ADP TOTALSOURCE, INC.

Aetna 2019 Dental FAQ
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1. **What is the contract situs for each plan? Do the plans recognize another state's mandates?**
   Florida is the contract situs for the PPO Dental Plans. Another state's mandates would not apply unless they are considered extraterritorial.

   Florida is the contract situs for the DMO Dental Plans, *with the exception* of the legal entity states: AZ, CA, NC, NJ, and TX.

   Another state's mandates **would not** apply to the DMO Dental Plans with contract situs of Florida.

   Another state's mandates **would not** apply to the legal entity states.

2. **How does the DMO Plan work?**
   Employees choose a primary care dentist (PCD) who participates in the Aetna DMO network. Each covered family member can select his or her own PCD.

   Depending on the DMO plan, members may pay for dental care in one of two ways:

   - *Copay — Member pays a set dollar amount*
   - *Coinsurance — Member pays a percentage of covered expenses*

   There are no deductibles or annual dollar maximums.

   The dentist usually submits claims.

3. **What is the dependent limiting age?**
   Dependent children are eligible for coverage until the end of year age 26 is attained.

4. **How are Handicapped Dependent Children covered?**
   Dental Expense Coverage for a disabled dependent child may be continued past the maximum age. A child is fully handicapped if:

   - s/he is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date s/he reaches the maximum age for dependent children under the plan; and
   - s/he depends chiefly on employee for support and maintenance.

   Proof that the child is fully handicapped must be submitted to Aetna no later than 90 days after the date the child reaches the maximum age under the plan.

   Coverage will cease on the first to occur of:

   - Cessation of the handicap.
   - Failure to give proof that the handicap continues.
   - Failure to have any required exam.

   - Termination of Dependent Coverage as to the child for any reason other than reaching the maximum age under the plan.

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

5. **Do employees have to complete a Handicapped/Disabled Dependent Form for their disabled dependent for dental coverage?**
   Yes, unless there is an approval already on record under the medical. If there is it can be applied to the dental as well.

6. **What is a dental emergency and how is it covered?**
   A dental emergency exists if there is one of the three: severe pain, swelling or bleeding.

   The plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a network provider up to the dental emergency maximum. The care provided must be a covered service or supply.

   A claim must be submitted to Aetna describing the care given. Additional dental care to treat the dental emergency will be covered at the appropriate coinsurance level.

7. **How is coverage handled when abroad?**
   PPO Dental plans: any services occurred aboard will be considered at the out of network level of coverage.

   DMO Dental plans: only emergency work will be considered as noted above in the dental emergency question.

8. **What is the Tooth Missing but Not Replaced Rule?**
   The plan does not cover expenses to replace a tooth that was extracted prior to coming onto the plan. This is waived in the case of a takeover and if the tooth was extracted while the member was covered under the prior plan.

9. **Coverage for Dental Work Begun Before You Are Covered by the Plan**
   The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

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

   Takeover exclusion may apply.

10. **Is the Orthodontic Lifetime Maximum separate from any Annual Plan Maximum?**
    Yes.

11. **Are braces included under Orthodontia?**
    Yes, braces are included in the full treatment plan for the orthodontia.

12. **What is the difference between "takeover" and "work in progress"?**
    "Takeover" occurs when the patient has been employed by the employer and the employer switches insurance carriers while the patient is in the middle of treatment. Treatment may be considered if:

    - Member was been covered under the prior plan at the time of the Takeover
    - Service was covered and the treatment plan considered under the prior plan
    - Service is not covered by the prior plan under an Extension of Benefits provision
    - For orthodontia the appliances were placed prior to the employer's effective date with Aetna and the bands were placed after the Aetna dependent limiting age*

    *Aetna's orthodontic maximum will be reduced by any amounts paid by the prior carrier

    "Work-in-progress (WIP)" will occur in two different situations:
    - When an employer did not originally offer Orthodontia, however, adds Orthodontia at a later date.
      OR
    - When an employee, who was not previously active with the employer, begins coverage with Aetna. Appliances were placed prior to their effective date with Aetna.

    It does not matter if the employee had Orthodontia coverage prior to becoming effective with Aetna.
    Aetna dental plans include a work-in-progress (WIP) exclusion. That is, there is no coverage for orthodontia treatment if is considered work-in-progress (WIP).

13. Will the plan honor a prior carrier deductible?

Yes. If an employee comes onto the plan on a date other than 01/01, Aetna will credit the deductible they have met with their prior carrier. Proof from the prior carrier, such as an EOB, is required. Employees should fax the last EOB from their prior carrier to 859-455-8650 with the Aetna ID# and indicate "requesting deductible credit". Deductible credit will not impact the yearly benefit maximum.

If a member is enrolled in an Aetna commercial plan and moving to an ADPTS Aetna plan, we will allow deductible credit and also allow the full yearly benefit maximum.

The dental plans are calendar year, the deductible and max allowed limits will reset on January 1st

14. Is there a 4th quarter deductible carryover provision included on dental plans?

No

15. Do the dental plans include a Coordination of Benefits provision?

Yes. The Coordination of Benefits (COB) provision applies to the plan when the covered employee or their covered dependent has dental coverage under more than one plan. The Order of Benefit Determination Rules determines which plan will pay as the primary plan.

The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Order of Benefit Determination Rules - The plan that covers the member as the employee pays first (primary payer). The plan covering the member as a dependent pays second (secondary payer).

The birthday rule is used to determine the primary payer for dependents (when parents are not divorced or separated). The plan of the parent whose birthday occurs earlier in the calendar year is primary (refers only to month and day in a calendar year, not the year in which the person was born).

16. What is the waiting period on major services?

There is no waiting period for timely enrollments.

17. Can a member get a second opinion or pre-treatment estimate?

Second opinions to another GP (general practitioner) are eligible and do not require the patient to switch GPs. Members should call customer service to request approval for a second opinion consultation. The second opinion benefits are for a consultation only (no x-rays as these should be obtained from their current PCD prior to the appointment). The purpose of the second opinion is to determine if the treatment plan is in the member's best interest and necessary.

A pre-treatment or pre-determination is recommended whenever a course of treatment is likely to cost more than $350

The claim review is voluntary. It is a service that provides the member and their dentist with information that can be considered when deciding on a course of treatment. The member's dentist must write down a full description of the treatment needed, using an Aetna claim form or an ADA approved claim form. The member's dentist should send the form to Aetna. Aetna may request supporting x-rays and other diagnostic records. Once all the information has been gathered, Aetna will review the proposed treatment plan and provide the member and their dentist with a statement outlining the benefits payable by theplan.

18. Does Aetna cover implants?

Implants are excluded on all plans except the new PPO 5000 plan effective 06/01/19.

The tooth being replaced by the implant is subject to the missing tooth exclusion rule. When a crown is placed over the implant, we will consider the benefit for the implant-related crown at the Major Services coverage level, subject to plan exclusions and limitations (e.g. Missing but Not Replaced Rule, Prosthodontic Frequency Limits, Alternate Benefit Provision). Ridge augmentation is considered medical in nature and not covered under the dental plan.

Members should reference the plan document to see what is specifically covered and not covered. Members can also check the clinical policy bulletin on the Aetna website relating to implants at the link below. When in doubt about whether something is covered or not covered, members should call the Member Services number on the back of their ID Card.

Ctrl +Click: Immediate Surgical Placement of Implant Body With Soft Tissue Grafting, Osseous Grafting and Guided Tissue Regeneration (009) | Aetna

19. Is a Pediatric dentist considered a Specialist under the DMO plan?

Under the DMO, Pediatric dentists are considered a specialist and children under the age of 6 can go with a direct referral from the DMO general dentist. Children 6 years and over can be seen by a Pediatric Dentist if the child needs extensive dental work, has a medical disability, or is uncooperative with the DMO general dentist. Pre-authorization would be required.

There are times when a general dentist will not see a member under a particular age. DMO providers are aware of our guidelines (noted above). If the general dentist refuses to see a child based only on age, the member will need to find another provider. If there are known situations of this, please also encourage the member to call member services and share the provider's name so that it can be referred to our network management area.

Dental PPO Pediatric Care

The Dental PPO plans do not have the above criteria/guidelines. A dependent at any age can see a Pediatric Dentist and no referral is necessary.

20. If a member had their teeth cleaned on April 10, and enrolls on Aetna dental on 6/1, does that cleaning count towards the maximum number of cleanings on the Aetna plan?

No. The frequency limits will start fresh once they are effective with the Aetna plan. Aetna will not count the cleanings done under their prior carrier toward their limit for the year.

21. What is the process to nominate a provider to Aetna?

If a provider is currently not in an Aetna Network, s/he can refer to the below link to request an application, learn about the provider enrollment process and discover the advantages of joining the Aetna provider network.

Ctrl + Click: Join the Aetna Network – Health Care Professionals | Aetna

Practitioners must complete the credentialing process before they can participate in an Aetna network and provide care to Aetna members. This process evaluates their qualifications.

Once Aetna receives the provider's completed application, their information will be evaluated according to our business requirements. Credentials will be validated. Once this process is complete, the provider will receive written notification as to their participation status with Aetna.

Dental Providers (excluding oral/maxillofacial surgeons) may also call 1-800-451-7715 to request application to join the Aetna network.

22. Does Aetna issue a dental ID card?

We do not produce and mail physical ID cards. Members can print out an ID card from their Aetna secure member website. Signing up is simple and free. Members can also access their ID card via the free Aetna mobile app.

Aetna Dental members do not need an ID card to get dental care. The dentist's office can verify coverage.

23. How can a member find a dental provider who participates in Aetna's network? (www.aetna.com) - Network Provider Lookup

It is important to choose the correct plan when obtaining provider information :

DMO Dental Members: Dental Maintenance Organization (DMO)

PPO Dental Members: Dental PPO/PDN with PPO II Network

DMO plan members must select a Primary Care Dentist.

24. What happens if a DMO member does not identify a Primary Care Dentist (PCD) at time of enrollment?

If a DMO enrollee does not select a PCD or selects an invalid PCD, the member will receive a letter notifying them that they need to make a PCD selection. Once they make a selection, they will get a confirmation letter with instructions on how to print an ID card from Aetna Navigator. (In CA and AZ, if member does not select a PCD within 20 days, we will auto assign one.)*

***Note:** Until an active primary care dentist is selected, benefits and claims reimbursements for the member(s) may be impacted.

25. Can a member switch their Primary Care Dentist (PCD)? When will the switch take effect?

Members can switch their PCD on the Aetna Navigator website, or by calling customer service. In order for the switch to be effective on the first day of the next month, the switch must be requested by the 15th day of the current month. Members can switch their PCD every month. Each family member may have a different PCD selection.

26. Under DMO Dental, can a pediatric dentist be a Primary Care Dentist (PCD)?

Unless required by state law, a pediatric dentist is considered a specialist and not a PCD. Members cannot sign-up with a pediatric dentist as their PCD. Most PCDs treat children.

27. Under DMO Dental, does a member need a referral to see a specialist?

The Primary Care Dentist (PCD) is responsible for determining the appropriate course of treatment. If necessary, they will arrange the referral to a specialist. Referrals are not required for orthodontic treatment provided by a participating provider.

28. How is oral surgery covered?

Most oral surgery will be covered under the medical plan. Generally extractions and tooth/gum related issues will be covered under dental. Prior to any scheduled services, members should contact Customer Service for benefit information.

29. How are out-of-network expenses reimbursed?

Note: Only applicable only to PPO Dental Plans. There is no out-of-network coverage on DMO Dental Plans.

The amount of an out-of-network provider's charge that is eligible for coverage is called the **recognized charge**. The **recognized charge** may be less than the provider's full charge. The member is responsible for all amounts above the **recognized charge**.

The **recognized charge** is determined based on the **Geographic Area** where the member receives the service or supply.

Geographic Area is made up of the first three digits of the U.S. Postal Service zip code. If Aetna determines we need more data for a particular service or supply, we may base rates on a wider Geographic Area such as an entire state.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of:

- what the provider bills or submits for that service or supply; and
- the 80th percentile of the **Prevailing Charge Rate**.

The **Prevailing Charge Rate** is defined as the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna has the right to substitute an alternative database that Aetna believes is comparable.

Aetna has the right to apply their reimbursement policies. Those policies may further reduce the **recognized charge**.

These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on our review of:

The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other

- external materials that say what billing and coding practices are and are not appropriate
- generally accepted standards of medical and dental practice and
- the views of physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Only applicable to PPO Dental Max Plans:
The recognized charge for benefits for both network and out-of-network care is based on the **PPO-negotiated fee** for the area. While network dentists accept the negotiated fee in full, members may be balanced bill by out-of-network dentists – up to the dentist's standard fee.

30. In what states is DMO Dental unavailable?
DMO is not available in the following states:

- ✓ Alabama
- ✓ Alaska,
- ✓ Arkansas
- ✓ Guam
- ✓ Louisiana
- ✓ Maine
- ✓ Mississippi
- ✓ Montana
- ✓ New Hampshire
- ✓ North Dakota
- ✓ Puerto Rico
- ✓ South Carolina
- ✓ South Dakota
- ✓ Vermont
- ✓ Virgin Islands
- ✓ Wyoming

31. Are Composite Filings covered?
Composite is a material used to restore a tooth; a composite filling is more natural in color (white). Aetna standardly covers anterior composites, but does not cover composites for posterior teeth (molars). A comparable amalgam ("silver" filling) restoration is covered.

For more DMO Frequently Asked Questions:
Ctrl + Click: Dental Maintenance Organization (DMO) – FAQs | Aetna

For more Dental PPO Frequently Asked Questions:
Ctrl + Click: Dental Preferred Provider Organization PPO – FAQs | Aetna