THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Guide to Your Dental Benefits

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Overview

The dental coverage described in this booklet is optional under the Benefits Plan of the Presbyterian Church (U.S.A.) and is intended to help make good dental care available and affordable for you and your family. A wide range of services are covered, including:

- preventive and diagnostic care, such as routine checkups and cleanings
- basic services, such as fillings
- major services, such as prosthodontics (the artificial replacement of teeth) and crowns
- orthodontic treatment (limitations may apply for orthodontic work already in progress when the member is first eligible for coverage)

The **Preferred Provider Organization (PPO)** option allows you to receive care from a dentist who participates in Aetna's dental network (a network provider) or one who does not (an out-of-network provider). When your care is provided by a network dentist, the plan provides a higher level of benefits, and you do not have to file claim forms. You also save money when using network dentists because they have agreed to provide services for lower, negotiated fees. If you live in an area not served by the Aetna dental network — a non-network area — and therefore cannot access a participating provider, you will be offered the **Passive PPO** option and your costs under the plan will be the same as if you were using a network provider. When your care is provided by a network provider, you do not have to file claim forms.

The **Dental Maintenance Organization (DMO)** option provides benefits when services are rendered by a participating DMO dentist. For a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. In some states, limited coverage may be available for nonemergency services referred by a nonparticipating provider.

This is a description of the main features of the PPO and DMO options. It does not create or confer any contractual rights. It should be understood that all rights, obligations, remedies, and interpretations will be governed by official plan texts, group master policies, and certificates of coverage issued by Aetna Life Insurance Company, government legislation, and company policy.

If there is any conflict between this booklet and the official plan documents or policies, the plan documents or policies will govern in all instances.

Summary of Plan Benefits

The summary provides a high-level overview of deductibles, maximums, and plan benefits. The sections outlining Covered Dental Expenses and Exclusions and Limitations include more detail about specific services and supplies.

For those enrolled in the PPO option, out-of-network services are paid subject to recognized charges, and any balance due is the responsibility of the participant. For DMO participants, out-of-network services generally are **not** covered.

Generally, a recognized charge is the *lowest* of:

- a provider's charge for performing the service, or
- 80% of the prevailing charge rate, as determined by Aetna, for the service or supply in the geographic area where it is furnished

Deductible

The amount of your covered dental expenses you pay each calendar year before the dental plan starts to pay benefits.

Plan Feature	Amount		
Annual Deductible	PPO Network (including Passive PPO)	PPO Out-of-Network	DMO
Individual	$50	$100	None
Family	$100	$200	None
Orthodontia Deductible	$50	$100	None
Annual Plan Maximum	$2,000	$1,000	None
Lifetime Orthodontia Benefit Maximum*	$2,000	$1,000	None

Covered Expense	Benefit		
	PPO Network (including Passive PPO)	PPO Out-of-Network	DMO
Preventive and Diagnostic Services	100% (no deductible)	100% (no deductible)	100%
Basic Services	80% (after deductible)	70% (after deductible)	100%
Major Services	60% (after deductible)	40% (after deductible)	60%
Orthodontia (children only)*	50% (after orthodontia deductible)	50% (after orthodontia deductible)	50%
Implants	See Major Services	See Major Services	Not covered

* Children must be under age 22 when treatment begins. When $2,000 of expenses has been applied to the maximum, no additional benefits will be paid for out-of-network dental expenses. Benefit may be reduced if reimbursement has occurred for orthodontic work in progress (prior to coverage in these dental benefits).

Note: For the PPO, out-of-network services are paid subject to reasonable and customary charges; any balance due is your responsibility. In the DMO, out-of-network services are not covered.

Eligibility

You and your eligible family members are eligible for the Dental Plan if your employer offers the Dental Plan as a benefit option.

Participation in the PPO/Passive PPO or DMO option is determined by your home address ZIP code. You are eligible to participate on the date you begin work or the date you become eligible for benefits, if later.

Eligible family members are:

- spouses
- children younger than 26, regardless of their financial dependency, marital status, or residency
- financially dependent, totally disabled children who are disabled and covered under the plan before they reach age 26

No person may be covered as both an employee and a family member, and no person may be covered as a family member of more than one employee. An employee and their family can only enroll in one dental option (PPO/Passive PPO or DMO) offered through the Benefits Plan, and it must be the same option.

Enrollment

To enroll for dental coverage, log on to Benefits Connect, the Board of Pensions website (refer to Benefits Connect Quick Start Guide for Employees on pensions.org). Benefits Connect will display only those options (PPO and/or DMO) that are available based on your home address ZIP code.

You may choose coverage for yourself and your eligible family members; your employer will deduct your required contributions for coverage. You must enroll within 30 days of starting employment or, if later, within 30 days of completing an initial benefits eligibility date set by your employer. You may also choose to waive this coverage.

You may also enroll or change benefits elections during Annual Enrollment, in the fall. Midyear changes typically are not allowed unless you have a qualifying life event, such as a marriage or birth of a child. Changes must be made within 60 days of the qualifying life event.

IF YOU EXPERIENCE A QUALIFYING LIFE EVENT

You must report any change in marital or eligible family member status to the Board of Pensions within 60 days of the event.

To report a life event, log on to Benefits Connect and from the homepage click the **Quick Actions** button on the **MY BENEFITS** tile under **MY TOOLS** to report your event, make changes to your coverage, and provide any required supporting documentation.

How the Dental Plan Works

The **PPO** option works much like a traditional dental plan. You choose a dentist to provide services. After you have satisfied the deductible, the plan pays a percentage of covered dental expenses up to any annual or benefit maximum. The deductible does not apply to preventive and diagnostic services.

You can visit the dentist of your choice, network or out-of-network, when you need care. You do not have to designate a primary care dentist. However, if you participate in the PPO option, the benefits are higher, and you do not need to file a claim when you use a network dentist. If you visit an out-of-network provider, your reimbursement is based on the reasonable and customary charge, and you pay the difference. (Participants in the Passive PPO option are also reimbursed based on reasonable and customary charges.)

In the **DMO** option, you access care through the primary care dentist (PCD) you select when you enroll. Each covered family member may select a different PCD. Your PCD provides basic and routine dental services and supplies and will refer you to other dental providers in the network when appropriate. You may select a PCD from the online provider directory available on the Aetna/Board of Pensions microsite at aetnaresource.com/n/board-of-pensions, or by logging on to myaetnawebsite.com. You can search Aetna's online provider directory for names and locations of network providers. Out-of-network services and supplies are not covered, except in the event of a dental emergency.

IMPORTANT REMINDER FOR DMO PARTICIPANTS

You must have a referral from your PCD in order to receive coverage for any services a specialist dentist provides. DMO participants may visit a network orthodontist without first obtaining a referral from their primary care dentist.

To locate network dentists, visit aetnaresource.com/n/board-of-pensions or log in to myaetnawebsite.com, the Aetna secure member website, which offers personalized plan information and links to other health information. You can also call Aetna at 877-238-6200 for provider information.

SHARING THE COST

Employees and family members enrolled in the PPO option share in the cost of dental care by paying an individual and family annual deductible. This is the amount you pay each calendar year before the plan starts to pay benefits for basic and major services. If you enroll any family members, once the eligible dental expenses of all covered family members reach the family deductible, no other deductible is required for the remainder of the calendar year.

After the annual deductible has been met, the plan pays a percentage of covered expenses, and you pay a percentage. This is known as coinsurance. The percentage the plan pays is outlined under Summary of Plan Benefits in this guide. If you participate in the PPO option, the plan's benefits are limited to an annual (or benefit) maximum, which is the most the plan will pay for covered expenses in a calendar year. Both network and out-of-network services apply to the calendar year maximum. However, no additional benefits will be paid for out-of-network expenses when $1,000 of expenses has been applied to the annual maximum.

There is a separate deductible and a separate maximum benefit for orthodontic services. Benefits for orthodontic treatment are available only for eligible children and are not counted against the annual plan maximum but are subject to a separate lifetime maximum. Benefits are reduced when reimbursement has occurred for orthodontic work in progress (prior to coverage in these dental benefits).

Employees and family members enrolled in the DMO option do not pay individual or family deductibles and are not subject to annual plan or lifetime maximums.

Covered Dental Expenses

The plan covers dentists' charges for the services and supplies listed below which, for the conditions being treated, are:

- necessary
- customarily used nationwide, and
- meet broadly accepted national standards of dental practice

DMO DENTAL

DMO members should review the DMO Dental Benefits Booklet on pensions.org for detailed information regarding covered expenses.

Covered dental services and supplies are subject to any limits described. Only nonoccupational injuries and illnesses are covered.

DENTAL CARE SCHEDULE

The dental care schedule is a list of dental services that are covered by the plan. There are several types of covered services:

- preventive and diagnostic care
- basic restorative care, such as fillings, simple extractions, and root canals (anterior and bicuspid teeth)
- major restorative care, such as inlays, onlays, crowns, and bridges
- orthodontics

Coverage is also provided for dental emergencies. Services for dental emergencies 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 the In Case of a Dental Emergency section.

IN CASE OF A 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 is considered a dental emergency.

If you have a dental emergency, you should consider calling your network dentist who may be more familiar with your dental needs. However, you can get treatment from any dentist.

If treatment is provided by an out-of-network provider, the plan pays a benefit at the network level of coverage up to a $75 dental emergency maximum. Any charges above the dental emergency maximum will be paid at the out-of-network coverage level. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given.

Follow-up care to treat your dental emergency will be covered at the appropriate coinsurance level based on the type of service and the dentist (network vs. out-of-network) that provides the care.

ADVANCE REVIEW

If you expect a course of dental treatment to cost more than $350 in covered charges, ask your dentist to submit a treatment plan to Aetna that includes estimated charges before work begins. As part of a treatment plan, Aetna may require all diagnostic and evaluative material. This includes X-rays, models, charts, and written reports.

Advance review of proposed treatment allows for resolution of coverage questions before, rather than after, work has been done. The benefit for a course of treatment may be for a lesser amount than would otherwise be paid if advance review is not requested or if required verifying material is not provided. In this case, benefits will be reduced by the amount of covered expenses that Aetna cannot verify.

PREVENTIVE AND DIAGNOSTIC SERVICES

Visits and exams

- routine oral exams twice per calendar year; includes prophylaxis (cleaning) and scaling of teeth
- problem-focused oral exams twice per calendar year
- topical application of sodium or stannous fluoride for covered children under age 16 once per calendar year
- sealants for covered children under age 16, once per tooth every three years for permanent molars only
- sealant repair, per tooth, for covered children under age 16 (permanent molars only)
- application of hydroxyapatite regeneration medicament, once per tooth every three years

Space maintainers —only when needed to preserve space resulting from premature loss of deciduous teeth, including adjustments (within 6 months of installation)

- fixed or removable (unilateral or bilateral)
- recementation or removal

X-rays and pathology

- one set of regular bitewing X-rays per calendar year
- one full mouth series of X-rays and one set of vertical bitewing X-rays every three years
- periapical X-rays

BASIC RESTORATIVE CARE

Restorative dental care focuses on repairing or replacing damaged or missing teeth. The plan covers:

- basic restorative care, including fillings and root canals (see below)
- major restorative care, including crowns, dentures, and bridges (see Major Restorative Care)

Visits and exams

- 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-rays and pathology

- periapical X-rays (single films up to 13)
- intra-oral, occlusal view
- extra-oral
- accession of tissue

Oral surgery

- extractions:
    - erupted tooth or exposed root
    - coronal remnants (deciduous tooth)
- surgical removal of erupted tooth, residual tooth roots
- removal of impacted tooth (soft tissue)
- primary closure of a sinus perforation
- incision and drainage of abscess
- removal of odontogenic cyst or tumor
- alveoplasty, in conjunction with extractions, per quadrant
- alveoplasty, in conjunction with extractions, one to three teeth or tooth spaces, per quadrant
- alveoplasty, not in conjunction with extraction, per quadrant
- alveoplasty, not in conjunction with extractions, one to three teeth or tooth spaces, per quadrant
- sialolithotomy (removal of salivary gland stones)
- closure of salivary fistula
- excision of hyperplastic tissue (per arch)
- removal of exostosis
- transplantation of tooth or tooth bud
- closure of fistula between oral cavity and maxillary sinus (oroantral fistula)
- sequestrectomy
- mobilization of erupted or malpositioned tooth to aid eruption
- removal of foreign body
- frenectomy/frenuloplasty
- suture of wounds
- surgical access of unerupted tooth
- placement of device to facilitate eruption of impacted tooth
- biopsy of oral tissue
- exfoliative cytological sample collection
- removal of odontogenic cysts or tumors
- removal of torus
- surgical reduction of osseous tuberosity
- excision of pericoronal gingiva
- surgical reduction of fibrous tuberosity
- excisional biopsy of minor salivary glands

Periodontics

- occlusal adjustment (other than with an appliance or by restoration)
- root planing and scaling, four or more teeth per quadrant (limited to four separate quadrants every two years)
- root planing and scaling, one to three teeth per quadrant (limited to one per site every two years)
- gingivectomy/gingivoplasty, four or more teeth per quadrant (limited to one per quadrant every three years)
- gingivectomy/gingivoplasty, one to three teeth per quadrant (limited to one per site every three years)
- gingival flap procedure, four or more teeth per quadrant (limited to one per quadrant every three years)
- gingival flap procedure, one to three teeth per quadrant (limited to one per site every three years)
- periodontal maintenance procedures following active therapy (limited to two per year)
- localized delivery of antimicrobial agents
- surgical revision procedure, per tooth
- apically positioned flap
- unscheduled dressing change (by someone other than treating dentist or their staff)

Endodontics

- pulp capping
- pulpal debridement
- pulpal therapy
- pulpotomy
- apexification/recalcification
- apicoectomy
- root canal therapy (including necessary X-rays) and retreatment:
    - anterior
    - bicuspid
- pulpal regeneration
- hemisection
- retrograde filling
- root amputation

Restorative

Excludes inlays, onlays, veneers, crowns (other than prefabricated), and bridges. Multiple restorations on one surface will be considered a single restoration.

- amalgam restorations
- resin-based composite restorations (other than for molars)
- placement of interim direct restoration
- reattachment of tooth fragment, incisal edge or cusp
- pin retention, per tooth, in addition to restoration
- prefabricated crowns (primary teeth only, excluding temporary crowns)
- excavation of a tooth resulting in the determination of nonrestorability

MAJOR RESTORATIVE CARE

Major restorative dental care is more extensive than fillings and root canals, and can include services such as crowns, dentures, and bridges.

Oral surgery

- surgical removal of impacted teeth:
  - partial bony impaction
  - complete bony impaction
- coronectomy

General anesthesia and intravenous sedation

- general anesthesia and intravenous sedation are covered only when medically necessary and only when provided as part of a covered surgical procedure
- evaluation by anesthesiologist for deep sedation or general anesthesia

Periodontics

- osseous surgery (including flap and closure), one to three teeth per quadrant (limited to one per site every three years)
- osseous surgery (including flap and closure), four or more teeth per quadrant (limited to one per quadrant every three years)
- soft tissue graft procedures
- clinical crown lengthening
- full mouth debridement (one per lifetime)

Endodontics

- root canal therapy (including necessary X-rays) and retreatment:
  - molar

Restorative

Inlays, onlays, labial veneers, and crowns (excluding temporary crowns) are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. (Limited to one per tooth every five 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

Restorative Care

Relining (Rebasing): To resurface the tissue side of a denture with new base material to achieve a more accurate fit.

Gingivectomy: Surgical removal of inflamed and/or infected tissue due to periodontitis from around the necks of teeth.

Endodontic Treatment: Treatment of the tooth root, dental pulp, and surrounding tissue.

Root Canal Therapy: The process of removing the infected pulp of a tooth and filling it with an inert material to save the natural tooth.

Without apicoectomy: The pulp is removed and the infection treated until the filling material can be packed.

With apicoectomy: The root is surgically removed after the pulp is removed and the root canal is filled.

Periodontal Treatment: Treatment of the tissue and structures surrounding and supporting the teeth.

- core buildup, including any pins
- post and core
- repairs, inlay, onlay, veneer, crown
- removal of an indirect restoration on a natural tooth
- recementation

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 five years old (see Tooth Missing but Not Replaced Rule). Replacement of existing bridges or dentures is limited to one every five years (see Replacement Rule).

- bridge abutments
- 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
- dentures and partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.):
  - complete upper denture
  - complete lower denture
  - partial upper and lower (including any conventional clasps, rests, and teeth)
  - removable unilateral partial denture
- stress breakers
- reline (partial or complete)
- special tissue conditioning, per denture
- rebase, per denture
- repairs, full and partial dentures
- adding teeth and clasps to existing partial denture
- repairs, bridges
- occlusal guard (for bruxism only), limited to one every three years
- adjustments, repair, or reline of occlusal guard
- cleaning and inspection of a removable appliance
- accessing and retorquing loose implant screw, per screw

Prosthodontics

Complete Denture: A complete or "full" set of artificial teeth that replaces all teeth in the upper or lower jaw.

Fixed Bridge: A permanent replacement of a missing tooth or teeth with a dental prosthesis (appliance) that is cemented or bonded to supporting teeth or implants adjacent to a space.

Prosthetic Device: An artificial device used to replace a missing body part, such as a tooth.

Replacement rule

Some eligible dental services are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to, existing:

- crowns
- inlays
- onlays
- veneers
- complete dentures

- removable partial dentures
- fixed partial dentures (bridges)
- other prosthetic services

These eligible dental services are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge, or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge, or other prosthetic item and:
    - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge, or other prosthetic item installed during the prior five years.
    - 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.
- The present item cannot be made serviceable, and is:
  - A crown installed at least five years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least five years before its replacement.

Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges, or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge, or prosthetic item installed during the prior five years.

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

Temporomandibular joint dysfunction/disorder

Effective Jan. 1, 2026, the plan will cover services for treatment of temporomandibular joint dysfunction/disorder (TMJ/TMD) or any similar disorder of the jaw joint, myofascial pain dysfunction (MPD) of the jaw, or any similar disorder involving the relationship between the jaw joint and the associated muscles and nerves, including:

- occlusal orthotic device, fabrication, and adjustments
- unspecified TMD therapy
- administration of neuromodulators

ORTHODONTIA SERVICES

Comprehensive orthodontic treatment is covered for eligible children if they are under age 22 when treatment begins. Limitations may apply for orthodontic work already in progress when the member is first eligible for coverage. Contact Aetna at 877-238-6200 for further information.

Orthodontic treatment

Coverage includes services or supplies to prevent, diagnose, or correct a misalignment of the teeth, bite, or jaws or jaw joint relationship, including:

- limited orthodontic treatment
- comprehensive orthodontic treatment of adolescent dentition
- comprehensive orthodontic treatment of adult dentition
- fixed appliance therapy
- removable appliance therapy
- orthodontic retention
- repair of orthodontic appliance
- interceptive orthodontic treatment
- limited orthodontic treatment
- comprehensive orthodontic treatment of adolescent dentition
- post-treatment stabilization
- removable appliance therapy to control harmful habits.

The following are ***not*** considered orthodontic treatment:

- installation of a space maintainer
- surgical procedures to correct malocclusion

The plan does not cover the following services or supplies:

- replacement of broken appliances
- retreatment 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)
- removable acrylic aligners (i.e., invisible aligners)

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

Orthodontic treatment plan and payment

To process a claim for orthodontic treatment, Aetna needs an Orthodontic Treatment Plan that includes the banding date, total charge, the malocclusion (or type of treatment), and the length of treatment.

Once the treatment plan is received, Aetna's initial payment will be 25% of the treatment plan. The remaining amount will be paid out over the length of the treatment in automated monthly/quarterly installments. Keep in mind that the plan will only pay up to the lifetime orthodontia benefit maximum, and benefits are reduced when reimbursement has occurred for orthodontic work in progress (prior to coverage in these dental benefits).

ADDITIONAL COVERED DENTAL SERVICES

The following additional dental services will be considered covered expenses for you (or your enrolled family member) if you have at least one of the following conditions:

- pregnancy
- coronary artery disease (CAD)/cardiovascular disease
- cerebrovascular disease
- diabetes

Additional dental services

- one additional prophylaxis (cleaning) per year
- scaling and root planing, per quadrant (four or more teeth)
- scaling and root planing, per quadrant (limited to one to three teeth)
- full mouth debridement
- periodontal maintenance

Under this provision, the annual deductible and coinsurance requirements will be waived for these additional covered dental services. Contact Aetna Member Services at 877-238-6200 for details if you or one of your covered family members is pregnant or has diabetes, CAD/cardiovascular disease, or cerebrovascular disease.

ALTERNATE TREATMENT

If more than one service can be used to treat a dental condition, coverage may be limited to a less costly covered service provided those services:

- are deemed to be appropriate by the dental profession, and
- meet broadly accepted national standards of dental practice

Exclusions and Limitations

The following expenses are not covered under the plan, except if otherwise noted in this booklet:

- charges for services or supplies that are:
  - provided by an out-of-network dentist in excess of the reasonable and customary charge
  - provided for your personal comfort or convenience or that of a third party, including a dentist
  - provided in connection with treatment or care not covered by the plan
- charges for cancelled or missed appointments, or for completion of claim forms
- any charges in excess of the benefit, dollar, or frequency limits under the plan
- court-ordered services and supplies, unless they are an eligible dental expense under the plan
- any dental examinations because they are required by a third party or needed to buy insurance or to get or keep a license; to travel; or to go to a school, camp, or sporting event, or to join in a sport or other recreational activity
- services provided by your spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law, or any member of your household
- charges for any dental services or supplies that are covered expenses under your medical plan
- charges made only because you have coverage or those you are not legally obligated to pay
- services and supplies Aetna determines are not necessary for the diagnosis, care, or treatment of the condition involved, even if they are prescribed, recommended, or approved by the attending physician or dentist
- services and supplies provided, paid for, or for which benefits are provided or required because of past or present services in the government armed forces
- services and supplies provided, paid for, or for which benefits are provided or required under any government law (does not include plans established by the government for employees or Medicaid)
- charges for treatment by anyone who is not a dentist (however, charges for cleaning or scaling of teeth and the topical application of fluoride by a licensed dental hygienist will be covered when the work is supervised and guided by a dentist)
- services by an unlicensed provider or not within the scope of the provider's license
- outpatient prescription drugs, and preventive care drugs and supplements
- charges for the replacement of lost or stolen prosthetic devices
- dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- services or supplies that are covered in whole or in part under any other plan of group benefits provided by or through your employer
- services and supplies to diagnose or treat an occupational disease or injury
- services not listed, unless otherwise specified, under Covered Dental Expenses in this booklet
- those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect
- cosmetic services and supplies (except to the extent coverage is specifically provided in the Covered Dental Expenses section) 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 services to protect, clean, whiten, bleach, or alter the appearance of teeth, whether or not for psychological or emotional reasons (facings on molar crowns and pontics will always be considered cosmetic)
- crowns, inlays, 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
- those for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals

- those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion, or erosion
- those for any of the following:
    - an appliance or modification of one if an impression for it was made before the person became covered
    - a crown, bridge, cast, or processed restoration if a tooth was prepared for it before the person became covered
    - root canal therapy if the pulp chamber for it was opened before the person became covered
- those for services intended for treatment of any jaw joint disorder, unless otherwise specified in this booklet
- those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth
- those for orthodontic treatment, unless otherwise specified in this booklet
- those for general anesthesia and intravenous sedation, unless specifically covered (if covered, they will not be eligible for benefits unless done in conjunction with another necessary covered service)
- those for a crown, cast, or processed restoration 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
- those for pontics, crowns, cast, or processed restorations made with high noble metals, unless otherwise specified in this booklet
- those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in this booklet
- services needed solely in connection with noncovered services
- services provided where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
- braces, mouth guards, and other devices to protect, replace, or reposition teeth
- removal of implants
- teledentistry
- work-related illness or injuries

Filing Claims

Network dentists are required to submit your claims for you. Out-of-network dentists may ask you to submit your own claim to Aetna. Claim forms are available by calling Aetna at 877-238-6200 or through Aetna's secure website.

The deadline for submitting a claim is 90 days after you incur the covered expense. If, through no fault of your own, you are unable to meet the deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the deadline, it will not be covered unless you are legally incapacitated.

COORDINATION OF BENEFITS

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the plan. Benefits available through other group plans and/or "no-fault" automobile coverage will be coordinated with the plan. Other group plans include any other plan of dental coverage provided by the following:

- group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured
- no-fault and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law
- governmental benefits

To find out if benefits under the plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent.
- For children of parents who are married or in a qualified domestic partnership, or living together, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first.
- When the parents of a covered child are separated, divorced, or their marriage or qualified domestic partnership has been dissolved, or are not living together:
    - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the healthcare expenses of the child, the parent birthday rule, immediately above, applies.
    - If a court decree gives responsibility for the child's dental coverage to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
    - If there is no such court decree, the order of benefits will be determined as follows:
        1. the plan of the custodial parent
        2. the plan of the spouse of the custodial parent (if any)
        3. the plan of the noncustodial parent
        4. the plan of the spouse of the noncustodial parent (if any)

- If an individual has coverage as an active employee (or as a dependent of an active employee), and also as a retired or laid-off employee (or as a dependent of a former employee), the plan that covers the individual as an active employee (or as a dependent of an active employee) is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which covers an individual as an employee or retiree or as the dependent of an employee or retiree.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits under this plan will be reduced. Aetna will reduce the payment based on any amount paid by the primary plan.

Right of Recovery

If Aetna pays more than it should under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or from 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.

CLAIM DENIALS AND APPEALS

If your claim is denied in whole or in part, you will receive written notice from Aetna. The notice will explain the reason for the denial and the procedure you need to follow to have your claim reviewed.

You may appeal adverse claim decisions either yourself or through an authorized representative. An authorized representative is someone you authorize, in writing, to act on your behalf. In the case of an urgent care claim or a preservice claim, a dentist familiar with the case may represent you in an appeal.

You may file an appeal in writing to the Aetna address included on your denial notice. In your written appeal, include your reasons for appealing and any additional information to support the appeal.

If your appeal is urgent, you may call Aetna at 877-238-6200.

(The Board of Pensions does not review claim denials or appeals.)

Recognized Charge

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

If Aetna has an agreement with a provider which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in the agreement.

Aetna may reduce the recognized charge based on factors that include:

- the duration/complexity of a service
- whether multiple procedures are billed at the same time, but no additional overhead is required
- whether an assistant surgeon was involved and necessary for the service
- if follow-up care is included
- any characteristics that may modify or make a particular service unique
- whether services described on multiple claim lines are part of or incidental to the primary service provided

Aetna reimbursement policies are based on its review of: policies developed for Medicare; generally accepted standards of medical and dental practice; and the views of physicians and dentists practicing in the relevant clinical areas.

Definition of terms:

Geographic area: 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 does not produce a statistically valid sample, groups are combined to produce a statistically valid sample. When it is necessary to group three ZIP codes, the grouping never crosses state lines.

Prevailing charge rates: The rates reported by FAIR Health, a nonprofit company that reviews and, if necessary, periodically changes the rates in their database. Aetna updates its systems with these changes within 180 days of receiving them from FAIR Health. What this means to you is that the recognized charge is based on the version of the rates in use by Aetna on the date that the service or supply was provided.

Recognized charge: The lesser of what the provider bills or submits for that service or supply, and the 80th percentile of the prevailing charge rate for the geographic area where the service is furnished.

Urgent Care Claims

If the plan requires advance approval of a service, supply, or procedure before a benefit is payable, or your dentist determines it is an urgent care claim, you will be notified of a decision not later than 72 hours after the claim is received.

An urgent care claim is a claim for dental care or treatment where delay could seriously jeopardize your life or health, affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Other Claims (Preservice and Postservice)

If you are required to obtain advance approval of a service, supply, or procedure before a benefit will be payable, the request for advance approval is considered a preservice claim. You will be notified of the decision no later than 15 days after receipt of the preservice claim. For postservice claims, you will be notified of the decision no later than 30 days after receipt of the claim.

For either a preservice or postservice claim, these time periods may be extended up to an additional 15 days due to circumstances beyond the plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period.

If an extension is necessary because Aetna needs more information to process your postservice claim, Aetna will allow an additional 45 days to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after receipt of the additional information, if earlier).

Ongoing Course of Treatment

If you received preauthorization for an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce its authorization. You will have an opportunity to appeal the decision and receive a decision on the appeal before the termination takes effect. If the course of treatment involves urgent care and you request an extension of the authorization for the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an Appeal of an Adverse Benefit Determination

You have 180 days following receipt of an adverse benefit decision to submit a written appeal. If your request is of an urgent nature, you may call Aetna at 877-238-6200.

For appeals of adverse benefit decisions regarding urgent care, you will be notified of the decision no later than 36 hours after the appeal is received.

Second-Level Appeals

If you are not satisfied with an urgent care claim appeal decision, you may file a second-level appeal. The second-level appeal may be made by telephone to Aetna at 877-238-6200 and you will be notified of a decision within 36 hours after the appeal is received.

If you are not satisfied with a preservice or postservice appeal decision, you may file a second-level appeal within 60 days of receipt of the first-level appeal decision. You will be notified of the appeal decision no later than 15 days (for preservice claims) or 30 days (for postservice claims) after the appeal is received.

Coverage Termination

Your coverage under this plan ends on the first to occur of the following events:

- you voluntarily terminate coverage
- the plan is terminated
- you are no longer employed in a benefit group eligible for plan coverage
- you fail to make the required contributions for coverage
- your employment stops unless you continue dental coverage through Ministers Bridge Coverage

Coverage for your spouse or other family members will end on the earliest to occur of the following events:

- when plan coverage for eligible family members is terminated
- when your spouse or child becomes covered as a plan member
- when the individual no longer meets the plan's definition of an eligible family member
- when your coverage terminates

REINSTATEMENT

If your coverage ends because you voluntarily terminate it or fail to make the required contributions, you may not reenroll yourself and your eligible family members until the next Annual Enrollment period, or within 60 days of a qualifying life event.

COVERAGE FOR DENTAL WORK COMPLETED AFTER TERMINATION OF COVERAGE

Your dental coverage may end while you or your covered family member is in the middle of treatment. The plan does not cover dental services that are provided after your coverage terminates.

There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan and installed within 30 days after your coverage ends:

- inlays
- onlays
- crowns
- removable bridges
- cast or processed restorations
- dentures
- fixed partial dentures (bridges)
- root canals

Ordered means:

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

Recovery of Overpayments

If a benefit payment is made by Aetna, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, Aetna has the right to:

- Require the return of the overpayment.
- Reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or another person in your family. Such right does not affect any other right of recovery by Aetna.

THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

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