

PPO OPTION

The **PPO** option has **in-network** and **out-of-network** coverage. **In-network** dental **providers** generally agree to accept fees at or lower than **reasonable and customary charges**. If you use an **out-of-network provider**, the reimbursement rates will generally be lower. If you live out-of-area, you will receive the **in-network** level of benefits. By visiting **in-network dental providers**, you will also benefit from **Aetna's** negotiated rates. See Appendix A for a list of **covered** services. See Appendix C for a list of the services not **covered** under the **PPO**.

Benefits

The **PPO** provides coverage for services, as follows:

	In-Network or Out-of-Area*	Out-of-Network**
Annual Deductible (for preventative care services)	\$25/individual \$50/two-person or family	\$25/individual \$50/two-person or family
Type A Services - Diagnostic and Preventative	100% of PPO fee***	90% of reasonable and customary charges
Type B Services - Basic Restorative	80% of PPO fee***	70% of reasonable and customary charges
Type C Services - Major Restorative	50% of PPO fee***	50% of reasonable and customary charges
Orthodontia	50% of PPO fee***	50% of reasonable and customary charges
* If you are Out-of-Area, benefits are paid as a percentage of reasonable and customary charges . ** In-network refers to benefits for services that are rendered by a participating PPO dentist. Out-of-network refers to benefits for services that are rendered by a dentist who does not participate in the PPO . *** PPO fee refers to the typically lower "negotiated fees" that participating PPO network dentists accept as "payment in full" from eligible participants.		

Maximum Benefits

The **PPO** option pays benefits for diagnostic, preventative, and restorative services up to an annual maximum of \$2,250 for both **in-network** and **out-of-network** services (combined) per **covered** person. This limit does not apply to orthodontia, which has a separate lifetime maximum of \$1,750 per **covered** person.

Comparing Benefits

The following example will give you an idea of how benefits are paid if you elect coverage under the **PPO** option.

Example:

Suppose you need a crown. Here is how the **PPO** option pays benefits:

	If you use a PPO provider	If you use a non-PPO provider
Dentist's usual fee	\$825	\$825
PPO negotiated fee	\$586	Not applicable
Reasonable and customary charge	Not applicable	\$750
Amount PPO option pays	\$293 (50% of PPO negotiated fee)	\$375 (50% of reasonable and customary charge)
Amount you pay	\$293 (\$586 minus \$293)	\$450 (\$825 minus \$375)
Amount you save by using a PPO provider	\$157 (\$450 minus \$293)	N/A
Note: The chart is for illustrative purposes only. Charges and PPO discounts will vary.		

Taking Advantage of the PPO

You can access a directory of participating **PPO** dentists online at www.AetnaNavigator.com, or contact the **Claims Administrator** (see "Important Contacts") to request a directory of participating **PPO** dentists for your area. You and your **covered dependents** can select the same or different dentists. You do not have to select a primary dentist in the **PPO** to take advantage of the feature; simply go to a participating dentist.

Participating **PPO** dentists have agreed to provide services at a negotiated rate for non-covered services such as cosmetic tooth whitening or inlays, so you generally pay less out of pocket. The reduced fees range from 10 to 40 percent off their average fee for service.

Getting the Most From Your Coverage

To ensure you receive the maximum benefit under the **PPO** option, it is important to keep the following in mind when arranging dental care.

Alternate Procedures

Often, there are several ways to treat a particular dental problem. For example, suppose that in repairing your tooth, the dentist has the option of using a filling or a crown, and that either treatment meets the professionally accepted dental standards. In such instances, the Dental Plan will cover only the less expensive treatment – in this case, the filling. So it is important to discuss the choices for treating your problem with your dentist before work begins. If your dentist used a crown instead, you would be responsible for the charges above what the Dental Plan would pay for the less expensive treatment – namely, the filling.

You can avoid such unnecessary charges by discussing treatment choices with your dentist prior to beginning work or by having your dentist file a predetermination of benefits as described below.

Predetermination of Benefits

If you need dental work costing over \$200, you should determine before treatment begins what is **covered** and how much the Dental Plan will pay. This procedure is called “predetermination of benefits.” Here is how predetermination works:

- If you do not have a claim form, get one from the **Claims Administrator** (see “Important Contacts”) or through the “Reference Materials & Forms” section of the Avaya Healthy Decisions Web site (www.AvayaHealthyDecisions.com) and give it to your dentist.
- Your dentist outlines the treatment plan and fees on the claim form, and sends it to the **Claims Administrator**.
- The **Claims Administrator** determines the amount the Dental Plan will pay, and informs you and your dentist.

If, after reviewing the predetermination, you and your dentist decide to change the treatment plan, the **Claims Administrator** will adjust its payment accordingly. If there is any change in the treatment plan, your dentist should submit a revised plan.

If you do not request predetermination of benefits, the **Claims Administrator** will pay the claim based on the information it has about your case. If it is determined a less expensive treatment was possible, you may receive a lower benefit than you expected. Predetermination of benefits could help you avoid expensive surprises.

If you have a treatment plan approved and then your coverage ends before the start of treatment or services being rendered, subsequent benefits are generally not payable.