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

The Dental Plan 2021

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

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1 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 ranges 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; and
- 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 dentist. In order 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 non-emergency 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.

2 Summary of Plan Benefits

Deductible

The amount of your covered dental expenses you pay each calendar year before the dental plan starts to pay 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 reasonable and customary charges, and any balance due is the responsibility of the participant. For DMO participants, out-of-network services are NOT covered.

Generally, a reasonable and customary charge is the lowest of

- a provider's usual charge for performing the service;
- the charge Aetna determines to be appropriate based on factors such as the cost of similar services or supplies; and
- the charge Aetna determines to be the prevailing charge for the service or supply in the geographic area where it is furnished.

Plan Feature	Amount		
Calendar Year Deductible	**PPO Network** (including Passive PPO)	**PPO Out-of-Network**	**DMO**
Individual	$50	$100	None
Family	$100	$200	None
Orthodontia Deductible	$50	$100	None
Calendar Year Benefits 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% (no deductible)
Basic Services	80% (after deductible)	70% (after deductible)	100% (after deductible)
Major Services	60% (after deductible)	40% (after deductible)	60% (after deductible)
Orthodontia (children only)*	50% (after orthodontia deductible)	50% (after orthodontia deductible)	50% (after orthodontia deductible)

*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).

3 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.

Your dependents include your

- spouse;
- qualified adult child(ren) under age 26; and
- dependent, permanently disabled child(ren).*

*Must be declared dependent permanently disabled prior to age 26.

No person may be covered as both an employee and a dependent, and no person may be covered as a dependent of more than one employee. An employee and his or her 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.

4 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 dependents; your employer will deduct your required contributions for coverage. You must enroll within 60 days of your eligibility or wait until the next annual enrollment or qualifying life event.

QUALIFYING LIFE EVENTS

The coverage you choose will remain in effect until you cancel or change it during an annual enrollment period or within 60 days of a qualifying life event. Qualifying life events are

- your marriage, divorce, or dissolution of marriage or qualified domestic partnership;
- the birth or adoption of a child;
- the death of your spouse or child;
- a change in your or your spouse's employment from full-time to part-time (or vice versa);
- the beginning or end of your spouse's employment;
- a significant change in your or your spouse's healthcare coverage due to a change in your spouse's employment; and
- the beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a qualifying life event, and you want to elect or change your level of coverage, you must report the change to the Board of Pensions within 60 days of the event. Otherwise, you must wait until the next annual enrollment period.

5 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 form when you use a dentist who participates in the network. 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 fee schedule.)

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. You may select a PCD from the Aetna network provider directory, or by logging on to Aetna's website at aetna.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: you must have a referral from your PCD in order to receive coverage for any services a specialist dentist provides. DMO participants may visit an orthodontist without first obtaining a referral from their primary care dentist.

Network dentists can be found at aetna.com. DocFind can also be accessed from the Aetna secure member website that offers personalized plan information and links to other health information. Or you can call Aetna Member Services at 877-238-6200 for provider information.

SHARING THE COST

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

After the deductible has been met, the plan pays the percentage of covered expenses as outlined in the Dental Benefits Summary on pensions.org. The plan's benefits are limited to a calendar year maximum. Dental expenses incurred for services provided by both network and out-of-network providers apply to the calendar year maximum. However, if you participate in the PPO option, no additional benefits will be paid for out-of-network expenses when $1,000 of expenses has been applied to the calendar year.

There is a separate deductible and maximum benefit for orthodontic services. Benefits for orthodontic treatment are available only for eligible dependent children and are not counted against the calendar year 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).

Members and dependents in the DMO option do not pay individual or family deductibles, and are not subject to calendar or lifetime maximums.

6 Covered Dental Expenses

Preventive and Diagnostic Services

Bitewing X-ray: An intraoral X-ray taken with the upper and lower teeth closed together, used for early detection of hidden decay and cavities between teeth.

Dental Prophylaxis: Cleaning the teeth for the prevention of periodontal disease and tooth decay.

DMO Dental

DMO members are encouraged to review the DMO Dental Benefits Summary on pensions.org for detailed information regarding covered 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.

The plan covers the dental services and supplies subject to any limits described. Only non-occupational injuries and illnesses are covered.

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 and diagnostic
- restorative
- oral surgery
- endodontics
- periodontics
- 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.

Dental Expense Coverage

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

- pregnancy
- coronary artery disease/ cardiovascular disease
- cerebrovascular disease
- diabetes

Additional Covered Dental Expenses

- one additional prophylaxis (cleaning) per year
- scaling and root planing - per quadrant (4 or more teeth)
- scaling and root planing - per quadrant
- full mouth debridement (limited to 1-3 teeth)
- periodontal maintenance (one additional treatment per year)
- localized delivery of antimicrobial agents (not covered for pregnancy)

You may contact Aetna Member Services at 877-238-6200 if you or one of your dependents is pregnant or has diabetes, CVD, or CAD to register for the program.

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.

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.

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

- routine oral exams twice per calendar year - includes prophylaxis, scaling, and cleaning of teeth
- problem-focused exams twice per calendar year
- topical application of sodium or stannous fluoride for covered children under age 16 once per calendar year
- one set of regular bitewing X-rays per calendar year
- one full mouth series X-rays and one set of vertical bitewing X-rays every 3 years
- sealants for dependents under age 16 once per tooth every 3 years for permanent molars only
- space maintainers
- X-rays - single films (up to 13) and additional films (up to 12)

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-rays and Pathology

- periapical X-rays (single films up to 13)
- 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 years)
- root planing and scaling - 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- gingivectomy - per quadrant (limited to 1 per quadrant every 3 years)
- gingivectomy - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- gingival flap procedure - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- periodontal maintenance procedures following active therapy (limited to 2 per year)
- localized delivery of antimicrobial agents

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 on 1 surface will be considered 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)

MAJOR RESTORATIVE CARE

Restorative procedures return a tooth to its original condition or function.

Oral Surgery

- surgical removal of impacted teeth
- removal of tooth (partially bony)
- removal of tooth (completely bony)
- recementation
- inlay
- crown
- bridge

Periodontics

- osseous surgery (including flap and closure) - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- osseous surgery (including flap and closure) - per quadrant (limited to 1 per quadrant every 3 years)
- soft tissue graft procedures
- crown lengthening

Endodontics

- root canal therapy, including necessary X-rays
- molar

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
- crown buildup
- 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

Major Restorative Care

Relining (Rebasing): To resurface the tissue side of a denture with new base material in order 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.

MAJOR RESTORATIVE CARE CONTINUED

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.

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. Replacement of existing bridges or dentures is limited to 1 every 5 years.

- 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 years

General anesthesia and intravenous sedation – Only when medically necessary and only when provided in conjunction with a covered surgical procedure.

ORTHODONTIA SERVICES

Comprehensive orthodontic treatment is covered for eligible children if they are under age 20 when treatment begins. Limitations may apply for orthodontic work already in progress when the member is first eligible for coverage. Contact Aetna Member Services at 877-238-6200 for further information.

Coverage includes services or supplies to prevent, diagnose, or correct a misalignment of the teeth or bite, such as

- interceptive orthodontic treatment;
- limited orthodontic treatment;
- comprehensive orthodontic treatment of adolescent dentition;
- post-treatment stabilization; and
- removable appliance therapy to control harmful habits.

The plan does not cover the following services or 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")
- removable acrylic aligners (i.e., "invisible aligners")
- preventive services

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

In order 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 installment will be 25 percent 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 orthodontic maximum, and benefits are reduced when reimbursement has occurred for orthodontic work in progress (prior to coverage in these dental benefits).

ALTERNATIVE TREATMENT

If more than one service or supply can be used to treat a dental condition, coverage will be limited to those services and supplies that are

- customarily deemed to be appropriate by the dental profession; and
- meet broadly accepted national standards of dental practice.

7 Exclusions and Limitations

Experimental or Investigational

A drug, device, procedure, or treatment will be determined to be experimental or investigational if

- there are insufficient 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;
- approval required by the FDA has not been granted for marketing;
- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes;
- 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 Health 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, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

The following expenses are not covered under the plan:

- 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 disease or injury involved, even if they are prescribed, recommended, or approved by a 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 by a dentist)
- charges for the replacement of lost or stolen prosthetic devices
- services or supplies to increase vertical dimension
- services or supplies that are covered in whole or in part
  - under any other part of this dental plan; or
  - 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 in the plan documents
- 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 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 Covered Dental Expenses section (facings on molar crowns and pontics will always be considered cosmetic)

- crowns, 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
- 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 the booklet
- those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the booklet
- services needed solely in connection with non-covered 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

Jaw Joint Disorder

A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint, a Myofacial Pain Dysfunction (MPD), or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

8 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's Member Services 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 or medical coverage provided by

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

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. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
  - The plan that covers the person as a dependent of a working spouse will pay first.
  - Medicare will pay second.
  - The plan that covers the person as a retired employee will pay third.
- Except for children of a separation, divorce, or dissolution of a marriage or qualified domestic partnership, the plan of the parent whose birthday 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. If the other plan does not have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are separated or divorced, or their marriage or qualified domestic partnership has been dissolved,
  - 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 financial responsibility for the child's medical, dental, or other healthcare expenses 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; and
  - if there is no such court decree, the order of benefits will be determined as follows:
    1. the plan of the natural parent with whom the child resides
    2. the plan of the stepparent with whom the child resides
    3. the plan of the natural parent with whom the child does not reside
    4. the plan of the stepparent with whom the child does not reside
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such 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 does not cover the person under a right of continuation.

- 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 calculate this reduced amount as 100 percent of allowable expenses less benefits payable from your other plan(s).

"Allowable expenses" are the necessary and reasonable health expenses covered (in whole or in part) under any of your plan(s) (or those of the person for whom you make a claim).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

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

(The Board of Pensions does not review claim denials or appeals because this dental plan is underwritten by Aetna.)

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; and
- 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 (Pre-Service and Post-Service)

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 pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the claim.

For either a pre-service or post-service 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 post-service 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 pre-authorization 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 Member Services 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 Member Services and you will be notified of a decision within 36 hours after the appeal is received.

If you are not satisfied with a pre-service or post-service 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 pre-service claims) or 30 days (for post-service claims) after the appeal is received.

9 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 transitional participation coverage

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

- when dependent coverage under the plan is terminated
- when a dependent becomes covered as a plan member
- when the individual no longer meets the plan's definition of a dependent
- when your coverage terminates

REINSTATEMENT

If your coverage ends because you voluntarily terminate it or fail to make the required contributions, you may not re-enroll yourself and your eligible dependents until the next annual enrollment, 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 dependent 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; and
- 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.

10 Recovery of Overpayments

HEALTH COVERAGE

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; or
- 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 Aetna may have with respect to such overpayment.

THE BOARD OF PENSIONS
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