



## Dental Benefits Summary

Monroe Township Board of Education

Effective Date: 07-01-2020

|                                                         | <u>Passive PPO</u><br><u>With PPOII Network</u><br><u>90th R&amp;C</u> |
|---------------------------------------------------------|------------------------------------------------------------------------|
| Annual Deductible*                                      |                                                                        |
| Individual                                              | \$50                                                                   |
| Family                                                  | \$100                                                                  |
| Preventive Services                                     | 80%                                                                    |
| Basic Services                                          | 80%                                                                    |
| Major Services                                          | 50%                                                                    |
| Annual Benefit Maximum                                  | \$2,000                                                                |
| Office Visit Copay                                      | N/A                                                                    |
| Orthodontic Services (Adult and Child)                  | 50%                                                                    |
| Orthodontic Deductible                                  | None                                                                   |
| Orthodontic Lifetime Maximum                            | \$1,000                                                                |
| *The deductible applies to: Basic & Major services only |                                                                        |

| <b>Partial List of Services</b>                               | <u>Passive PPO</u><br><u>With PPOII Network</u><br><u>90th R&amp;C</u> |
|---------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Preventive</b>                                             |                                                                        |
| Oral examinations (a)                                         | 80%                                                                    |
| Cleanings (a) Adult/Child                                     | 80%                                                                    |
| Fluoride (a)                                                  | 80%                                                                    |
| Sealants (permanent molars only) (a)                          | 80%                                                                    |
| Bitewing Images (a)                                           | 80%                                                                    |
| Full mouth series Images (a)                                  | 80%                                                                    |
| Space Maintainers                                             | 80%                                                                    |
| <b>Basic</b>                                                  |                                                                        |
| Root canal therapy                                            |                                                                        |
| Anterior teeth / Bicuspid teeth                               | 80%                                                                    |
| Root canal therapy, molar teeth                               | 80%                                                                    |
| Scaling and root planing (a)                                  | 80%                                                                    |
| Gingivectomy (a)*                                             | 80%                                                                    |
| Amalgam (silver) fillings                                     | 80%                                                                    |
| Composite fillings (anterior teeth only)                      | 80%                                                                    |
| Stainless steel crowns                                        | 80%                                                                    |
| Incision and drainage of abscess*                             | 80%                                                                    |
| Uncomplicated extractions                                     | 80%                                                                    |
| Surgical removal of erupted tooth*                            | 80%                                                                    |
| Surgical removal of impacted tooth (soft tissue)*             | 80%                                                                    |
| Osseous surgery (a)*                                          | 80%                                                                    |
| Surgical removal of impacted tooth (partial bony/ full bony)* | 80%                                                                    |
| General anesthesia/intravenous sedation*                      | 80%                                                                    |
| Inlays                                                        | 80%                                                                    |
| Denture repairs                                               | 80%                                                                    |
| Onlays                                                        | 80%                                                                    |
| Crown Build-Ups                                               | 80%                                                                    |
| Crowns                                                        | 80%                                                                    |
| Crown Lengthening                                             | 80%                                                                    |
| <b>Major</b>                                                  |                                                                        |
| Full & partial dentures                                       | 50%                                                                    |
| Pontics                                                       | 50%                                                                    |
| Implants                                                      | 50%                                                                    |

\*Certain services may be covered under the Medical Plan. Contact Member Services for more details.

(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

**Other Important Information**

This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to recognized charge limits.

**Emergency Dental Care**

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

**Partial List of Exclusions and Limitations\* - Coverage is not provided for the following:**

1. Services or supplies that are covered in whole or in part:
  - (a) under any other part of this Dental Care Plan; or
  - (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
  - (a) a non-occupational disease; or
  - (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. 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.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. 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.
7. 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.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
  - (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
  - (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
  - (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
  - (a) during the first 31 days the person is eligible for this coverage, or
  - (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
    - (i) after the end of the 12-month period starting on the date the person became a covered person; or
    - (ii) as a result of accidental injuries sustained while the person was a covered person; or
    - (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
  - (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or



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- (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

\*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

### Your Dental Care Plan Coverage Is Subject to the Following Rules:

#### Replacement Rule

The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- (a) the service must be listed on the Dental Care Schedule;
- (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- (c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- (a) the copayment for the approved less costly service; plus
- (b) the difference in cost between the approved less costly service and the more costly covered service.

### Finding Participating Providers

Consult Aetna Dentals online provider search for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider search available at [www.aetna.com](http://www.aetna.com).

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

**Dental Benefits Summary**

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),  
[CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

TTY:711

| English       | To access language services at no cost to you, call the number on your ID card.                                                        |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Albanian      | Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.                                    |
| Amharic       | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ።                                                                                  |
| Arabic        | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.                                           |
| Armenian      | Ձեր նախընտրած լեզվով ավելճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական աստիճանականության քարտի վրա նշված հեռախոսահամարով |
| Bantu-Kirundi | Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe                                                  |
| Bengali       | আপনকে বিনামূল্যে ও য প্রসিবে পত্র হল আপন প্রচলিত দ্রষ্টব্য নম্বরে টেলিফোন করুন।                                                        |
| Burmese       | သင့်အနေဖြင့် အခမဲ့အခမဲ့ မပေးရဘဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။              |
| Catalan       | Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.            |
| Cebuano       | Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.                       |



[illegible]



**Dental Benefits Summary**

Yoruba

Láti ráyèsí àwọn iṣẹ èdè fún ọ lẹfẹẹ, pe nọmbà tò wà lórí kààdì idánimọ rẹ.