's why Associates have three Dental options. And, you and your family must enroll to have dental coverage even if you don't choose medical coverage.

Aetna's Role

This plan or policy is administered by Aetna Life Insurance Company (Aetna). Aetna is the claims administrator and named fiduciary for benefit claims under the Dental Basic and Dental Plus options and the insurer for the DMO option. You may contact Aetna for more information, to request a free copy of the policy, including a detailed list of what's covered, limitations and exclusions and claims and appeals procedures, or to find out how a specific benefit works.

In This Section — **See Page**

Benefits At-a-Glance **58**
Participation **59**
- Eligibility 59
- Cost of Coverage 59
- When Coverage Begins 59
- Changing Your Coverage 60
- When Coverage Ends 61
- Continuing Your Coverage 62

How the Plan Works **63**
- Comparing Your Options 63
- Eligible Expenses 67
- Expenses Not Covered 67
- Alternate Procedures 68
- Pre-Treatment Estimates 68
- Coordination of Benefits 69
- More Information 69
- Filing Claims 69

This information is intended to be a summary of your benefits and does not include all plan or policy provisions, limitations and exclusions. If there is a discrepancy between this book and the plan(s) or policy(ies) issued by the Company or the insurer, the terms of the plan(s) or policy(ies) will govern. You may obtain copies of the plans from the Company. You may obtain copies of the policies by contacting the insurers. The Company reserves the right to terminate or amend its benefit plans at any time.

Benefits At-a-Glance

Option	Eligibility	Coverage Levels	Key Features
Dental Basic	All Benefits Eligible Associates and their eligible dependents (except those in Hawaii)	▪ Associate Only ▪ Associate + Spouse/DP ▪ Associate + Child(ren) ▪ Associate + Family	▪ Preventive care at 100% with no deductible ▪ Basic care at 70% after deductible ▪ Major care is not covered ▪ Orthodontia is not covered
Dental Plus	All Benefits Eligible Associates and their eligible dependents (except those in Hawaii)	▪ Associate Only ▪ Associate + Spouse/DP ▪ Associate + Child(ren) ▪ Associate + Family	▪ Preventive care at 100% with no deductible ▪ Basic care at 80% after deductible ▪ Major care at 50% after deductible ▪ Orthodontia is covered
DMO (available in some areas)	All Benefits Eligible Associates and their eligible dependents (except those in Hawaii and Puerto Rico) may enroll in this option if your home or work ZIP code is in the network	▪ Associate Only ▪ Associate + Spouse/DP ▪ Associate + Child(ren) ▪ Associate + Family	▪ No deductible ▪ Preventive care at 100% ▪ Basic care at 100% ▪ Major care at 50% ▪ Orthodontia is covered ▪ Primary care dentist required

For Associates in Hawaii, please refer to the “HMO Benefits” section of the *Medical Plan.*

Participation

Eligibility

You are eligible to enroll in Dental when you become Benefits Eligible (except Associates in Hawaii).

The Dental option also allows you to purchase coverage for your eligible dependents.

Eligible dependents include:

- **Spouse** – The individual of the opposite gender to whom you are legally married under the laws of your home state.
- **Domestic Partner (DP)** – A same-gender spouse, civil union member or registered domestic partner under the laws of your home state, or a same-gender individual that has lived with you in a committed relationship for at least 12 months and meets the other requirements listed in the Company's domestic partner online certificate.
- **Child** – Your or your spouse/DP's unmarried child(ren) under the age of 19, if a full-time student under the age of 24, or any age if incapacitated before age 19 (age 24 if a full-time student). Children include natural born, legally adopted, placed for adoption, foster child(ren) or court-appointed ward(s) that live with you at least six months of the year and do not provide more than one half of their own support.

See the *Eligibility and Enrollment* section for details about becoming Benefits Eligible.

Cost of Coverage

The cost for Dental coverage is based on the option and coverage level you select. JCPenney pays a portion of the cost and you pay the remainder through before-tax paycheck deductions (except in Puerto Rico where deductions are taken after taxes). Coverage for a DP or a DP's child is paid by the Associate on an after-tax basis. In addition to premiums deducted from your paycheck, you may be responsible for paying deductibles, copayments and coinsurance depending on the option you elect.

For more cost information, see the premium tables on *Your Benefits Homepage* by logging on to the Associate Kiosk. Coverage for an Associate on a leave is direct billed. See the *Time Away From Work* section for details.

When Coverage Begins

After you enroll, coverage is effective on:

- Your Benefits Eligible effective date
- The Annual Enrollment effective date
- The first day of the month in which your qualified change in status or special enrollment right, such as marriage or birth of a child, etc. is effective. (For more information about special enrollment rights, see the *Legal Notices* section.) See the *Eligibility and Enrollment* section for more information.

About ABC Program Coverage

As a newly hired Associate, you can enroll in the ABC Program options, including Medical, Dental, Vision, Term Life/AD&D, Accident, Critical Illness and Universal Life.

When you become Benefits Eligible, coverage for ABC Medical, Dental and Term Life/AD&D are automatically cancelled.

If you lose Benefits Eligible status, you can re-enroll in ABC Medical, Dental and Term Life/AD&D by calling the ABC Service Center. You must enroll within 30 days of loss of Benefits Eligible status.

Changing Your Coverage

Within 60 days of a life event, you must notify PowerLine of the change in your status.

Proof of the event may be required. Any change requested must be consistent with your life event.

If You...	What Happens to Your Dental Coverage
Become Benefits Eligible	You may enroll yourself and your eligible dependents in Dental. ABC Medical, Dental and Term Life coverage will automatically be cancelled.
Lose Benefits Eligible status	Coverage ends for you and your covered dependents on the date you lose Benefits Eligible status. You and/or your dependents may elect to continue coverage under COBRA and/or enroll in the ABC Dental option. You must enroll for the ABC coverage within 30 days and within 60 days for COBRA coverage.
Get married/form a partnership	You may enroll, add, change options or drop coverage for yourself and/or your new dependents.
Have a spouse/DP who loses benefits coverage	You may enroll, add, change options or drop coverage for yourself and/or your new dependents.
Get divorced/ separated/ annulment/ terminate a partnership	You may enroll, drop, or change coverage options for yourself and your children. Spouse/DP coverage ends on the last day of the month in which the divorce or legal separation occurs or partnership ends unless otherwise required by state law. A QMCSO may require you or your spouse to cover your children. See "Qualified Medical Child Support Order (QMCSO)" in the *Legal Notices* section for more information.
Have or adopt a child	You may enroll, add, change options or drop coverage for yourself and/or your new dependents.
Have a child who loses eligibility	Child coverage ends on the last day of the month before he or she reaches age 19 or age 24 if a full-time student or is no longer incapacitated. Child coverage also ends on the first of the month in which your child marries.
Become disabled	Coverage ends on the last day of the month in which employment ends, unless you and/or your dependents continue coverage under COBRA. If you were hired or rehired before January 1, 2002, and you are determined to be Social Security Disabled, you are eligible for Dental coverage if, on the date your employment ends: ▪ Your disability that began while you were employed by the Company is that same disability that qualifies you for Social Security Disability benefits ▪ You are a Benefits Eligible Associate and a participant in Dental or can provide proof of other creditable coverage from the time your employment ends until you request coverage under Dental, and ▪ You have completed at least 10 years of total service, with five consecutive years immediately before your employment ends.
Go on an approved leave of absence	Coverage ends on the last day of the month in which your unpaid leave begins or for which a full month's premium was paid. You or your dependents may continue your coverage through direct billing. See the *Time Away From Work* section for more details.
Return from an approved leave of absence	If you continued coverage during your leave, coverage continues on a before-tax basis after you return. If you stopped coverage during your leave, coverage in effect immediately before you went on leave automatically begins again on the first day of the month in which you return to work. See the *Time Away From Work* section for more details.

If You…	What Happens to Your Dental Coverage
Leave the Company	Coverage ends on the last day of the month in which your employment ends, unless you and/or your dependents continue coverage under COBRA. You may be eligible for coverage as a retired or disabled Associate if you were hired or rehired January 1, 2002.
Retire	You may continue coverage as a retiree if you were hired or rehired before January 1, 2002, and if on the date your employment ends: ▪ You are at least age 55 ▪ You are Benefits Eligible and already enrolled in Dental or you can provide proof of other creditable coverage ▪ You have at least 10 years of total service, with five consecutive years immediately before you retire, and ▪ Your age plus years of total service is equal to 80 points or more. Alternatively, you and your dependents may choose to continue coverage under COBRA. However, if you elect COBRA continuation coverage, you will not be able to enroll in Dental as a retired Associate at a later date. Request a *Your Retiree Benefits Book 1* from PowerLine for additional information.

When Coverage Ends

Generally, coverage ends after:

- You or your dependent loses eligibility
- You begin a leave of absence
- The policy ends or is cancelled and is not replaced
- Premiums are not paid
- You cancel coverage, if allowed
- Your employment ends
- You or your dependent(s) die
- You cancel coverage for your dependents
- The benefit or policy is no longer offered by your participating employer
- The plan is terminated or amended to end coverage for a group or class that includes you or your dependent, or
- You make a misrepresentation or fraudulent claim for benefits.

If your coverage ends, you and your covered dependents may be eligible to continue coverage under COBRA.

Continuing Your Coverage

You may be able to continue your benefits coverage for you and/or your eligible dependents under certain circumstances. If you:

- Lose Benefits Eligible status – See "Changing Your Coverage" on page 60 and the *Legal Notices* section for more information.
- Begin or Return from a Leave of Absence – See "Changing Your Coverage" on page 60 and the *Time Away from Work* section for more information.
- Leave or Retire from the Company – See "Changing Your Coverage" on page 60 and the *Eligibility and Enrollment* section for more information.
- Become Disabled – See "Changing Your Coverage" on page 60 and the *Eligibility and Enrollment* section for more information.
- Die – See "Changing Your Coverage" on page 60 and the *Eligibility and Enrollment* section for more information.

What happens if I am in the middle of treatment when my coverage ends?

Most services are not covered after your coverage ends. Some supplies and services are covered if they are ordered by the dentist before coverage ends and are installed or delivered no later than 30 days after coverage ends. Some examples are:

- Inlays or onlays
- Crowns
- Removable or fixed bridgework
- Cast or processed restorations
- Dentures, and
- Root canals.

For more information about how your coverage would work in these situations, contact Aetna at 1-800-811-5671.

How the Plan Works

JCPenney offers three Dental options — Dental Basic, Dental Plus and a DMO. You choose the option that best suits your needs. Dental insurance helps with dental expenses and coordinates with your Medical Plan coverage on some benefits and on prescription drugs that are prescribed by your dental provider. Aetna is the named administrator for benefit claims processing for the Dental Basic and Dental Plus options and the insurer for the DMO option.

Aetna provides Associates access to a large national network of dentists that have agreed to provide services at reduced rates. When you use a network provider, you save money.

Quick Tip: Use Network Dentists to Save Money

You can use DocFind, Aetna's on-line provider directory, on the Aetna Web site at www.aetna.com/custom/jcpenney to find a dentist in your area. To receive a free list of network providers for the Dental Basic, Dental Plus or DMO options, contact Aetna.

When does coverage end for my child?

Your child's coverage will end on the last day of the month before he/she turns 19 (age 24 if a full-time student). So, if your child's birthday is April 6, his/her coverage ends March 31.

Comparing Your Options

Dental Plan Comparison Chart

Plan Feature	Dental Basic*	Dental Plus*	DMO
Annual Deductible			
▪ Per person ▪ Family	$50 $150	$50 $150	None None
The Plan pays up to the amount noted below for covered expenses:			
Annual Maximum Benefit per person (for all services combined except when noted)	$1,000	$1,500	None (does not include orthodontia)
Preventive Care Oral exams, cleanings, X-rays**, etc.	100% (no deductible)	100% (no deductible)	100%
Basic Care Fillings, extractions, sealants, etc.	70% after deductible	80% after deductible	100%
Major Care Bridgework, crowns, inlays, etc.	Not Covered	50% after deductible	50%
Special Services Realignment of teeth due to tumors, cysts, accidental injury or birth defects	Not Covered	50% after deductible (lifetime maximum benefit per person of $1,500)	Not Covered
Orthodontia Braces, retainers, etc. (for dependent children when treatment begins before age 19)	Not Covered	50% (no deductible)	50% (no deductible)

Plan Feature	Dental Basic*	Dental Plus*	DMO
The Plan pays up to the amount noted below for covered expenses:			
Lifetime Maximum Orthodontia Benefit per person	Not Applicable	$1,500	One complete course of Treatment
Prescription Drugs (if not covered under Medical)	80%	80%	80%

* The amount paid is subject to R&C limits.

** Certain X-rays are subject to plan limits. Please contact your carrier for more information.

Key Terms:

Reasonable and Customary (R&C) – A range of fees typically charged by most dental providers in your area. R&C applies to all dental services — including cleanings, X-rays, fillings, dentures and oral surgery. Network dentists automatically charge R&C for their services. Dentists outside the network may charge more than R&C. Before you have dental work, you can call Aetna to find out in advance if the charge will be R&C. You will have to pay any charges that are more than the R&C costs.

Network – A network is a group of dentists that agree to provide services at negotiated rates to people who belong to certain options. Because the fees are pre-set, the cost for in-network care is lower.

Dental Basic and Dental Plus

The Dental Basic and Dental Plus options are dental Preferred Provider Organizations (PPOs). When you use a PPO, you can see any dentist you choose. However, there is a network of dentists who agree to provide services to PPO members for a discounted rate. Dentists who are not in the network may charge more than network dentists and may not file a claim for you. In most cases, your expenses will be lower if you use a network provider.

The Dental Basic and Dental Plus options only pay for services up to the R&C limit. Dentists in the network have agreed to charge fees that are within the R&C limit. If you elect to receive services from a non-network provider, you will be responsible for any charges in excess of R&C.

Paying for Dental Expenses

In addition to the monthly premium, which is based on the option and the coverage level you select, you must pay a deductible and coinsurance on eligible Basic Care, Major Care, Special Services and Orthodontia for the Dental Plus option. You must pay a deductible and coinsurance on eligible Basic Services for the Dental Basic option.

Deductible

Your deductible is an amount you pay once a year before your coinsurance begins. There is an individual deductible and a family deductible. The family deductible is met when eligible expenses for you and/or any covered dependent reach the family deductible amount.

- Individual: $50
- Family: $150

Example: You are enrolled in the Dental Basic option and get a filling that in-network costs $200. Here's how it works:

- You would pay your $50 deductible and there would be a balance of $150
- Then, the plan's coinsurance would kick in and the plan would pay $105 (70 percent coinsurance of $150) and you would pay the remaining $45 (30 percent coinsurance of $150)
- You would pay a total of $95 ($50 deductible + $45 coinsurance)

Since you have now met your deductible, you would pay only coinsurance for the rest of the year. For example, if you had another filling that costs $175 later in the year:

- The plan would pay $122.50 (70 percent coinsurance)
- You would pay $52.50 (30 percent coinsurance)

Key Terms:

Coinsurance – The percentage of a covered expense that is shared by you and JCPenney.

The following expenses do not count toward your annual deductible:

- Amounts above the level considered R&C (only applies if you receive services out of network)
- Services not covered by Dental
- Prescription drugs purchased under the Prescription Drug Program (see the *Medical* section for further information), and
- Charges above the maximum benefit provided for that type of service.

Annual Maximum

The maximum benefit that you and each of your covered dependents may receive during a calendar year is:

- For the Dental Basic option: $1,000
- For the Dental Plus option: $1,500

This maximum includes all covered services (except for orthodontia, which is covered under the Dental Plus option but not under the Dental Basic option). These non-orthodontia covered services include:

- For the Dental Basic option: services for preventive care, basic care, and prescription drug amounts
- For the Dental Plus option: services for preventive care, basic care, prescription drug amounts, major care, and special services

Can I cover my dependent who lives in another state or city?

If your spouse/DP or your child lives in another city or state for part of the year, you may cover that dependent, but you should carefully consider which option is right for you. The DMO network may not be available in all cities. You can find out by contacting Aetna.

Example: You are enrolled in the Dental Basic option and get some fillings and have other teeth pulled that, in-network, costs a total of $1,900. Here's how the annual maximum would work:

- You pay your deductible of $50 leaving a balance of $1,850
- The plan's coinsurance kicks in and the plan pays $1,000 toward the balance even though the 70 percent coinsurance would equal $1,295 (70 percent of $1,850). That's because the annual maximum is $1,000
- You would be responsible for your coinsurance amount of $555 (30 percent of $1,850) plus the $295 over the $1,000 annual maximum
- You would pay a total of $900 ($50 deductible + $295 in excess of annual maximum and your coinsurance of $555)

Lifetime Maximum

The Dental Plus option has a lifetime maximum for orthodontia of $1,500 per person.

Emergency Care

With the Dental Basic or Dental Plus option, you can use any dentist at any time. If you have an emergency, your services will be paid the same way they would be paid in any other situation.

If you must receive emergency care from a non-network provider, treatment will be covered up to the lesser of the R&C limits or the actual charges.

DMO

The DMO is a dental maintenance organization. When you choose this option, you can only use dentists in the DMO network. Dental care is not covered when you use a non-network dentist, except in certain emergency situations. When you call for an appointment with a network provider, it's a good idea to double check that the provider is still in the Aetna DMO network.

Primary Care Dentist

If you choose the DMO, you must have a Primary Care Dentist (PCD) on file with Aetna. The PCD is the dentist that you'll see for all your dental care. If your PCD leaves the DMO network, you must select a new PCD to be covered, even if you have treatment in process.

You may change your PCD at any time by calling Aetna at 1-800-811-5671. If you change your PCD on or before the 15th of the month, your change goes into effect on the first day of the following month. If you call after the 15th of the month, your change goes into effect on the first day of the second following month. You will receive a new dental ID card if you are in the DMO and select a new PCD.

If you were referred to a specialty dentist who leaves the DMO network while treatment is in progress, you may complete the treatment and charges will still be covered.

Paying for Dental Expenses

In addition to the monthly premium, which is based on the option and the coverage level you select, you must pay coinsurance on major care and orthodontia.

Annual Maximum

There are no annual maximums for the DMO option.

Lifetime Maximum

The DMO option limits you to one complete course of orthodontia per lifetime per person.

Emergency Care

Your emergency care is covered 24-hours-a-day, seven-days-a-week. If you need emergency care after regular office hours, contact your PCD at the telephone number shown on the front of your Dental ID card. If you can't reach your PCD or you are out of town, call Aetna at 1-800-811-5671 for help.

If you must receive emergency care from a non-network provider, treatment will be covered up to the lesser of the R&C limits or the actual charges.

Key Terms:

Primary Care Dentist (PCD) – A dentist who is responsible for providing and managing all your dental care. When you are enrolled in the DMO, you and each covered family member must choose a PCD. All your dental care, except orthodontia, must be coordinated through your PCD (or a specialty dentist for orthodontia).

Specialty Dentist – A dentist that specializes in certain treatments, including, but not limited to orthodontists, periodontists, pediodontists, endodontists and oral surgeons.

The DMO option is provided through Aetna — the insurer. You may contact Aetna for more information, to request a copy of the policy at no charge (including covered charges, limitations and exclusions, and claims and appeals procedures) or with questions regarding how a specific benefit works.

Eligible Expenses

Generally, the Dental options cover certain charges, subject to certain limits, for:

- Basic option: preventive and basic services
- Plus option: preventive, basic, major, and special services, as well as orthodontia
- DMO option: preventive, basic, major, and special services, as well as orthodontia

You can obtain a list, free of charge, of all covered charges, services and exclusions by logging on to www.aetna.com/custom/jcpenney.

Expenses Not Covered

Generally, you are responsible for all costs not covered by the plan, including:

- Amounts over the R&C limits
- Services and supplies that are experimental or investigational (as determined by Aetna)
- Some alternate procedures
- Some services such as exams, cleanings and major appliances that are subject to certain limits (get the detailed list of services by contacting Aetna), and
- Services and supplies that are not medically necessary (as determined by Aetna).

Other limitations and exclusions apply. You can obtain a list, free of charge, of all covered charges, services and exclusions by logging on to www.aetna.com/custom/jcpenney.

Alternate Procedures

In some cases, there may be more than one way to treat your dental condition. When that happens, Dental pays for the least expensive treatment that will give you a result that meets professional dentistry standards.

For example, if you need a filling on one of your back teeth, Dental will only cover the R&C cost of a silver-colored filling. If your dentist fills your tooth with an enamel, tooth-colored material, you will have to pay the difference between the silver filling and the enamel one.

Because you will have to pay for any additional costs if you choose, or your dentist performs, a more costly procedure, it's very important that you get a pre-treatment estimate.

Key Terms:

Medically Necessary – In general, this term is used to ensure healthcare plans are paying for services that:

- Are appropriate and have been proven to work well
- Will help the doctor or dentist diagnose your health problem and give you the proper treatment, and
- Aren't more expensive than other services or supplies that would be just as helpful.

Aetna has strict rules about medically necessary services and supplies. When you are considering having dental work done, call Aetna at 1-800-811-5671 to make sure the services will be covered.

Pre-Treatment Estimates

A pre-treatment estimate is an estimate of how Dental will cover upcoming dental work. It's a good idea to have your dentist get a pre-treatment estimate when you are planning to have services that will cost more than $350 or when your dentist suggests:

- Orthodontia
- Oral surgery
- Periodontia (treatment of gums)
- Full or partial dentures
- Fixed bridgework
- Crowns, or
- Any significant dental treatments.

While the pre-treatment estimate is a good indication of what you will be expected to pay, it is not a guarantee of how your services will be covered.

Quick Tip: Your Treatment Plan Checklist

When your dentist recommends a treatment plan:

- Ask your dentist to help you file a pre-treatment estimate. Sometimes it's called a "predetermination of benefit."
- Aetna will work with your dentist to create your pre-treatment estimate.
- Your dentist should review the estimate with you. At that time, you can work with your dentist to decide how to move forward with your treatment plan.
- Once you've had the treatment, your dentist should submit your claim form and the pre-treatment estimate to Aetna. Your dentist may ask you to pay your estimated portion of the cost when you receive the treatment.

Coordination of Benefits

- **Dental Basic and Dental Plus** – Reimbursements are coordinated with benefits you and/or your covered dependents may have under another group plan so that benefits are not duplicated. Aetna will determine which plan is primary and will pay your claims as appropriate. For specific information about how benefits are coordinated between plans, see the *Legal Notices* section or contact Aetna.
- **DMO** – Reimbursements are coordinated with benefits you and/or your covered dependents may have under another group plan so that benefits are not duplicated. Aetna will determine which plan is primary and will pay your claims as appropriate. For more information on how the DMO coordinates benefits, see the policy or contact Aetna.

Key Terms:

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) laws allow you and/or your eligible dependents to continue your current coverage under the Medical, Dental and Health Care FSA Plans if your coverage ends for a reason specified in the regulations. See the *Legal Notices* section for more details about COBRA.

More Information

Refer to the *Legal Notices* section for more information about:

- Special Enrollment Rights
- Coordination of Benefits
- Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)
- Qualified Medical Child Support Orders (QMCSO)
- Your Right to Documentation of Healthcare Coverage
- Creditable Prescription Drug Coverage
- Health Plans Privacy Notice
- Records, Overpayment, Reimbursement and Subrogation

Filing Claims

When you visit a network provider, your dentist will file your claim for you. If your dentist isn't in the network, he or she may file the claim for you or ask you to pay for the services up front.

If you pay the dentist up front, you can file a claim to be reimbursed. Instructions for filing the claim are on the claim form. Forms are available online. Be sure to keep copies of your claims and receipts.

You must send your claim to Aetna by June 30 of the year following the date the covered expense was incurred. If Aetna does not receive your claim by June 30, you will not receive reimbursement for the claim.

Dental pays benefits for certain dental services and supplies based on the date the expense is incurred. The following rules are used to determine when an expense is incurred:

- Full and partial dentures – The plan pays based on when the final impression is taken.
- Fixed bridges, crowns, inlays and onlays – The plan pays based on when the teeth are first prepared.
- Root canal therapy – The plan pays based on when the pulp chamber is opened.
- Orthodontia – The plan pays based on when the appliances or bands are placed.

If your claim is denied, your administrator/insurer will send you a written letter explaining why the claim was denied along with the time limits for filing an appeal.

Filing an Appeal

If you disagree with the way your claim was paid or your claim for benefits is denied, in whole or in part, you can file an appeal within 180 days after receiving the denial. See the *Administrative Information* section for further details about filing an appeal or contact your claims administrator or insurer.