

YOUR BENEFIT PLAN

Dental Plans

Montgomery County Public Schools

Summary Plan Description

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Dental Plans

Montgomery County Public Schools offers two dental plans administered by Aetna, Inc.

- **Preferred Provider Organization (PPO)** – You have the flexibility to select your dentist from either:
 - a list of participating PPO-network dentists; or
 - a dentist who is outside the PPO network.

Generally, you obtain a higher level of benefits when you receive dental services from participating PPO-network dentists. If you use an out-of-network dentist, you may have to pay additional fees out of your own pocket. The eligible expenses for services rendered by participating PPO network dentists are reimbursed based on negotiated fees and are subject to a deductible and coinsurance. When utilizing an out-of-network PPO dentist, reimbursement is based on Aetna, Inc. determined reasonable and customary charges for your provider's geographic area, and is subject to a deductible, coinsurance, and a maximum eligible charge for major services.

PPO orthodontic benefits are available for covered children if they were less than 20 years old when the procedure began. All orthodontic benefits for services not already in progress cease on a covered child's 20th birthday. The PPO orthodontic deductible is \$50 for network dentists, and \$100 deductible if you use an out-of-network PPO dentist. The orthodontic benefit is 50% for services rendered by a participating PPO dentist and 30% from an out-of-network PPO dentist, up to a lifetime benefit maximum of \$1,500 per covered child.

- **Dental Maintenance Organization (DMO)** – You must select a dentist from a list of participating DMO dentists. There are no annual deductibles or maximum annual benefit limitations. Depending on the type of service provided, benefits are paid at 100% or 75%. If you do not receive care (with the exception of emergency care) from your provider or a specialist recommended by your personal provider, benefits will not be paid.

Orthodontic benefits are available for covered children if they were less than 20 years old when the procedure began. All orthodontic benefits for services not already in progress cease on a covered child's 20th birthday. The orthodontic benefit is 50% of the scheduled fee, limited to one full treatment per covered child.

A provider listing (including dentists, specialists, and orthodontists) for the DMO plan is available from the Employee and Retiree Service Center, or you may contact Aetna, Inc.

- The PPO customer service toll-free number is 1-800-282-0555.
- The DMO customer service toll-free number is 1-800-843-3661.

In addition, for the most current provider information, please visit Aetna, Inc.'s Web site at www.aetna.com/docfind.

Dental Plans

Once you have enrolled in either the PPO or DMO dental plan, you will receive an identification (ID) card (one for the entire family) with the appropriate customer service toll-free phone number. You may only move between the PPO and DMO dental plans during the annual open enrollment season.

Dental Plans At-A-Glance

Both dental plans pay benefits for covered dental care provided by licensed dentists practicing within the scope of their profession, or any licensed doctor furnishing dental services for which he/she is licensed. Benefits are payable for eligible services provided to you or a covered dependent. The benefit charges for eligible services rendered by an out-of-network PPO dentist are based on reasonable and customary (R&C) charges, while eligible charges for services rendered by a participating PPO dentist are based on negotiated fees. Coordination of Benefits between your MCPS plan and your spouse's plan for dependents will be based on the **Birthday rule** (the parent whose birthday comes first in the calendar year is the parent considered to have primary coverage for the dependent). DMO coverage is available only when services are provided by DMO dentists. Frequency limits apply to certain DMO services.

The following chart compares the PPO and DMO dental plans. This is **not** an all-inclusive list. Please contact Aetna, Inc. for additional information regarding covered services not shown on this chart.

Description	PPO® In-Network	PPO® Out-of-Network	DMO® Personal Dentist
Annual Benefit Maximum Per Person	\$2,000	\$2,000	None
Annual Deductible (Basic & Major Services)	\$50	\$100	None
Maximum for each separate major service	None	\$400*	None
Visit for Oral Examination (includes emergency oral exams)	100% (three per calendar year)	80% (Three per calendar year)	100% (four if medically necessary)
Bitewing X-rays	100% (two sets per calendar year)	80% (two sets per calendar year)	100% (two sets per calendar year)
Complete X-ray Series (full mouth and/or panorama)	100% (one set every 3 years)	80% (one set every 3 years)	100% (one set every 3 years)
Prophylaxis, including scaling and polishing	100% (two per calendar year)	80% (two per calendar year)	100% (up to six per calendar year based on medical necessity)
Fluoride (one treatment per benefit year for children under 18)	100%	80%	100%
Biopsy and examination of oral tissue	100%	80%	100%
Emergency Palliative Treatment	100%	80%	100%
Oral Hygiene Instruction	Not covered	Not covered	100%

Dental Plans

*An annual \$400 major service benefit maximum applies for each separate major service.

Dental Plans At-A-Glance, cont'd.

Description	PPO® In-Network	PPO® Out-of-Network	DMO® Personal Dentist
Sealants (permanent molars only - every three years)	Not covered	Not covered	100%
Amalgam (silver fillings)	100% after \$50 deductible	80% after \$100 deductible	100%
Composite fillings (anterior teeth)	100% after \$50 deductible	80% after \$100 deductible	100%
Retention Pins	100% after \$50 deductible	80% after \$100 deductible	100%
Recementing Inlays, Crowns, and Bridges	50% after \$50 deductible	40% after \$100 deductible	100%
Inlays, Onlays, and Crowns (other than stainless)	50% after \$50 deductible	40% after \$100 deductible*	75%
Stainless Steel Crowns	100% after \$50 deductible	80% after \$100 deductible	100%
Pulp Capping	100% after \$50 deductible	80% after \$100 deductible	100%
Pulpotomy	100% after \$50 deductible	80% after \$100 deductible	100%
Root Canal Therapy (anterior and premolar)	100% after \$50 deductible	80% after \$100 deductible	100%
Root Canal Therapy (molar tooth)	100% after \$50 deductible	80% after \$100 deductible	75%
Apicoectomy	100% after \$50 deductible	80% after \$100 deductible	100%
Retrograde Filling	100% after \$50 deductible	80% after \$100 deductible	100%
Extractions	100% after \$50 deductible	80% after \$100 deductible	100%
Root Planning & Scaling/Subgingival Curettage (Four quadrants of Root Planning & Scaling OR Subgingival Curettage))	100% after \$50 deductible	80% after \$100 deductible	100%
Gingivectomy or Gingivoplasty	100% after \$50 deductible	80% after \$100 deductible	100%
Gingival Flap Procedure	100% after \$50 deductible	80% after \$100 deductible	100%
Free Soft Tissue Graft	100% after \$50 deductible	80% after \$100 deductible	100%
Occlusal Adjustment (not including those done with an appliance or restoration)	100% after \$50 deductible	80% after \$100 deductible	100%

* An annual \$400 major service benefit maximum applies for each separate major service.

Dental Plans

Dental Plans At-A-Glance, cont'd.

Description	PPO® In-Network	PPO® Out-of-Network	DMO® Personal Dentist
Removal of Full or Partial Bony Impacted Tooth	100% after \$50 deductible	80% after \$100 deductible	75%
Incision and Drainage of Abscess (Not covered if extraoral)	100% after \$50 deductible	80% after \$100 deductible	100%
Removal of Residual Root	100% after \$50 deductible	80% after \$100 deductible	100%
Removal of Odontogenic Cyst	100% after \$50 deductible	80% after \$100 deductible	100%
Sequestrectomy (Covered based on medical approval)	100% after \$50 deductible	80% after \$100 deductible	100%
Frenectomy	100% after \$50 deductible	80% after \$100 deductible	100%
Sialolithotomy (Removal of Salivary Calculus) (Covered based on medical approval)	100% after \$50 deductible	80% after \$100 deductible	100%
Closure of Salivary Fistula (Covered based on medical approval)	100% after \$50 deductible	80% after \$100 deductible	100%
Full and Partial Dentures	50% after \$50 deductible	40% after \$100 deductible*	75% (includes adjustments within six months of installation)
Full and Partial Denture Repairs (Basic Expense)	100% after \$50 deductible	80% after \$100 deductible	75%
Relining/Rebasing Dentures	50% after \$50 deductible	40% after \$100 deductible*	75%
Bridge Pontics and Abutments	50% after \$50 deductible	40% after \$100 deductible*	75%
Crown and Bridge Repairs	50% after \$50 deductible	40% after \$100 deductible*	75%
Posts and Core	50% after \$50 deductible	40% after \$100 deductible*	75%
Stay Plates (applies only to anterior teeth)	50% after \$50 deductible	40% after \$100 deductible*	75%
Occlusal Guard for Bruxism	100% after \$50 deductible	80% after \$100 deductible*	75%
Space Maintainers (including adjustments within six months of installation)	100% after \$50 deductible	80% after \$100 deductible	75%
General Anesthesia (covered only when associated with eligible expenses)	100% after \$50 deductible	80% after \$100 deductible	75%
Osseous Surgery (Periodontal Surgery) (including flap entry and closure)	100% after \$50 deductible	80% after \$100 deductible	75%

* An annual \$400 major services benefit maximum applies for each separate major service.

Dental Plans

Dental Plans At-A-Glance, cont'd.

Description	PPO® In-Network	PPO® Out-of-Network	DMO® Personal Dentist
Orthodontic appliances and treatment: Maximum Coinsurance (Benefit %)	50%	30%	50%
Lifetime Orthodontic Benefit Maximum	\$1,000	\$1,000	None**

* An annual \$400 major services benefit maximum applies for each separate major service.

** DMO orthodontic benefits are restricted to one full treatment per lifetime per child. If your child was receiving orthodontic benefits under the PPO and you switch to the DMO, the remainder of the treatment will be subject to the benefit level and lifetime maximum that applied under the PPO.

The Preferred Provider Organization

When you enroll in the Preferred Provider Organization (PPO) Plan, you may choose to receive care from a dentist who is a member of the PPO network, or you may visit a dentist of your choice. However, your out-of-pocket costs will be lower if you receive care from a dentist who participates in the plan's network of dentists. **A change to the PPO plan in 2005 includes coverage extended to sealants.**

A list of participating dentists is available on Aetna, Inc.'s Web site at www.aetna.com/docfind. Please be advised that a dentist could be listed as an in-network provider, however, this does not guarantee the dentist's continued participation in the PPO network. To ensure the dentist you select is still participating in the network, please contact the dentist directly.

How Benefit Amounts Are Determined

In-network allowable charges based on negotiated discounted fees between Aetna, Inc. and participating PPO dental providers. The benefit level you receive is based on the type of care provided. **A pre-determination of benefits for the PPO dental plan should be completed by your provider and submitted for review to Aetna, Inc. when the charge may exceed \$350 or more.** For more information on benefit levels, please refer to the Dental Plans At-A-Glance chart included in this document.

Out-of-network R&C charges are based on fees the dentists in your geographic area usually charge patients for a specific service or supply.

It is important to remember that an out-of-network dentist's charges may be higher than the R&C charge. In this case, you would have to pay the difference between what the Plan pays and the dentist's actual charge.

Dental Plans

Annual Deductibles For Basic And Major Services

When you receive basic or major dental services under the PPO, you will have to meet specific annual deductibles. If you receive care in-network, you have:

- a \$50 deductible for basic services; and
- a separate \$50 deductible for major services.

If you receive care out-of-network, you have:

- a \$100 deductible for basic services; and
- a separate \$100 deductible for major services.

NOTE: Deductibles must be met *once* during the calendar year per covered member.

Maximum Allowable Charge For Out-of-Network Major Services

When you receive major dental services out-of-network under the PPO, the maximum allowable charge that will be considered for coverage is:

- \$400 per person per service. Any charges in excess of this amount per service will be the employee's responsibility.

This limit applies to each enrolled member that receives major dental services.

Maximum Annual Benefit

Each calendar year, your annual maximum benefit is \$2,000 per person. Each of your covered dependents are limited to \$2,000 in benefits annually. This applies to any combination of in- and out-of-network benefits. Please note this limit *does not* include the orthodontic benefit described below.

Orthodontic Lifetime Maximum

Under the PPO, there is a lifetime maximum benefit of \$1,000 for one orthodontic treatment per eligible dependent. This applies to in-network and out-of-network care combined. In addition, orthodontia is only covered for plan participants through age 19. Orthodontic benefits are **not** available to eligible dependents of retirees.

Dental Plans

What Is Covered

Preventive Services

Under the PPO Dental Plan, if you receive in-network care from a dentist who participates in the plan's network of dentists, preventive services are covered at 100% of the negotiated fee with no deductible. If you receive care out-of-network, services are covered at 80% of the reasonable and customary fees with no deductible. See the Dental Plans At-A-Glance chart contained in this document for details.

Basic Services

Under the PPO Dental Plan, if you receive in-network care from a dentist who participates in the plan's network of dentists, basic services are covered in full after a \$50 per person annual deductible. If you receive care out-of-network, services are covered at 80% after a \$100 per person annual deductible. See the Dental Plans At-A-Glance chart contained in this document for details.

Major Services

Under the PPO Dental Plan, if you receive in-network care from a dentist that participates in the plan's network of dentists, major services are covered at 50% after a \$50 per person annual deductible. If you receive out-of-network care, services are subject to a \$100 deductible and are reimbursed at 40%, to a benefit maximum of \$400 per service. There are limits to the maximum allowable charges that will be considered for coverage. See the Dental Plans At-A-Glance chart contained in this document for details.

Orthodontic Services

The PPO provides orthodontic benefits for your eligible dependent children through age 19. The plan pays 50% of the pre-arranged fee for eligible orthodontic services received in-network and 30% of eligible orthodontic services received out-of-network. There is a lifetime maximum benefit of \$1,000, for combined services rendered in-network or out-of-network. See list of exclusions included in this document.

Eligible orthodontic services are services or supplies included in the Orthodontic Treatment Plan. The treatment plan must include the following information:

- description of the recommended treatment;
- listing of the estimated charge; and
- any necessary supporting evidence, such as cephalometric X-rays and study models.

Dental Plans

Your Orthodontic Treatment Plan will be reviewed by Aetna, Inc. and returned to your dentist, detailing the estimated benefits.

In addition, orthodontic services must be provided to correct one of the following conditions:

- overbite;
- cross-bite; or
- protrusive or retrusive relationship of at least one cusp.

Payment for orthodontic services will be made in installments. You will begin receiving benefits as soon as the orthodontic appliances are first inserted. Once treatment has begun, you will receive quarterly payments as long as the patient is under treatment, up to the \$1,000 lifetime maximum. Your first payment will be a double payment, and any additional payments will be made in equal amounts.

If You Need Emergency Care For The PPO

Emergency palliative treatment provided by a participating PPO provider is covered based on the services rendered. For a PPO member who is 50 or more miles away from home, the emergency palliative benefit is \$75 for services rendered by a non-participating PPO provider. The member must call the Aetna, Inc. PPO Customer Service at 1-800-282-0555 to have emergency benefits authorized.

The Dental Maintenance Organization

Under the Dental Maintenance Organization (DMO), benefits are provided for preventive care, basic services, major services, emergency care, and orthodontic procedures. There is no deductible or lifetime maximum. However, in order to receive benefits, you must select a personal dentist from the list of participating dentists. Your personal dentist will provide all of your basic dental care needs and most specialty services. Each member of your family can choose a different personal dentist. For other special dental care needs, your personal dentist may refer you to a participating Specialty dentist. Your personal dentist may also provide or coordinate any emergency treatment you may require.

For a list of participating providers, call Aetna, Inc. at 1-800-843-3661 or visit their Web site at www.aetna.com/docfind.

You may change your personal provider at any time. Call the number on your ID card by the 15th of the month, and your new choice will be effective the first day of the month following your request.

Dental Plans

NOTE: Although a provider is listed in the directory their continued participation in the DMO is not guaranteed. To ensure the provider you select still participates in the network, please contact the provider directly.

Using the DMO plan is easy. Once you have selected your personal provider, make an appointment exactly as you would with any other provider. At the time of your visit, show your DMO ID card.

Eligible Charges

In order for benefits to be paid, the dental service must meet the following conditions:

- care must be received by you or a covered dependent;
- care must be received while you or your covered dependent is enrolled in the Plan; and
- services provided must be included in the List of Dental Services.

If You Need Emergency Care For The DMO

Emergency palliative treatment provided by a participating DMO provider is covered based on the services rendered. For a DMO member who is 50 or more miles from home, the emergency palliative treatment benefit is \$100 for services rendered by a non-participating DMO provider. The member must call the Aetna, Inc. DMO Customer Service at 1-800-843-3661 to have emergency benefits authorized.

What Is Covered

Preventive Services

Under the DMO, preventive care is covered at 100%.

Basic Services

Under the DMO, basic services are covered at 100%.

Major Services

Under the DMO, major services are covered at 75%.

See the Dental Plans At-A-Glance chart contained in this document for details.

Orthodontic Services

Dental Plans

The DMO provides orthodontic benefits for your eligible dependent children through age 19. The Plan will pay 50% of the negotiated fees for orthodontic services received. There is no lifetime benefit maximum.

Your Orthodontic Treatment Plan will be reviewed by Aetna, Inc. prior to the start of treatment and returned to your DMO specialist, showing the estimated benefits.

In addition, orthodontic services must be provided to correct one of the following conditions:

- overbite of at least four millimeters;
- cross-bite; or
- protrusive or retrusive relationship of at least one cusp.

Under the DMO plan, the member is responsible for 50% of the negotiated fee with the DMO provider. The DMO provider can request that the member pay up front or via a payment plan. The member will not receive quarterly payments from Aetna, Inc.

Recovery of Overpayment

If a benefit payment is made by Aetna, Inc to or on behalf of any person, that exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Alternate Procedures for the PPO and DMO

If more than one service can be used to treat a covered person's dental condition, Aetna, Inc. 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 or dental practice. If treatment is being provided by a participating dental provider and the covered person asks for a more costly covered service than for coverage is approved; the specific co-payment for the service will consist of: (a) The co-payment for the approved less costly service; plus (b) The

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difference in cost between the approved less costly service and the more costly covered service.

What Is Not Covered Under the PPO and DMO

Benefits are not provided under either the PPO or DMO Plan for the following:

- Orthodontic benefits are **not** applicable to eligible dependents of retirees under the dental plan.
- services which are not medically necessary or not reasonably necessary;
- charges for services which are not provided by a dentist (other than charges for a dental hygienist's or X-ray technician's services);
- services and/or supplies provided by the U.S. government or any other government, unless required by law;
- replacement or modification within five years of the last benefit reimbursement for:
 - a partial or full removable denture;
 - a removable or fixed bridge; and
 - a crown or restoration;
- addition of teeth to:
 - a partial or full removable denture; and
 - a removable or fixed bridge;
- dental implants;
- charges for the replacement or modification of the following (if it includes the replacement of one or more natural teeth which were missing before the person became eligible for coverage):
 - a partial or full removable denture; or
 - a removable or fixed bridge;

NOTE: This does not include dentures, bridges, or bridgework that also include the replacement of a tooth that was not an abutment to a partial denture, removable bridge, or fixed bridge that was installed during the past five years. In addition, if the tooth was removed while the patient was covered under an MCPS Dental Plan, benefits will be paid.

- appliances, or modifications to the appliance, if the impression was made *before* the patient became covered under an MCPS Dental Plan;
- crowns, bridges, or gold restorations for which a tooth was prepared *before* the patient became covered under an MCPS Dental Plan;
- restorations or crowns unless:
 - provided to treat decay or traumatic injury and the tooth cannot be restored with a filling material; or

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- the tooth is an abutment to a covered partial denture or fixed bridge;
- root canal therapy if the pulp chamber was opened *before* the patient became covered under an MCPS Dental Plan;
- DMO charges for members ages five and over that were not covered during the first 31 calendar days of eligibility. However, this does not include any charges for:
 - visits and exams (regular);
 - X-rays (regular);
 - visits and X-rays (preventive or basic);
 - X-rays and pathology (preventive or basic); and
 - restorative dentistry (preventive or basic);
- charges for cosmetic services, including facings on crowns or pontics that are behind the second bicuspid. If services are provided as the result of an accidental injury, benefits will be provided;
- charges for the replacement of lost or stolen appliances;
- charges for appliances or restorations which are needed to:
 - change vertical dimensions;
 - restore occlusion; or
 - splint or correct attrition or abrasion;
- charges for the treatment of the jaw joint, including:
 - Temporomandibular joint syndrome (TMJ);
 - craniomandibular disorders;
 - other conditions of the joint linking the jaw bone and the skull; or
 - other conditions of the complex of muscles, nerves, and other related tissues; and
- charges for any illnesses or injuries that are work-related or covered under Workers' Compensation laws.

Orthodontic Exclusions for the PPO and DMO

The following limitations apply to orthodontic services for the PPO and DMO Plans for:

- any charges for an Orthodontia treatment if an active appliance for that Orthodontia treatment has been installed before the first day on which the dependent became covered by the Plan;
- plan participants who are age 20 or over when orthodontic treatment begins. Benefits are limited to a lifetime maximum of one complete course of treatment per covered member; and
- orthodontic appliances that were installed *before* the member was covered under the PPO will be limited to the lesser of the PPO benefit or the previous plan's benefit level.

Dental Plans

Coordination of Benefits

Some members have dental coverage in addition to coverage under the MCPS Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

A. 100% of "Allowable Expenses" incurred by the person for who the claim is made.

B. The benefits payable by the "other plans." (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

Aetna, Inc. has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

How To File A Claim

Under The PPO Plan

If you receive care from an in-network dentist, the dentist will usually submit claims for you. If you receive care from an out-of-network dentist, you or your dentist must file claim forms. Claim forms are available on the Employee and Retiree Service Center's Web site at www.montgomeryschoolsmd.org/departments/ersc. Aetna, Inc. must receive a completed dental claim form within two years of the date for you to receive the appropriate plan benefit.

Under The DMO Plan

If you receive care from your participating personal dentist, or a specialty dentist your personal dentist refers you to, the dentist will file claims for you.

How To Appeal A Claims Decision

You have the right to appeal a claim you feel has been incorrectly paid or denied. All claim appeals should be sent to Aetna, Inc. at the following address:

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

With the exception of urgent care claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna Inc.'s Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claims either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision no later than 72 hours after the urgent appeal is received.

Montgomery County Public Schools (MCPS) expects to continue the benefit plans described in this *Summary Plan Description*, but reserves the right to modify, amend, suspend, or terminate any plan at any time and for any reason except as limited by applicable union contracts. If there is any conflict between this *Summary Plan Description* and the plan documents, the plan documents will always govern. You should not rely on any oral description(s) of the plan since the written terms of the plan documents will always govern. Based on its discretionary authority, the Plan Administrator will interpret the plan provisions.