BENEFIT PLAN

Prepared Exclusively for
Fairfax County Public Schools
(FCPS)

PPO Dental Plan
(Dental PPO/PDN with PPO II Network)

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

The dental benefits Plan described in this *Booklet* is a benefit Plan of the Employer. These benefits are not insured with **Aetna** but will be paid from the Employer's funds. **Aetna** will provide certain administrative services under the **Aetna** dental benefits Plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** dental benefits Plan.

The *Booklet* describes your rights and obligations, what the **Aetna** dental benefits Plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supersedes all **Aetna** *Booklets* describing coverage for the dental benefits Plan described in this *Booklet* that you may previously have received.

Employer:	Fairfax County Public Schools
Contract Number:	724425
Effective Date:	January 1, 2021
Issue Date:	October 1, 2020

Schedule of Benefits

Employer: **Fairfax County Public Schools**

ASA: 724425

Issue Date: October 1, 2020
Effective Date: January 1, 2021

For: PPO Dental Plan (Dental PPO/PDN with PPO II Network)

Dental PPO/PDN with PPO II Network Plan

Schedule of PPO Dental Plan (Dental PPO/PDN with PPO II Network Plan) Benefits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year **Deductible**	Individual None Family None	Individual $50 Family $150

The Calendar Year **deductible** applies to all covered expenses except Type A Expenses.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the Plan will pay varies by the type of expense.

PLAN PAYMENT PERCENTAGE*	NETWORK PAYMENT PERCENTAGE	OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	90%
Type B Expenses	80%	70%
Type C Expenses	50%	40%
Orthodontic Treatment	50%	40%

* Details on type A, B, C and orthodontic treatment can be found on pages 15-19, under the Dental Care Schedule of the Booklet/Certificate.

Calendar Year Maximum Benefit
Calendar Year Maximum: $1,750 **Network**
$1,500 **Out-of-Network**

The most the Plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year Maximum Benefit applies to all covered expenses except Type A Expenses.

The Calendar Year maximum benefit applies to **network** and **out-of-network covered** dental expenses combined. However, when your **covered expenses** totaling $1,500 have been applied to your maximum, the Plan will no longer pay benefits for any further **out-of-network** dental expenses that you or your dependents incur.

Orthodontic coverage is only for covered dependent children who are under age 20 on the date active orthodontic treatment begins.

Orthodontic Lifetime Deductible
The orthodontic lifetime **deductible** applies separately to each of your covered dependents. After covered expenses reach the orthodontic lifetime deductible, the Plan will begin to pay benefits for covered orthodontic expenses.

	NETWORK	**OUT-OF-NETWORK**
Orthodontic Lifetime Deductible	None	$50

Orthodontic Lifetime Maximum Benefit
Orthodontic Lifetime Maximum: $1,500 **Network**
$1,000 **Out-of-Network**

Dental Emergency Maximum Benefit
Dental Emergency Maximum: $75

The most the Plan will pay for **covered expenses** incurred by a covered person for any one Dental Emergency is called the Dental Emergency Maximum.

Expense Provisions

The following provisions apply to your dental expense Plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached dental expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your Plan of dental benefits.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits.*

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

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

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

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

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Orthodontic Lifetime Maximum Benefit
The most the Plan will pay for covered orthodontic expenses incurred by any one covered person during their lifetime is called the Orthodontic Lifetime Maximum Benefit.

The Orthodontic Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses.

Coverage for You and Your Dependents

Dental Expense Coverage

Benefits are payable for covered dental care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a dental care service or supply.

Coverage under this Plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of dental care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered dental care services and supplies you receive.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the Plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Is Eligible

Employees

To be covered by this Plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and…
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are an eligible employee as defined by School Board regulations; and,
- You have completed the waiting period; or
- You are an eligible retiree as defined by School Board regulations.

Determining When You Become Eligible

You become eligible for the Plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this Plan, your coverage eligibility date is the effective date of the Plan.

After the Effective Date of the Plan

If you are hired after the effective date of this Plan, your eligibility coverage date is the first day of the month coinciding with or next following the date you commence active work for FCPS, or if later, the date you enter the eligible class, as determined by Fairfax County Public Schools.

If you enter an eligible class after the effective date of this Plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

To be eligible for coverage, a dependent child must be under 26 years of age. Your dependents can be covered under this Plan, provided they meet the eligibility criteria* and you request coverage within the appropriate timeframes as specified in the FCPS Employee Benefit Handbook and/or FCPS Retiree Benefits Handbook.

*Refer to the FCPS Employee Benefits Handbook and/or FCPS Retiree Benefits Handbook for more information, including documentation that you must submit at time of enrollment to verify your spouse/dependent's eligibility.

Coverage for Dependent Children
To be eligible for coverage, a dependent child must be under 26 years of age.

*Child (ren) age 26 or older who is wholly dependent on the employee for support and maintenance due to a disability that occurred prior to age 26. Coverage for a disabled child may be continued past the age limits shown above. See *Disabled Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan
You will be required to enroll in a manner determined by Fairfax County Public Schools (FCPS).

Annual Enrollment
During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you have a qualifying life event.

When Your Coverage Begins

Your Effective Date of Coverage
Your coverage takes effect on the later of:

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

Important Notice:
You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage
Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents within 30 days of a qualifying event.

Requirements For Coverage

To be covered by the Plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the Plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, dentist, or other dental care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of dental practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or **dental provider** or other dental care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Important Note

- Not every service or supply that fits the definition for **medical necessity** is covered by the Plan. Exclusions and limitations apply to certain dental services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the Plan limits and maximums.

How Your Aetna Dental Plan Works

Understanding Your Aetna Dental Plan

It is important that you have the information and useful resources to help you get the most out of your **Aetna** dental Plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the Plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, **complaints** and **appeals,** termination, continuation of coverage and general administration of the Plan.

Important Notes:
Unless otherwise indicated, "you" refers to you and your covered dependents.

This Booklet applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental Plan.

Getting Started: Common Terms

Many terms throughout this Booklet are defined in the *Glossary* Section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your Plan works and provide you with useful information regarding your coverage.

About the PPO Dental Plan

The Plan is a Preferred **Provider** Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the Dental PPO/PDN with PPO II network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the Dental PPO/PDN with PPO II network. You may pay more if you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the Plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice is Yours
You have a choice each time you need dental care:

Using Network Providers
- You will receive the Plan's higher level of coverage when your care is provided by a **network provider**.
- The Plan begins to pay benefits after you satisfy a **deductible, except for Type A services**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge**. Your **payment percentage** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of-pocket expenses when the Plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **deductibles, payment percentage** and **copayments**, if any.
- You will receive notification of what the Plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, copayment, payment percentage** or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Claims for services incurred outside of the United States can be submitted for consideration under the out-of-network benefits on the PPO Plan. Additional processing time may occur due to translation, currency amounts, and verification of services provided. **Network providers** can be located by using our online provider search tool. You can access this tool on **the FCPS microsite** at https://www.ih-aetna.com/fcps/dental or you can use **Aetna**'s toll-free Member Services phone number on your ID card.

Availability of Providers
Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

Using Out-of-Network Providers
You can obtain dental care from **dental providers** who are not in the network. The Plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

You must satisfy a **deductible** before the Plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**).

If your **out-of-network provider** charges more than the **Recognized Charge**, you will be responsible for any expenses incurred above the **Recognized Charge**. The **Recognized Charge** is the maximum amount **Aetna** will pay for a covered expense from an **out-of-network provider**.

You must file a claim to receive reimbursement from the Plan.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductibles**, **copays**, **payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

Getting an Advance Claim Review

The purpose of the advance claim review, also referred to as pre-treatment review, is to determine, in advance, the benefits the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note
The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment Plan and provide you and your **dentist** with a statement outlining the benefits payable by the Plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See *Benefits When Alternate Procedures Are Available* for more information on alternate dental procedures.)

What is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

In Case of a Dental Emergency

The Plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a **network provider** up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given. Additional dental care to treat your **dental emergency** will be covered at the appropriate **coinsurance** level.

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

PPO Dental is merely a name of the benefits in this section. The Plan does not pay a benefit for all dental care expenses you incur.

Important Reminder
Your dental services and supplies must meet the following rules to be covered by the Plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the Plan.
- You must be covered by the Plan when you incur the expense.

Covered expenses include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule.

The next sentence applies if:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one of more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that **Aetna** determines would have produced a professionally acceptable result.

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the Plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the **network** level of benefits even if services and supplies are not provided by a **network provider**. There is a maximum benefit payable. For additional information, please refer to *In Case of a Dental Emergency section.*

PPO Dental Expense Coverage Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage ***through Aetna*** and have at least one of the following conditions:

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

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year).

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the Plan.

The **payment percentage** applied to the other covered dental expenses above will be 100% for **network** expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder
The **deductible**, **payment percentage** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the **network** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the out-of-network level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays
Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every calendar year)
- Problem-focused examination (limited to 2 visits every calendar year)

Adult & Child Prophylaxis (cleaning) (limited to 2 treatments per calendar year)
Topical application of fluoride, (limited to two courses of treatment per calendar year and to children under age 19)
Sealants, per tooth (limited to one application every 3 calendar years for permanent molars only, and to children under age 16)
Bitewing X-rays (limited to 1 set per calendar year)
Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 calendar years)
Vertical bitewing X-rays (limited to 1 set every 3 calendar years)
Periapical x-rays (single films up to 13)

Space Maintainers Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)

Type B Expenses: Basic Restorative Care

Visits and X-Rays
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit

X-Ray and Pathology
Intra-oral, occlusal view, maxillary or mandibular
Upper or lower jaw, extra-oral
Biopsy and histopathologic examination of oral tissue

Oral Surgery
Extractions
- Erupted tooth or exposed root
- Coronal remnants
- Surgical removal of erupted tooth/root tip

Impacted Teeth
- Removal of tooth (soft tissue)

Odontogenic Cysts and Neoplasms

Incision and drainage of abscess
Removal of odontogenic cyst or tumor
Other Surgical Procedures
Alveoplasty, in conjunction with extractions - per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Excision of hyperplastic tissue
Removal of exostosis
Transplantation of tooth or tooth bud
Closure of oral fistula of maxillary sinus
Sequestrectomy
Crown exposure to aid eruption Removal
of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

Periodontics
Occlusal adjustment (other than with an appliance or by restoration)
Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 calendar years)
Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 calendar years)
Gingivectomy, per quadrant (limited to 1 per quadrant every 3 calendar years)
Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 calendar years
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 calendar years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 calendar years)
Periodontal maintenance procedures following active therapy (limited to 2 per calendar year)
Localized delivery of antimicrobial agents
Full mouth debridement (limited to 1 per lifetime)

Endodontics
Pulp capping
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
Anterior
Bicuspid

Restorative Dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)
Pins
Pin retention—per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
Prefabricated stainless steel
Prefabricated resin crown (excluding temporary crowns)

Recementation
- Inlay
- Crown
- Bridge
- Post and core
- Implant/abutment supported crown or denture
- Fixed partial

Type C Expenses: Major Restorative Care

Oral Surgery
Surgical removal of impacted teeth
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)

Periodontics
Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 calendar years
Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 calendar years
Soft tissue graft procedures
Clinical crown lengthening, hard tissue

Endodontics
Root canal therapy, molar teeth, including necessary X-rays

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years- see *Replacement Rule*).
Inlays/Onlays
Labial Veneers
- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns
- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic

Post and core, if medically necessary
Core build-ups, if medically necessary

Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 5 years. (See *Replacement Rule*.)
Bridge Abutments (See Inlays and Crowns)
Pontics
- Base metal (full cast)
- Noble metal (full cast)

Porcelain with noble metal
Porcelain with base metal
Resin with noble metal
Resin with base metal

Removable Bridge (unilateral)
One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
Complete upper denture
Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
Laboratory reline
Special tissue conditioning, per denture
Rebase, per denture
Adjustment to denture more than 6 months after installation

Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth

Adding teeth to existing partial denture
Each tooth
Each clasp

Repairs: crowns and bridges

Occlusal guard (for bruxism only), limited to 1 every 3 calendar years

Implant coverage: Endosteal implant, abutment, abutment supported crown covered as medically necessary.

General Anesthesia and Intravenous Sedation (only when **medically necessary** and only when provided in conjunction with a covered surgical procedure).

Orthodontics (paid in installments throughout course of treatment provided patient remains active under the Plan)

Interceptive orthodontic treatment

Limited orthodontic treatment

Comprehensive orthodontic treatment of the transitional dentition

Comprehensive orthodontic treatment of adolescent dentition

Comprehensive orthodontic treatment of adult dentition

Post treatment stabilization

Removable appliance therapy to control harmful habits

Fixed appliance therapy to control harmful habits

Rules and Limits That Apply to the Dental Plan

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

Orthodontic Treatment Rule

Orthodontic coverage is only for covered dependent children who are under age 20 on the date active orthodontic treatment begins.

The Plan does not cover the following orthodontic services and supplies:

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

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the Plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to **Aetna** that:

- While you were covered by the Plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the Plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

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

Coverage for Dental Work Begun Before You Are Covered by the Plan

The Plan does not cover dental work that began before you were covered by the Plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the Plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the Plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the Plan.

Coverage for Dental Work Completed After Termination of Coverage

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

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

"Ordered" means:

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

What The PPO Dental Plan Does Not Cover

Not every dental care service or supply is covered by the Plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The Plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

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

- Under any other part of this Plan; or
- Under any other Plan of group benefits provided by the contract holder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

Except as covered in the *What the Plan Covers* section, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply. For additional clarification/information refer to Aetna's Clinical Policy Bulletin which can be found at www.aetna.com.

Orthodontic treatment except as covered in the *What the Plan Covers* section.

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the Plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Treatment by other than a **dentist**. However, the Plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:

- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Additional Items Not Covered By A Dental Plan

Not every dental service or supply is covered by the Plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The Plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the Plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

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

Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

When Coverage Ends

Coverage under your Plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your **Aetna** dental benefits coverage will end if:

- The **Aetna** dental benefits Plan is discontinued;
- You voluntarily stop your coverage;
- The group contract ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another Plan offered by your employer; or
- Your employment ceases at a termination date determined by FCPS.

It is your employer's responsibility to let **Aetna** know when your employment ends.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the Plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group Plan offered by your employer.

Coverage for dependents may continue for a period after your death. Coverage for disabled dependents may continue after they reach any limiting age.

Disabled Dependent Children

Dental Expense Coverage for your fully disabled dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of an intellectual or physical disability which started prior to the date he or she reaches the maximum age for dependent children under your Plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully disabled must be submitted to **Aetna** no later than 30 days after the date your child reaches the maximum age under your Plan.

Coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your Plan.

Aetna will have the right to require proof of the continuation of the disability. **Aetna** also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your Plan.

COBRA Continuation of Coverage

Please refer to the FCPS Employee Benefits Handbook or COBRA Continuation Notice you received from Optum, the FCPS third party administrator, for more details.

Coordination of Benefits - What Happens When There is More Than One Dental Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein. The Order of Benefit Determination Rules below determines which Plan will pay as the primary Plan. The primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A secondary Plan pays after the primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a dental care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a dental care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a dental savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any dental expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary Plan has a negotiated fee or payment amount different from the primary Plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary Plan to determine benefits.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A Plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of dental care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise dental insurance policies issued by insurers, including dental care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization Plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate Plans. For example, Medical coverage will be coordinated with other Medical Plans, and dental coverage will be coordinated with other dental Plans.

This Plan is any part of the contract that provides benefits for dental care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more **Plans** pay benefits, the rules for determining the order of payment are as follows:

- The primary Plan pays or provides its benefits as if the secondary Plan or Plans did not exist.
- A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out-of-network benefits.
- A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one **Plan** is:

   A. The primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage or if the decree states that both parents are responsible for dental coverage. If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

   B. If the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no dental coverage for the dependent child's dental care expenses, but that parent's spouse does, the Plan of the parent's spouse is the primary Plan.

   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for dental coverage, the order of benefits is:
      - The Plan of the **custodial parent**;
      - The Plan of the spouse of the **custodial parent**;
      - The Plan of the non**custodial parent**; and then
      - The Plan of the spouse of the non**custodial parent**.

   For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The Plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary Plan. The Plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary Plan. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan**,** the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber longer is primary.

6. If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

In determining the amount to be paid when this Plan is secondary on a claim, the secondary Plan will calculate the benefits that it would have paid on the claim in the absence of other dental insurance coverage and apply that amount to any allowable expense under this Plan that was unpaid by the primary Plan. The amount will be reduced so that when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary Plan will credit to its Plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this Plan, the amount normally reimbursed for covered benefits or expenses under this Plan is reduced to take into account payments made by other Plans. The general rule is that the benefits otherwise payable under this Plan for all covered benefits or expenses will be reduced by all other Plan benefits payable for those expenses. When the COB rules of this Plan and another Plan both agree that this Plan determines its benefits before such other Plan, the benefits of the other Plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel Plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both Plans.

Right To Receive And Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits under this Plan and other Plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another Plan may include an amount, which should have been paid under this Plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

General Provisions

Type of Coverage

Coverage under the Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The Plan covers charges made for services and supplies only while the person is covered under the Plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive dental care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the Plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The Plan may be changed or discontinued with respect to your coverage.

Financial Sanctions Exclusions
If any benefit provided by this Plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resourcecenter/sanctions/Pages/default.aspx.

Assignments

Coverage and your rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this Plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this Plan.

Recovery of Overpayments

Dental Coverage

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

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

Reporting of Claims

A claim must be submitted to **Aetna** in writing. 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 is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for dental benefits will not be covered if they are filed more than 2 years after the deadline.

You may use **Aetna**'s toll-free Member Services phone number (877) 238-6200 or visit **Aetna**'s web site at www.aetna.com.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered dental benefits are payable to you. However, **Aetna** has the right to pay any dental benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **dentists** who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll-free Member Services phone number (877) 238-6200 or visit **Aetna**'s web site at www.aetna.com.

Discount Programs

Discount Arrangements

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

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

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

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the Plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Pre-Service Claim: Any claim for dental care or treatment that requires approval before the dental care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30-calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

You may use **Aetna**'s toll-free Member Services phone number (877) 238-6200 or visit **Aetna**'s web site at www.aetna.com.

The Dental Appeals address for written appeal submissions is:
Aetna Life Insurance Company
P.O. Box 14597
Lexington, KY 40512

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;

- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number (877) 238-6200.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing verbal or written consent to Aetna.

Level One Appeal - Group Dental Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Pre-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of **a Pre-Service Claim**, **or a Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

Pre-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

The Dental Appeals address for written appeal submissions is:
Aetna Life Insurance Company
P.O. Box 14597
Lexington, KY 40512

Exhaustion of Process
You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Dental Claims – Voluntary Appeals

You may file a voluntary appeal for external review of any Level 1 and Level 2 appeal determination that qualifies.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

External Review

Aetna may deny a claim because it determines that the care is not appropriate, or a service or treatment is **experimental or investigational** in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and Plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna, the Company and the Dental Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

The notice of an adverse benefit determination will include the address where the appeal can be sent. For more information about Aetna's External Review process, call the toll-free Customer Services telephone number (877) 238-6200.

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

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

C

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The Plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Dental services and supplies shown as covered under this Booklet.

D

Deductible
The part of your **covered expenses** you pay before the Plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dental Provider
This is:

- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

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

Directory
A listing of all **network providers** serving the class of employees to which you belong. The contract holder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider search tool.

E

Experimental or Investigational
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Dental and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
- drug;
- device;
- procedure; or
- treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
- drug;
- device;
- procedure; or
- treatment.

that states that it is **experimental or investigational**, or for research purposes.

H

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

M

Medically Necessary or Medical Necessity
These are dental services, and supplies or **prescription drug**s that a **physician**, other care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other dental care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same

therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N

Negotiated Charge

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Provider

A **dental provider** who has contracted to furnish services or supplies for this Plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Dental care service or supply that is:

- Furnished by a **network provider**

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Lifetime Maximum
This is the most the Plan will pay for **covered** orthodontic **expenses** incurred by any one covered person in their lifetime.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

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

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

whether or not for the purpose of relieving pain.

Out-of-Network Service(s) and Supply(ies)
Dental care service or supply that is:

- Furnished by an **out-of-network provider**.

Out-of-Network Provider
A **dental provider** who has not contracted with **Aetna**, an affiliate, or a third-party vendor, to furnish services or supplies for this Plan.

P

Payment Percentage
Payment percentage is both the percentage of **covered expenses** that the Plan pays, and the percentage of **covered expenses** that you pay. The percentage that the Plan pays is referred to as the "Plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a dental professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended, or the drugs prescribed are considered **covered expenses** under the Plan. It is not a guarantee that benefits will be payable.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

R

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge.**

As to dental expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 85th percentile of the Prevailing Charge Rate;
  for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.
What this means to you is that the **Recognized Charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

R.N.
A registered nurse.

S

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist
Any **dentist** 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.

Specialty Care
Dental care services or supplies that require the services of a **specialist**