

**DENTIST COMPENSATION SCHEDULE
FOR AETNA DENTAL® MANAGED PLANS/DENTAL NETWORK ONLY (DNO)***

The compensation payable to Provider hereunder will be determined and paid in accordance with the then-current reimbursement methodologies and policies of Company, including those found in the Dental Office Guide. Except as otherwise specifically set forth herein, this Compensation Schedule is subject to all applicable terms and conditions of the Agreement and the applicable Plan.

1. Applicability

Except where otherwise indicated, this Compensation Schedule applies to all of the following Aetna Dental® managed Plans for which Provider serves as a Participating Provider: Discount Dental, Basic Dental (Stand Alone Dental), Family Preventive Dental, Aetna Advantage™ Dental Plan, Aetna Advantage™ Student Dental, Dental Maintenance Organization (DMO®)/Dental Network Only (DNO)* Plans, and such other Plans as may be designated by Company from time to time in writing.

*DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary care dentist to coordinate their care with in-network providers.

2. Description of Provider Compensation – applicable to all Aetna Dental managed Plans except Discount Only Plans

Company or the applicable Payer will compensate Provider for Covered Services provided to Members in accordance with the following:

- (a) Provider compensation will consist of payments from the following sources: (i) all applicable Member payments to Provider, including but not limited to payments for copayments and coinsurance amounts (collectively “Member Payments”), and (ii) Capitation payments to Provider as set forth in Section 2(b) below (“Paid Compensation”). (These combined amounts, together with any other agreed-upon amounts, are called “Total Provider Compensation.”)
- (b) Company shall make capitation payments to Provider on a monthly basis (the “Capitation”). The Capitation will be based on the Members who have selected the Provider as their Primary Dentist. Payment shall be prorated in a manner determined by Company for any portion of time less than one month.
- (c) Company will advance a portion of the Paid Compensation each month to Provider. This advance portion will be based upon the Members who have selected Provider as their Primary Dentist and the then-current Capitation rate. The monthly payment will include any adjustments due to changes in Members in previous periods.
- (d) In addition to the compensation terms set forth above (or a alternative to the compensation terms set forth above, as the case may be), Company shall compensate Provider as set forth in **Attachment 1** hereto.

3. Discount Only Plans

The methodology set forth in Section 2 above shall not apply to Members of the Discount Dental Plan or such other discount-only Plans as may be designated by Company from time to time. Provider compensation for such discount Plans shall be limited to applicable payments from Members for Reduced Fee Services, in accordance with the terms of the Agreement and the applicable Plan. Members are solely responsible for payment to Provider under such Plans and neither Company nor Payer shall have any obligation to pay for services provided under such Plans.

4. General Provisions

- (a) Provider shall be solely responsible for collecting all applicable Member Payments from Members, and neither Company nor Payer shall have any obligation for either the collection or the payment of such amounts.
- (b) Company reserves the right to modify its reimbursement methodologies and applicable schedules upon written notice to Provider. (Notwithstanding any notice provisions contained in the Agreement, such notice may include, but not be limited to, notice provided to Provider in the applicable dental office guide, provider manual or any other document provided by Company to Provider.) Such modifications may include, without limitation, adjustments in response to any existing or new federal or state law or regulation. Acceptance of payment following such notice shall be deemed acceptance of the modified terms.
- (c) Company shall, from time to time, provide Provider with applicable Member Payment schedules. In no event may Provider bill or charge Members for Covered Services/ Reduced Fee Services an amount greater than amount specified on such schedules for the relevant service. Plan designs vary with respect to Member Payments. Some Plans treat certain services as Covered Services and/or Reduced Fee Services while other Plans may exclude or limit coverage for such services. Member Payments that are based on a percentage shall be based on the Provider's usual and customary fee for that service, reviewed and approved by Company for reasonableness.
- (d) All fees or charges for services not specifically listed on the applicable Member Payment schedule shall be as determined in Company's sole discretion. Additional codes may be added to and codes may be removed from the applicable schedule in Company's sole discretion.
- (e) Provider acknowledges the highly confidential and proprietary nature of Company's provider compensation arrangements and agrees to maintain the terms of this Schedule in strict confidence and not to disclose them to any person or entity without the express written consent of Company, except as required by a competent regulatory or judicial authority. Provider understands and agrees that failure to keep confidential the terms of this Compensation Schedule shall result in irreparable harm to Company.

(Attachment 1 follows.)

DENTIST COMPENSATION SCHEDULE

Attachment 1

Capitation Factor

Provider's monthly base Capitation amount shall be multiplied by a capitation factor of 1.00.

This compensation methodology shall not apply to the Discount Dental Plan or any other discount-only Plans.

Earnings Per Hour Guarantee

In addition to the compensation described in the Compensation Schedule, Company agrees that Provider shall be entitled to receive a guaranteed Earnings Per Hour rate of Eighty Dollars (\$80.00) per hour, as described below (the "EPH Rate").

Periodically (generally once each calendar quarter or as specified otherwise by Company), Company will reconcile the Paid Compensation with Provider's actual provision of Covered Services for Members for the immediately preceding 12-month period in accordance with Company's policies, using encounter data submitted by Provider. Then:

(1) If the Paid Compensation is equal to or greater than the product of the total number of hours expended by Provider in performing Covered Services times the EPH rate, then no additional compensation shall be paid by Company to Provider.

(2) If the Paid Compensation is less than the product of the total number of hours expended by Provider in performing Covered Services times the EPH Rate, then Company shall pay Provider the difference.

This compensation methodology shall not apply to the Discount Dental Plan or any other discount-only Plans.

Maximum Procedure Supplement

In addition to the compensation described in the Compensation Schedule, Provider shall be entitled to receive additional compensation ("Procedure Compensation") for the dental services listed below that are rendered to Members of Dental Maintenance Organization (DMO)/Dental Network Only (DNO)* Plans, as follows:

If the Member Payment for a service listed below is less than the Procedure Compensation amount listed next to such service, Company shall compensate Provider in an amount equal to the difference between the Procedure Compensation amount and the Member Payment.

This Information is Proprietary and Confidential

**FEE SCHEDULE FOR
Pacific Dental Services - MD
AETNA DENTAL MAINTENANCE ORGANIZATION (DMO®) PLANS*
GENERAL DENTIST**

<u>Code</u>	<u>Description of Service</u>	<u>Scheduled Benefit Amount</u>
D4341	periodontal Scaling & Root Planing - Four or More Teeth per Quadrant	\$ 50.00
D4910	Periodontal Maintenance	\$ 45.00

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Special Notes:

Not all services listed above may be covered by all Plans. Aetna reserves the right to modify benefit plans, at any time, to add or eliminate covered services.

Alternative benefit provisions may apply to some services. Whether or not specifically noted in this fee schedule, the charge for some services may be included in the charge for associated services, in accordance with Aetna policies and procedures.

Except as specified otherwise, codes on this fee schedule refer to American Dental Association ('ADA') codes. The appropriate current ADA code must be designated when billing.

Copayment amounts (that are not a fixed dollar amount) and coinsurance amounts shall be based on the lower of: (a) the Scheduled Benefit Amount above for the applicable service; and (b) Provider's reasonable and customary billed charges. In some Plans, office visit copayments may apply in addition to copayments for specific services.

General anesthesia and intravenous sedation are covered only when medically necessary and only when performed in conjunction with another Covered Service.

Prior to receiving any payment under this Attachment, Provider must submit a procedure claim form to Company, in a form approved by Company.

This compensation methodology shall not apply to the Discount Dental Plan or any other discount-only Plans.

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**FEE SCHEDULE FOR
Pacific Dental Services - MD**

**AETNA DENTAL MAINTENANCE ORGANIZATION (DMO®) PLANS*
SPECIALIST**

<u>Code</u>	<u>Description of Service</u>	<u>Scheduled Benefit Amount</u>
D1120	Prophylaxis - Child	\$ 55.00
D1206	Topical Application Fluoride Varnish	\$ 36.00
D1351	Sealant - per Tooth	\$ 37.00
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient -	\$ 47.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$ 122.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$ 132.00
D2390	Resin-Based Composite Crown, Anterior	\$ 205.00
D2391	Resin-Based Composite - One Surface, Posterior	\$ 93.00
D2392	Resin-Based Composite - Two Surfaces, Posterior	\$ 100.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	\$ 132.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$ 152.00
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp	\$ 90.00
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final	\$ 95.00
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding	\$ 130.00
D3310	Endodontic Therapy - Anterior (Excluding Final Restoration)	\$ 500.00
D3320	Endodontic Therapy - Premolar (Excluding Final Restoration)	\$ 650.00
D3330	Endodontic Therapy - Molar Tooth (Excluding Final Restoration)	\$ 860.00
D3346	Retreatment of Previous Root Canal Therapy - Anterior	\$ 600.00
D3347	Retreatment of Previous Root Canal Therapy - Premolar	\$ 675.00
D3348	Retreatment of Previous Root Canal Therapy - Molar	\$ 750.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation &/or Forceps Removal)	\$ 100.00
D9239	IV Sedation/Anesthesia - 1st 15 Minutes	\$ 154.00
D9248	Non-Intravenous Conscious Sedation	\$ 213.00
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other Than	\$ 80.00

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Alternative benefit provisions may apply to some services. Whether or not specifically noted in this fee schedule, the charge for some services may be included in the charge for associated services, in accordance with Aetna policies and procedures.

Except as specified otherwise, codes on this fee schedule refer to American Dental Association ("ADA") codes. The appropriate current ADA code must be designated when billing.

Copayment amounts (that are not a fixed dollar amount) and coinsurance amounts shall be based on the lower of: (a) the Scheduled Benefit Amount above for the applicable service; and (b) Provider's reasonable and customary billed charges. In some Plans, office visit copayments may apply in addition to copayments for specific services.

General anesthesia and intravenous sedation are covered only when medically necessary and only when performed in conjunction with another Covered Service.