

2009

Summary Material Modification - Dental Care

Aetna has refiled with the New York State Department of Insurance the following change to its “Definitions” since the Benefits Fund published its most recent Summary Plan Description in 2008. Please keep this information with the Summary Plan Description you received in 2008 or when you became a participant of the NYSNA Benefits Fund.

Under the “Definitions” section, beginning on Page 46, new definitions and new terms have been added, while some existing terms are no longer in use.

Terms that are no longer in use and should be removed from “Definitions” between Pages 46 and 47 are:

- Preferred care provider
- Non-preferred care
- Preferred care
- Necessary
- Reasonable charge.

Terms with new definitions are:

• **Hospital** – An institution that is primarily engaged in providing, on its premises, inpatient medical, surgical, and diagnostic services; is supervised by a staff of physicians; provides 24-hour-a-day RN service; charges patients for its services; and operates in accordance with the laws of the jurisdiction in which it is located.

An institution may still be defined as a hospital if it does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a

convalescent home or any institution or part of one that is used primarily as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

• **Physician** – A duly licensed member of a medical profession who has an MD or DO degree; is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; and provides medical services that are within the scope of her license or certificate.

This also includes a health professional who: is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; provides medical services that are within the scope of her license or certificate; under applicable insurance law, is considered a “physician” for purposes of this coverage; has the medical training and clinical expertise suitable to treat your condition; specializes in psychiatry if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse, or a mental disorder; and is not you or related to you.

New terms to add within the “Definitions” section of the Summary Plan Description on Pages 46 and 47 are:

- **Dental provider** – Any dentist, group, organization, dental facility, or other institution or person legally qualified to furnish dental services or supplies.
- **Medically necessary or medical**

necessity – Health care or dental services, supplies, or prescription drugs that a physician, other health care, or dental provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms if that provision of the service, supply, or prescription is:

- In accordance with generally accepted standards of dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient’s illness, injury, or disease;
- Not primarily for the convenience of the patient, physician, other health care, or dental provider;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

For these purposes, “generally accepted standards of medical or dental practice” means standards based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations, and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

• **Non-occupational illness** – An illness that does not arise out of (or in the course of) any work for pay or

profit or result in any way from an illness that does. An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that illness under such law.

• **Network provider** – A dental provider who has contracted to furnish services or supplies for a negotiated charge but only if the provider is, with Aetna's consent, included in the directory as a network provider for the service or supply involved and the class of employees to which you belong.

• **Out-of-network provider** – A dental provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

• **Recognized charge** – Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it;
- The charge Aetna determines to be appropriate based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed, or coded; or the provider charge data from the Prevailing HealthCare Charges System at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months;

– The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is unusual; or not often provided in the geographic area; or provided by only a small number of providers in the geographic area, Aetna may take into account factors such as the:

- Complexity,
- Degree of skill needed,
- Type of specialty of the provider,
- Range of services or supplies

provided by a facility,

– Recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in this agreement.

As used above, the term "geographic area" means a Prevailing HealthCare Charges System expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service ZIP Codes. If the volume of charges in a single three-digit ZIP Code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit ZIP Code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit ZIP Codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit ZIP Codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are used.

• **Specialist dentist** – Any dentist who, by virtue of advanced training, is board-eligible or certified by a specialty board as being qualified to practice in a special field of dentistry.

Aetna also has clarified and provided additional information to some provisions of its dental care coverage since the Benefits Fund published its most recent Summary Plan Description in 2008.

Covered services

Additional information has been provided to clarify the first bullet point on Page 37 under "Type A expenses (diagnostic and preventive)" to read: Periodontal maintenance procedures (eligible with no history or surgery

required and limited to two per year; limit is combined with the prophylaxis frequency).

The following additional information should be included after the last bullet item on Page 40 under the Prosthodontics section of "Type C expenses (major):"

• Crowns, inlays, onlays, and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures, or bridges are covered only when you give proof to Aetna that:

– While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.

– The present crown, inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.

– You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one, which replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date the temporary denture was installed.

• The "Missing Tooth and Not Replaced" rule does not apply to the dental plan. The dentures, bridges, or other prosthetic services needed to replace one or more natural teeth that were removed prior to becoming a participant in the plan will be covered.