

Aetna Dental[®]

<http://www.aetnafeds.com>

aetna[®]

2017

A Nationwide Dental PPO Plan

Who may enroll in this plan: All Federal employees and annuitants in the United States and overseas who are eligible to enroll in the Federal Employees Dental and Vision Insurance Program

Enrollment Options for this Plan:

- High Option – Self Only
- High Option – Self Plus One
- High Option – Self and Family

This Plan has 6 enrollment regions, including overseas; please see the end of this brochure to determine your region and corresponding rates



Authorized for distribution by the:



**United States
Office of Personnel Management**

Healthcare and Insurance
www.opm.gov/healthcare-insurance

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of Aetna Dental under Aetna Life Insurance Company's contract OPM01-FEDVIP-01AP-1 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Aetna Dental
Federal Plans
PO Box 550
Blue Bell, PA 19422-0550

1-800-537-9384
www.aetnafeds.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2017, unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

Aetna is responsible for the selection of doctors in their network. Visit www.aetnafeds.com or contact us at 1-800-537-9384 for a list participating doctors. Continued participation of any specific doctor cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. You cannot change plans because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

Aetna and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.aetnafeds.com then click on the "Privacy Notices" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-800-537-9384.

Discrimination is Against the Law

Aetna complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557, Aetna does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy and gender identity).

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com . Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2016 Open Season, your coverage will begin on January 1, 2017. Premium deductions will start with the first full pay period beginning on/after January 1, 2017. You can use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 14, 2016 through midnight EST December 12, 2016; You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in this plan for the entire waiting period.

How We Have Changed For 2017

Changes to the High Option include:

- Increasing the in-network annual benefit maximum from \$10,000 to \$25,000.

We have added the following Dental codes for 2017:

Class A services – adding codes

- D0251 Extraoral – Posterior Dental Radiographic Image
- D1354 Interim caries arresting medicament application

Class C services – adding codes

- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D5221 Immediate maxillary partial denture – resin base
- D5222 Immediate mandibular partial denture – resin base
- D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases
- D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases
- D9223 Deep sedation/general anesthesia – each 15 minutes.
- D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minutes
- D9932 Cleaning and inspection of removable complete denture, maxillary
- D9933 Cleaning and inspection of removable complete denture, mandibular
- D9934 Cleaning and inspection of removable partial denture, maxillary
- D9935 Cleaning and inspection of removable partial denture, mandibular

Class D Orthodontic – adding codes

- D8681 Removable orthodontic retainer adjustment

General Services – Miscellaneous Services

- D9943 Occlusal guard adjustment

The plan has clarified the following as not covered:

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

The plan has clarified the following regarding claims filing and disputed claims process:

Deadline for Filing Your Claim

You must submit claims by December 31 of the year after the year you received the service unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as possible. Once we pay the benefits, there is a two-year limitation of uncashed checks.

Section 1 Eligibility

Federal Employees	<p>If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program or a Health Insurance Marketplace (Exchange) plan is not required.</p>
Federal Annuitants	<p>You are eligible to enroll if you:</p> <ul style="list-style-type: none">retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government. <p>Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.</p> <p>Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again, when you begin to receive your annuity.</p>
Survivor Annuitants	<p>If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.</p>
Compensationers	<p>A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.</p>
Family Members	<p>Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.</p> <p>FEDVIP rules and FEHB rules for family member eligibility are NOT the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.</p>
Not Eligible	<p>The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:</p> <ul style="list-style-type: none">Deferred annuitantsFormer spouses of employees or annuitantsFEHB Temporary Continuation of Coverage (TCC) enrolleeAnyone receiving an insurable interest annuity who is not also an eligible family member

Section 2 Enrollment

Enroll Through BENEFEDES

You must use BENEFEDES to enroll or change enrollment in a FEDVIP plan. BENEFEDES is a secure enrollment website (www.BENEFEDES.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, **your enrollment will continue automatically.** **Please Note:** your plans' premiums may change for 2017.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDES.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family, however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 14 through midnight EST December 12, 2016 Open Season. Coverage is effective January 1, 2017.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. **Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDES receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take.

Qualifying Life Event	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	Yes (if first time enrollment or cancelled during LWOP)	No	No	No	Yes (if enrollment cancelled during LWOP)
Annuity/compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

*Position must be with a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium and you elect to enroll.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of the loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

This is a one time opportunity. Once you make an election, you may not change your elected plan until the next Open Season.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends when you:

- no longer meet the definition of an eligible employee or annuitant;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments; or
- cancel the enrollment during Open Season.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to \$500 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of \$100. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

For a health care or limited expense account, each participant must contribute a minimum of \$100 to a maximum of \$2,550.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058.

Aetna will transmit plan payment information for members that enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) to the FSAFEDS carrier. Members that participate are not required to submit claims on behalf of the Aetna Dental plan to be reimbursed.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Section 3 How You Obtain Care

Identification cards/ Enrollment Confirmation	<p>ID cards are not provided, and are not required to obtain service. We will send you an enrollment confirmation letter when you enroll. For members who wish to carry an ID card, you may print one online from Aetna Navigator.</p> <p>It is important to tell your provider about your FEHB coverage at every appointment since most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage. This ensures that you receive the maximum allowable benefit under each Program.</p>
Where You Get Covered Care	<p>You may obtain care from any licensed dentist in the United States or overseas.</p>
Plan Providers	<p>We list plan providers in the provider directory, which we update periodically. The list is also on our website which is updated three times per week at: www.aetnafeds.com.</p>
In-Network	<p>We negotiate rates with dentists and other health care providers to help save you money. We refer to these providers as “In-Network providers”. These negotiated rates are our Plan allowance for network providers. If you use in-network dentists to obtain covered care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance. You are not responsible for the difference between the plan payment and the amount billed.</p>
Out-of-Network	<p>You may obtain care from any licensed dentist. If the dentist you use is not part of our network, benefits will be considered out-of-network. Because these providers are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. You are responsible for the difference between the Plan payment and the amount billed.</p>
Pre-Certification	<p>You and your dentist may request us to precertify dental procedures that your dentist plans to perform. We will provide an explanation of benefits to both you and your dentist that will indicate if procedures are covered and what we will pay for those specific services.</p>
First Payor	<p>When you visit a provider who participates with both, your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB payor. We are responsible for facilitating the process with the primary FEHB payor.</p> <p>SPECIAL NOTE: If you are enrolled in Aetna’s Consumer Driven Health Plan (CDHP) under the FEHB, the Dental Fund will not follow the First Payor rule for any service provided by a network dentist. However, preventive services provided by a non-network dentist would be payable from the Dental Fund and follow the First Payor rule.</p>
Coordination of Benefits	<p>We will coordinate benefit payments with the payment of benefits under other group health benefits coverage (non-FEHB) you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.</p> <p>SPECIAL NOTE: If you are enrolled in Aetna’s Consumer Driven Health Plan (CDHP) under the FEHB, the Dental Fund will not follow the First Payor rule for any service provided by a network dentist. However, preventive services provided by a non-network dentist would be payable from the Dental Fund and follow the First Payor rule.</p> <p>We may request that you verify/identify your health insurance plan(s) annually or at time of service.</p> <p>Here is an example of how we would coordinate benefits if a non-FEHB plan was primary:</p>

Primary plan payment based on schedule fee, we are secondary.	
In-Network Dentist's Fee	\$200.00*
Plan Allowance	\$150.00
Primary Plan's Scheduled Amount	\$125.00
Primary Plan's Payment	\$125.00
FEDVIP Payment	\$25.00 (\$150.00 - \$125.00)
Member Payment	\$0.00

*You are not responsible for the \$50.00 difference between the dentist's fee and the plan allowance, when you use an in-network dentist. The dentist cannot bill you for this amount.

Rating Areas

Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates may change because of the move.

Limited Access Areas

If you live in an area with limited access to a network provider and you receive covered services from an out-of-network provider, we will pay the same benefit level as if you utilized the services of an in-network provider. You are responsible for any difference between the amount billed and our payment. Call us at 1-800-537-9384, if you are having problems locating a dentist in your area.

Alternate Benefit

If more than one service or procedure can be used to treat the covered person's dental condition, Aetna may decide to authorize coverage only for the less costly covered service or procedure when that service is deemed by the dental profession to be an appropriate method of treatment and the service selected must meet broadly accepted national standards of dental practice.

Dental Review

Our review process includes periodontal surgery, crowns, occlusal adjustments and there are other services that are looked at, if they are submitted on the same claim as another service. Your provider should submit x-rays with crowns and periodontal charting with periodontal surgeries.

Section 4 Your Cost For Covered Services

This is what you will pay out-of-pocket for covered care:

Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our plan, you pay 40% for minor restorative service.
Annual Benefit Maximum	Once you reach this amount, you are responsible for all charges. Each member has a \$25,000 In-Network or \$2,000 Out-of-Network annual benefit maximum under this plan. In no event will benefits be greater than \$25,000. Note: In-Network and Out-of-Network amounts cross apply. Once the \$2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the \$25,000 maximum.
Lifetime Benefit Maximum	We have a lifetime benefit maximum for orthodontic services. Once you reach this amount, you are responsible for all charges. Our lifetime orthodontic benefit maximum is \$2,000.
In-Network Services	You pay the coinsurance percentage of our network allowance for covered services. You are not responsible for charges above that allowance.
Out-of-Network Services	If the dentist you use is not part of our network, benefits will be considered out-of-network. Because these providers are not part of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Please see Plan allowance below to review how we determine Plan allowance for out-of-network services.
Emergency Services	Emergency services are defined as those dental services needed to relieve pain or prevent the worsening of a condition when that would be caused by a delay.
Plan Allowance	Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network provider plans determine their allowance in different ways. We determine our allowance as follows: <ul style="list-style-type: none">• Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as “Network providers”. These negotiated rates are our Plan allowance for network providers. We calculate a member’s coinsurance using these negotiated rates. The member is not responsible for amounts that are billed by network providers that are greater than our Plan allowance.• Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Here is how we figure out the Plan allowance.

We get information from Fair Health. Health plans send Fair Health copies of claims for services they receive from providers. The claims include the date and place of service, the procedure code and the provider’s charge. Fair Health combines this information into databases that show how much providers charge for just about any service in any zip code. Providers’ charges for specific procedures are grouped in percentiles from low to high. Charges that fall in the middle are grouped into the 50th percentile. We use the 80th percentile to calculate how much to pay for out of network services. Payment of the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code. We use the 80th percentile amount as the Plan allowance. We would use the Plan allowance when calculating a member’s coinsurance amount. The member would be responsible for any amounts billed by the non-network provider that are above the Plan allowance, plus their coinsurance amount.

Section 5 Dental Services and Supplies Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- The annual benefit maximum is \$25,000 In-Network or \$2,000 Out-of-Network per covered person for Class A, B and C services.
- Note: In-Network and Out-of-Network amounts cross apply. Once the \$2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the \$25,000 maximum.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

You Pay:

- **In-Network:** \$0. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** \$0 up to the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation – *Limited to two per calendar year – see benefit limitations at the end of this section*

D0140 Limited oral evaluation – problem focused – *Limited to two per calendar year – see benefit limitations*

D0145 Oral evaluation for a child under three years of age and counseling with the primary caregiver – *Limited to two per calendar year*

D0150 Comprehensive oral evaluation – *Limited to two per calendar year – see benefit limitations*

D0160 Detailed and extensive oral exam – problem focused – *Limited to two per calendar year – see benefit limitations*

D0180 Comprehensive periodontal evaluation – *Limited to two per calendar year*

D0210 Intraoral – complete series (including bitewings) – *Limited to one set every 36 months. (Full Mouth series or panoramic x-ray)*

D0220 Intraoral – periapical – first film

D0230 Intraoral – periapical – each additional film

D0240 Intraoral – occlusal film

D0250 Extraoral - first radiographic image

D0251 Extraoral - Posterior Dental Radiographic Image

D0270 Bitewing – single film – *Limited to one set of Bitewing films or set per calendar year*

D0272 Bitewings – two films – *Limited to one set of Bitewing films or set per calendar year*

D0273 Bitewings – three films – *Limited to one set of Bitewing films or set per calendar year*

D0274 Bitewings – four films – *Limited to one set of Bitewing films or set per calendar year*

D0277 Vertical bitewings – 7 to 8 films – *Limited to one set every 36 months.*

D0330 Panoramic film – *Limited to one set every 36 months. (Full Mouth series or panoramic x-ray)*

D0425 Caries susceptibility tests

Preventive Services

D1110 Prophylaxis – adult – *Limited to twice per calendar year*

D1120 Prophylaxis – child – *Limited to twice per calendar year*

D1206 Topical application of fluoride - varnish limited to twice per calendar year

D1208 Topical application of fluoride limited to twice per calendar year

D1351 Sealant – per tooth – *Limited to children under age 19. One sealant per tooth in a 3-year period*

D1352 Preventive resin restoration in a moderate caries risk – permanent tooth

D1353 Sealant Repair (Per Tooth)

D1354 Interim caries arresting medicament application

D1510 Space maintainer – fixed – unilateral – *Limited to children under age 19*

D1515 Space maintainer – fixed – bilateral – *Limited to children under age 19*

D1520 Space maintainer – removable – unilateral – *Limited to children under age 19*

D1525 Space maintainer – removable – bilateral – *Limited to children under age 19*

D1550 Re-cementation of space maintainer – *Limited to children under age 19*

D1555 Removal of fixed space maintainer (when done by a dentist that did not place the appliance)

D2990 Resin infiltration/smooth surface

Additional Procedures covered as Basic Services

D9110 Palliative treatment of dental pain – minor procedure

D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)

D9440 Office visit after regularly scheduled hours

Benefit limitations:

- *Periodic oral exam (D0120), Oral evaluation for a child under the age of 3 (D0145) and Comprehensive oral exam (D0150) are limited to 2 exams in total, per calendar year*
- *Problem focused – Limited oral (D0140), Comprehensive exam (D0160) and Comprehensive periodontal evaluations (D0180) are limited to 2 exams in total, per calendar year*

Not covered:

- *Plaque control programs*
- *Oral hygiene instruction*
- *Dietary instructions*
- *Sealants for teeth other than permanent molars*
- *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- The annual benefit maximum is \$25,000 In-Network or \$2,000 Out-of-Network per covered person for Class A, B and C services.
- Note: In-Network and Out-of-Network amounts cross apply. Once the \$2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the \$25,000 maximum.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment.

You Pay:

- **In-Network:** 40% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 40% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Minor Restorative Services

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin-based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)

D2390 Resin based composite crown - anterior

D2391 Resin-based composite - one surface posterior - an alternate benefit of an amalgam will be provided on posterior teeth

D2392 Resin-based composite - two surface posterior - an alternate benefit of an amalgam will be provided on posterior teeth

D2393 Resin-based composite - three surface posterior - an alternate benefit of an amalgam will be provided on posterior teeth

D2394 Resin-based composite - four or more surface posterior - an alternate benefit of an amalgam will be provided on posterior teeth

D2910 Re-cement inlay - *Limited to once per 6 month period per tooth*

D2915 Re-cement cast or prefab post and core

D2920 Re-cement crown - *Limited to once per 6 month period per tooth*

D2921 Reattachment of tooth fragment - incisal edge or cusp

D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one per patient, per tooth, per lifetime*

D2931 Prefabricated stainless steel crown - permanent tooth - *Limited to one per patient, per tooth, per lifetime*

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)

D2951 Pin retention - per tooth, in addition to restoration

Not Covered:

- Restorations, including veneers, which are placed for cosmetic purposes only
- Gold foil restorations
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.

Endodontic Services

D3110 Pulp cap - direct (excluding final restoration)

D3120 Pulp cap – indirect (excluding final restoration)

D3220 Therapeutic pulpotomy (excluding final restoration)

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when you discontinue treatment.

D3355 Pulpal regeneration - initial visit

D3356 Pulpal regeneration - interim medication replacement

D3357 Pulpal regeneration - completion of treatment

Periodontal Services

D4341 Periodontal scaling and root planning-four or more teeth per quadrant – *Limited to once per quadrant every 24 months*

D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – *Limited to once per site every 24 months*

D4381 Localized delivery of antimicrobial agents

D4910 Periodontal maintenance following active periodontal therapy – *Limited to twice per calendar year*

Prosthodontic Services

D5410 Adjust complete denture - maxillary

D5411 Adjust complete denture - mandibular

D5421 Adjust partial denture - maxillary

D5422 Adjust partial denture - mandibular

D5510 Repair broken complete denture base

D5520 Replace missing or broken teeth - complete denture (each tooth)

D5610 Repair resin denture base

D5620 Repair cast framework

D5630 Repair or replace broken clasp

D5640 Replace broken teeth - per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5670 Replace all teeth and acrylic on cast metal framework, maxillary

D5671 Replace all teeth and acrylic on cast metal framework, mandibular

D5710 Rebase complete maxillary denture – *not covered within first six months of placement, limited to once in a 36-month period*

D5711 Rebase lower complete denture - *not covered within first six months of placement, limited to once in a 36-month period*

D5720 Rebase maxillary partial denture – *not covered within first six months of placement, limited to once in a 36-month period*

Prosthodontic Services (cont.)

D5721 Rebase mandibular partial denture – *not covered within first six months of placement, limited to once in a 36-month period*

D5730 Reline complete maxillary denture (chairside) – *not covered within first six months of placement, limited to once in a 36-month period*

D5731 Reline complete mandibular denture (chairside) – *not covered within first six months of placement, limited to once in a 36-month period*

D5740 Reline maxillary partial denture (chairside) – *not covered within first six months of placement, limited to once in a 36-month period*

D5741 Reline mandibular partial denture (chairside) – *not covered within first six months of placement, limited to once in a 36-month period*

D5750 Reline complete maxillary denture (laboratory) – *not covered within first six months of placement, limited to once in a 36-month period*

D5751 Reline complete mandibular denture (laboratory) – *not covered within first six months of placement, limited to once in a 36-month period*

D5760 Reline maxillary partial denture (laboratory) – *not covered within first six months of placement, limited to once in a 36-month period*

D5761 Reline mandibular partial denture (laboratory) – *not covered within first six months of placement, limited to once in a 36-month period*

D5850 Tissue conditioning (maxillary)

D5851 Tissue conditioning (mandibular)

D6092 Re-cement Implant / Abutment supported crown

D6093 Re-cement Implant / Abutment supported fixed partial denture

D6930 Re-cement fixed partial denture

D6980 Fixed partial denture repair, by report

Oral Surgery

D7111 Extraction, coronal remnants - deciduous tooth

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

D7220 Removal of impacted tooth - soft tissue

D7230 Removal of impacted tooth - partially bony

D7240 Removal of impacted tooth - completely bony

D7241 Removal of impacted tooth – complete bony complications

D7250 Surgical removal of residual tooth roots (cutting procedure)

D7251 Coronectomy – intentional partial tooth removal

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7280 Surgical access of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - per quadrant

D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

D7320 Alveoloplasty not in conjunction with extractions - per quadrant

D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

D7471 Removal of exostosis

D7510 Incision and drainage of abscess - intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7971 Excision of pericoronal gingiva

D7999 Unspecified oral surgery procedure, by report

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- The annual benefit maximum is \$25,000 In-Network or \$2,000 Out-of-Network per covered person for Class A, B and C services.
- Note: In-Network and Out-of-Network amounts cross apply. Once the \$2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the \$25,000 maximum.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment.

You Pay:

- **In-Network:** 60% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 60% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between plan payment and the amount billed by the dentist.

Major Restorative Services

D2520 Inlay - metallic - two surfaces - an alternate benefit will be provided
D2510 Inlay - metallic - one surface - an alternate benefit will be provided
D2530 Inlay - metallic - three surfaces - an alternate benefit will be provided
D2542 Onlay - metallic - two surfaces
D2543 Onlay - metallic - three surfaces
D2544 Onlay - metallic - four or more surfaces
D2740 Crown - porcelain/ceramic substrate - an alternate benefit will be provided on posterior teeth
D2750 Crown - porcelain fused to high noble metal - an alternate benefit will be provided on posterior teeth
D2751 Crown - porcelain fused to predominately base metal - an alternate benefit will be provided on posterior teeth
D2752 Crown - porcelain fused to noble metal - an alternate benefit will be provided on posterior teeth
D2780 Crown - 3/4 cast high noble metal - an alternate benefit will be provided on posterior teeth
D2781 Crown - 3/4 cast predominately base metal
D2782 Crown - 3/4 noble metal
D2783 Crown - 3/4 porcelain/ceramic - an alternate benefit will be provided on posterior teeth
D2790 Crown - full cast high noble metal - an alternate benefit will be provided on posterior teeth
D2791 Crown - full cast predominately base metal
D2792 Crown - full cast noble metal
D2794 Crown - titanium - an alternate benefit will be provided on posterior teeth
D2950 Core buildup, including any pins
D2954 Prefabricated post and core, in addition to crown
D2980 Crown repair, by report
D2981 Inlay repair necessitated by restorative material failure
D2982 Onlay repair necessitated by restorative material failure

Major Restorative Services (cont.)

D2983 Veneer repair necessitated by restorative material failure

Not covered:

- *Gold foil restorations*
- *Sedative restorations*
- *Restorations for cosmetic purposes only*
- *Porcelain/Ceramic inlays, Composite resin inlays Porcelain/Ceramic onlays, Composite resin onlays*
- *Cast or processed restorations and crowns for purposes other than treatment for decay or acute traumatic injury, when teeth can be restored with a filling material*

Endodontic Services

D3310 Anterior root canal (excluding final restoration)

D3320 Bicuspid root canal (excluding final restoration)

D3330 Molar root canal (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - bicuspid

D3348 Retreatment of previous root canal therapy - molar

D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

D3410 Apicoectomy/periradicular surgery - anterior

D3421 Apicoectomy/periradicular surgery - bicuspid (first root)

D3425 Apicoectomy/periradicular surgery - molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3427 Periradicular surgery without apicoectomy

D3430 Retrograde filling - per root

D3450 Root amputation - per root

D3920 Hemisection (including any root removal) - not including root canal therapy

Periodontal Services

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces, per quadrant - limited to once in a 36 month period

D4211 Gingivectomy or gingivoplasty - one to three teeth, per quadrant - limited to once in a 36 month period

D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth

D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant

D4241 Gingival flap procedure, including root planning - one to three teeth per quadrant

D4249 Clinical crown lengthening-hard tissue

D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant - limited to once in a 36 month period

D4261 Osseous surgery (including flap entry and closure) - one to three teeth per quadrant - limited to once in a 36 month period

D4270 Pedicle soft tissue graft procedure

D4268 Surgical revision procedure, per tooth

D4271 Free soft tissue graft procedure (including donor site surgery)

D4273 Subepithelial connective tissue graft procedures (including donor site surgery)

Periodontal Services - continued on next page

Periodontal Services (cont.)

D4275 Soft tissue allograft

D4276 Combined connective tissue and double pedicle graft, per tooth

D4277 Free soft tissue graft procedure, first tooth or edentulous tooth position in a graft

D4278 Free soft tissue graft procedure, each additional contiguous tooth or edentulous tooth position in a graft

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - *Limited to once per lifetime*

D4999 Periodontal procedure, unspecified by report.

Prosthodontic Services

D5110 Complete denture - maxillary

D5120 Complete denture - mandibular

D5130 Immediate denture - maxillary

D5140 Immediate denture - mandibular

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)

D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)

D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5220 Mandibular partial denture, flexible base

D5221 Immediate maxillary partial denture - resin base

D5222 Immediate mandibular partial denture - resin base

D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases

D5225 Maxillary partial denture, flexible base

D5226 Mandibular partial denture, flexible base

D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth)

Note: An **implant** is a covered procedure of the plan only if determined to be a dental necessity. Aetna claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

D6010 Endosteal implant - surgical placement

D6013 Surgical placement of mini implant

D6040 Subperiosteal implant

D6050 Transosseous mandibular implant

D6052 Semi-precision attachment abutment

D6055 Implant supported or abutment supported connecting bar

D6056 Prefabricated abutment - includes placement

D6057 Custom abutment - includes placement

D6058 Implant/abutment supported single porcelain/ceramic crown

D6059 Implant/abutment supported single porcelain fused to metal crown high noble

D6060 Implant/abutment supported single porcelain fused to metal crown predominantly base metal

D6061 Implant/abutment supported single porcelain fused to metal crown noble metal

Prosthodontic Services (cont.)

D6062 Implant/abutment supported single cast metal crown high noble metal
D6063 Implant/abutment supported single cast metal crown predominantly base metal
D6064 Implant/abutment supported single cast metal crown noble metal
D6065 Implant supported single porcelain/ceramic crown
D6066 Implant supported single porcelain fused to metal crown titanium, titanium alloy, high noble metal.
D6067 Implant supported single metal crown titanium, titanium alloy, high noble metal
D6068 Implant/abutment supported fixed partial denture retainer for porcelain/ceramic
D6069 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal high noble metal
D6070 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal predominantly base metal
D6071 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal noble metal
D6072 Implant/abutment supported fixed partial denture retainer for cast metal high noble metal
D6073 Implant/abutment supported fixed partial denture retainer for cast metal predominantly base metal
D6074 Implant/abutment supported fixed partial denture retainer for cast metal noble metal
D6075 Implant supported fixed partial retainer for ceramic
D6076 Implant supported fixed partial retainer for porcelain fused to metal titanium, titanium alloy, high noble metal
D6077 Implant supported fixed partial retainer for cast metal titanium, titanium alloy, high noble metal
D6080 Implant maintenance procedures
D6090 Repair Implant Prosthesis
D6091 Replacement of Semi-Precision or Precision Attachment
D6094 Abutment supported crown - titanium
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
D6102 Debridement of periimplant defect
D6104 Bone graft at the time of implant placement
D6110 Implant/abutment supported removable denture for completely edentulous arch-maxillary
D6111 Implant/abutment supported removable denture for completely edentulous arch-mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114 Implant/abutment supported fixed denture for completely edentulous arch - maxillary
D6115 Implant/abutment supported fixed denture for completely edentulous arch - mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular
D6194 Abutment supported retainer crown for FPD-titanium
D6205 Pontic - indirect resin based composite -an alternate benefit will be provided on posterior teeth
D6210 Pontic - cast high noble metal - an alternate benefit will be provided on posterior teeth
D6211 Pontic - cast predominately base metal
D6212 Pontic - cast noble metal
D6214 Pontic - titanium - an alternate benefit will be provided on posterior teeth
D6240 Pontic - porcelain fused to high noble metal - an alternate benefit will be provided on posterior teeth
D6241 Pontic - porcelain fused to predominately base metal - an alternate benefit will be provided on posterior teeth
D6242 Pontic - porcelain fused to noble metal - an alternate benefit will be provided on posterior teeth
D6245 Pontic - porcelain/ceramic - an alternate benefit will be provided on posterior teeth
D6545 Retainer - cast metal for resin bonded fixed prosthesis

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - an alternate benefit will be provided on posterior teeth
D6601 Inlay/onlay - porcelain/ceramic, three or more surfaces
D6604 Inlay - cast predominantly base metal, two surfaces
D6605 Inlay - cast predominantly base metal, three or more surfaces
D6613 Onlay - cast predominantly base metal, three or more surfaces
D6740 Crown - porcelain/ceramic - an alternate benefit will be provided on posterior teeth
D6750 Crown - porcelain fused to high noble metal - an alternate benefit will be provided on posterior teeth
D6751 Crown - porcelain fused to predominately base metal - an alternate benefit will be provided on posterior teeth
D6752 Crown - porcelain fused to noble metal - an alternate benefit will be provided on posterior teeth
D6780 Crown - 3/4 cast high noble metal - an alternate benefit will be provided on posterior teeth
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic - an alternate benefit will be provided on posterior teeth
D6790 Crown - full cast high noble metal - an alternate benefit will be provided on posterior teeth
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D6973 Core buildup for retainer, including any pins
D6794 Crown - titanium – an alternate benefit will be provided on posterior teeth
D9223 Deep sedation/general anesthesia - each 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each 15 minutes
D9931 Cleaning and inspection of a removable appliance
D9932 Cleaning and inspection of removable complete denture, maxillary
D9933 Cleaning and inspection of removable complete denture, mandibular
D9934 Cleaning and inspection of removable partial denture, maxillary
D9935 Cleaning and inspection of removable partial denture, mandibular
D9999 Unspecified Adjunctive procedure, by report

Not covered:

- Partial or full removable denture, fixed bridgework or other covered prosthetic services (including implant abutments/crowns) if it includes replacement of one or more natural teeth missing prior to you being covered under a participating FEDVIP plan. This does not apply if it also includes replacement of a natural tooth that is removed while you are covered and was not an abutment to a prosthetic appliance installed during the prior five years
- Precision attachments, personalization, precious metal bases, and other specialized technique
- Replacement of existing dentures, casts and processed restorations, crowns, removable dentures, fixed bridgework, or other covered prosthetic services that had been installed less than five years prior to the current replacement
- Replacement of dentures that have been lost, stolen or misplaced
- Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date. This does not apply to prostheses that were initiated during the coverage period and inserted/cemented within 30 days of the coverage ending date.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- The waiting period for orthodontic services is 12 months. The person receiving services must be covered under this plan for the entire waiting period.
- The lifetime maximum for orthodontic services is \$2,000.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment.

You Pay:

- **In-Network:** 50% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 50% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Orthodontic Services

D0340 Cephalometric film

D0350 Oral/facial images (including intra and extraoral images)

D0351 3D photographic image

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8040 Limited orthodontic treatment of adult dentition

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of adult dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

D8681 Removable orthodontic retainer adjustment

D8690 Orthodontic treatment (alternative billing to a contract fee)

Orthodontic Services - continued on next page

Orthodontic Services (cont.)

Not covered:

- *Repair of damaged orthodontic appliances*
 - *Replacement of lost or missing appliance*
 - *Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.*
 - *Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth*
-

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- The annual benefit maximum is \$25,000 In-Network or \$2,000 Out-of-Network.

Note: In-Network and Out-of-Network amounts cross apply. Once the \$2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the \$25,000 maximum.

- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment.

You Pay:

Anesthesia Services, Intravenous Sedation and Miscellaneous Services

- **In-Network:** 60% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 60% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Consultations, Office Visits, Medications and Post-Surgical Services

- **In-Network:** 40% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 40% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist

Anesthesia Services

D9219 Evaluation for deep sedation or general anesthesia

D9220 Deep sedation/general anesthesia - first 30 minutes

D9221 Deep sedation/general anesthesia - each additional 15 minutes

Intravenous Sedation

D9241 Intravenous conscious sedation/analgesia - first 30 minutes

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes

Medications

D9610 Therapeutic parental drug - single administration

D9612 Therapeutic parental drugs - two or more administrations, different drugs

Post-Surgical Services

D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Miscellaneous Services

D9940 Occlusal guard, by report - *for bruxism only - limited to once in a 36 month period*

D9941 Fabrication of athletic mouthguard - *Limited to one per 12 month period*

D9943 Occlusal guard adjustment

D9974 Internal bleaching - per tooth - *Limited to once per tooth per three year period*

Not covered:

- *Nitrous oxide*
 - *Oral sedation*
 - *General anesthesia and IV sedation when determined to be medically necessary and unless done in conjunction with another necessary covered service*
-

Section 6 International Services and Supplies

**International Claims
Payment**

If you receive dental services while overseas, you will need to submit your claims to Aetna. Upon receipt of the claim, Aetna will translate the claim, if necessary, and process it. We use the rate of exchange in effect at the time we process the claim. Claims are paid in U.S. currency.

**Finding an International
Provider**

You may use any dentist while overseas. We do not have a participating dental network outside the U.S.

**Filing International
Claims**

Please send us all of your documents for your claim to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

**Customer Service
Website and Phone
Numbers**

You may look up information on our plan or ask a question at www.aetnafeds.com. (Our toll-free number will not work overseas).

International Rates

There is one international region. Please see the rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.** *Also, please see Section 5, Dental Services and Supplies, for other exclusions and limitations.*

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service;
- Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse;
- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services submitted by a dentist which are for the same services performed on the same day for the same member by another dentist;
- Services and treatment which are experimental or investigational;
- Services provided free of charge by any government unit, except where this exclusion is prohibited by law;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment for which the cost is later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law;
- Services for which the member would have no obligation to pay in the absence of this or any other insurance;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
- Services and treatment performed prior to your effective coverage date including orthodontic treatment, except partial or full removable denture, fixed bridgework or other covered prosthetic services if it includes replacement of one or more natural teeth missing prior to you being covered under a participating FEDVIP plan;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to you by a participating dentist unless the dentist notifies you of your liability prior to treatment and you choose to receive the treatment. Participating dentists should document such notification in their records.);
- Services and treatment not meeting accepted standards of dental practice;
- Services performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Services which are for unusual procedures or techniques;
- Services related to diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;

- State or territorial taxes on dental services performed;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Hospital costs or any additional fees that the dentist or hospital charges are for treatment at the hospital (inpatient or outpatient);
- Adjunctive dental care services that are covered by other medical insurance even when provided by a general dentist or oral surgeon;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Duplicate and temporary devices, appliances, and services;

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To obtain claim forms or other claim filing advice or answers about your benefits, contact us at 1-800-537-9384 or go to our web site at www.aetnafeds.com.

Deadline for Filing Your Claim

Send us all of the documents for your claim, as soon as possible, to: Aetna, PO Box 14094, Lexington, KY 40512-4094.

You must submit claims by December 31 of the year after the year you received the service unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as possible. Once we pay the benefits, there is a two-year limitation of uncashed checks.

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

1. Ask us in writing to reconsider our initial decision. You must:

- a) Write to us within 6 months from the date of our decision; and
- b) Send your request to us at: Aetna, Attention: National Accounts, P.O. Box 14597, Lexington, KY 40512-4597; and

Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. This is your first level appeal.

2. We have 30 days from the date we receive your request to:

- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- b) Write to you and maintain our denial – go to step 3; or
- c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

3. If the dispute is not resolved through the reconsideration process, and the reason for the denial was based on medical necessity or for experimental or investigational reasons, you have the right to file a second level appeal. That appeal must be submitted within 60 days following the receipt of our first level denial.

4. If you do not agree with our final decision, and the amount of your claim is more than \$300 and the plan denied your claim because it did not consider the treatment medical necessity, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. You have 30 days from the date you received our final decision to request a third party review.

The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Alternate Benefit	If more than one service or procedure can be used to treat the covered person's dental condition, Aetna may decide to authorize coverage only for the less costly covered service or procedure when that service is deemed by the dental profession to be an appropriate method of treatment and the service selected must meet broadly accepted national standards of dental practice.
Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Services that are customarily used nationwide and "deemed by the profession to be appropriate". They must meet broadly accepted national standards of practice.
Plan Allowance	<p>Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network provider plans determine their allowance in different ways. We determine our allowance as follows:</p> <ul style="list-style-type: none">• Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as “Network providers”. These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts that are billed by network providers that are greater than our Plan allowance.• Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Here is how we figure out the Plan allowance.

We get information from Fair Health. Health plans send Fair Health copies of claims for services they receive from providers. The claims include the date and place of service, the procedure code and the provider's charge. Fair Health combines this information into databases that show how much providers charge for just about any service in any zip code. Providers' charges for specific procedures are grouped in percentiles from low to high. Charges that fall in the middle are grouped into the 50th percentile. We use the 80th percentile to calculate how much to pay for out of network services. Payment of the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code. We use the 80th percentile amount as the Plan allowance. We would use the Plan allowance when calculating a member's coinsurance amount. The member would be responsible for any amounts billed by the non-network provider that are above the Plan allowance, plus their coinsurance amount.

Pre-Certification

This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.

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 services are needed to replace one or more natural teeth that were removed while covered under a participating FEDVIP plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of third molars does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Waiting Period

The amount of time that you must be enrolled in this plan before you can receive orthodontic services.

We/Us

Aetna Dental

You

Enrollee or eligible family member.

Non-FEDVIP Benefits Available to Plan Members

The benefits on this page are not part of the FEDVIP contract or premium, and you cannot file an FEDVIP disputed claim about them. Fees you pay for these services do not count towards any FEDVIP maximums.

Aetna Vision SM Discounts

You are eligible to receive substantial discounts on eyeglasses, contact lenses, Lasik — the laser vision corrective procedure, and nonprescription items including sunglasses and eyewear products through the Aetna Vision Discounts Program with more than 13,000 providers across the country.

If your health plan also includes coverage for eyewear such as prescription eyeglasses or contact lenses, your out-of-pocket expense can be reduced when you use Aetna Vision discount. You may purchase your eyewear at Aetna Vision locations at discounted rates, and your allowance will automatically be applied at point of purchase. You don't have to submit the receipt for reimbursement. Your allowance applies to prescription eyeglasses or contact lenses only.

For more information on Aetna Vision Discounts eyewear call toll free 1-800-793-8616. For a referral to a Lasik provider, call 1-800-422-6600.

Aetna Navigator

Aetna Navigator, our secure member self service website, provides you with the tools and personalized information to help you manage your health. Click on My Navigator from www.aetnafeds.com to register and access a secure, personalized view of your Aetna benefits.

With Aetna Navigator, you can:

- Review PCP selections
- Print temporary ID cards
- Download details about a claim such as the amount paid and the member's responsibility
- Contact member services at your convenience through secure messages
- Access cost and quality information through Aetna's transparency tools
- View and update your Personal Health Record
- Find information about the member extras that come with your plan
- Access health information through Aetna Healthwise® Knowledgebase

Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 1-800-225-3375. Register today at www.aetnafeds.com.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-537-9384 and explain the situation.
- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self-support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure, prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Notes

Notes

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.
- There is no deductible.

	You Pay
High Option Benefits	
Class A (Basic) Services – preventive and diagnostic	Nothing
Class B (Intermediate) Services – includes minor restorative services	40%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	60%
Class A, B, and C Services are subject to a \$25,000 In-Network or \$2,000 Out-of-Network annual maximum benefit	
Class D Services – orthodontic \$2,000 Lifetime Maximum	50%
Note:	
Plan payment percentages are applied to the plan allowance. When you use an out-of-network provider, in addition to your coinsurance percentage, you are responsible for the difference between the plan allowance and the billed charges.	

