



# RESOURCE

SMART WORKFORCE SOLUTIONS

## 2007 Benefit Program

*Michigan Staff*

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**Please Note:** This booklet provides only a brief summary of your benefits. We have tried to ensure the information in this Guide is accurate, but if there is any discrepancy between this information and the official plan documents, the official plan documents will rule. Resource reserves the right to modify or cancel any of these plans at any time.

### Carrier Information

Provider	Benefit	Information	
BCBSM	Medical (PPO)	(800) 637-2227	<a href="http://www.bcbsm.com">www.bcbsm.com</a>
BCN	Medical (HMO)	(800) 662-6667	<a href="http://www.mibcn.com">www.mibcn.com</a>
Aetna	Dental	(877) 238-6200	<a href="http://www.aetna.com">www.aetna.com</a>
Spectera	Vision	(800) 638-3120	<a href="http://www.spectera.com">www.spectera.com</a>
Arcadia	FSA	(866) 329-4333	<a href="http://www.arcadiabenefits.com">www.arcadiabenefits.com</a>
Unum	Life, STD, LTD, Critical Illness	(800) 421-0344	<a href="http://www.unum.com">www.unum.com</a>

# Introduction

Resource is committed to providing our employees with a comprehensive benefit package that offers flexibility and personal choices which are cost-effective and in line with industry standards. Resource’s benefit package offers choices in a number of benefit areas, the freedom to make changes each plan year as your needs change, and the ability to maximize tax advantages through pre-tax deductions. We are pleased to offer our full time employees a complete benefit package that includes the following:

- Medical & Prescription Drug
- Dental
- Voluntary Vision
- Flexible Spending Accounts
- Life & Accidental Death & Dismemberment
- Voluntary Employee & Dependent Life
- Voluntary Short Term Disability
- Voluntary Long Term Disability
- Specified Critical Illness Insurance
- Prepaid Legal
- 401(k)
- Employee Managed Time Off

## Eligibility

All full time employees of Resource working 30 or more hours per week are eligible to enroll and participate in our benefit plans (unless otherwise stated in your contract). Each plan has a waiting period that must be met before coverage will begin. The specific plan waiting periods for each plan are outlined below:

<b>Medical, Dental, Vision, Core Life, Accidental Death &amp; Dismemberment, &amp; Flexible Spending Coverage:</b>	
• Contract Employees:	1 <sup>st</sup> of the month following 30 days of employment
• In-House Employees:	1 <sup>st</sup> of the month following 90 days of employment
<b>Voluntary Life Insurance, Short Term Disability, Long Term Disability, and Critical Illness Coverage:</b>	
• All Employees:	1 <sup>st</sup> of the month following 90 days of employment
<b>401(k) Savings Plan:</b>	
• All Employees Age 21 and older:	1 <sup>st</sup> of the month following 90 days of employment
<b>Pre-paid Legal Plan:</b>	
• All Employees:	Upon Enrollment

When you enroll in one of our health and welfare benefit plans your benefit elections are effective through May 31 (our annual enrollment). Between annual enrollments, you can change your benefit coverage decisions only if you have a change in status. Change in status events include the following (change must be reported to Human Resources within 30 days and must have proper documentation to support the change):

- Birth, adoption of a child, marriage, legal separation, annulment, divorce, or death of a dependent.
- A change in residence where you are no longer in a service area (applies to HMO enrollees, for example).
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

When you enroll in one of our benefit plans, you can also enroll your eligible dependents. An eligible dependent includes all of the following:

- Your Legal Spouse
- Eligible Dependent Children (natural, adopted, or step children residing in your home)
  - Birth to age 19 (25 if a full time student taking 12 or more credit hours per semester at an accredited school- **documentation required**)
  - Child who reached age 19 but is totally disabled

## Medical Options

Resource offers our employees a choice of four medical plan options. We offer an Enhanced PPO plan insured through Blue Cross Blue Shield of Michigan (BCBSM), a Standard PPO plan insured through BCBSM, an HMO insured through Blue Care Network, or the ability to opt out if you have other medical coverage.

**PPO stands for “Preferred Provider Organization”.** Quite simply, a PPO is a group of doctors and hospitals that work under one umbrella to provide medical services at a discount to its membership. The Resource Enhanced and Standard PPO plans utilize the BCBS network of providers. Each time you receive care from in-network providers, services are covered at a higher level than from non-network providers. You will still be able to receive care from non-network providers but by doing so you will pay more out-of-pocket. To see what providers are in the Enhanced and Standard PPO plans, please access the BCBS directory available through [www.bcbsm.com](http://www.bcbsm.com). Select Community Blue/Blue Preferred PPO when asked to select your plan.

**HMO stands for “Health Maintenance Organization”.** Most services are covered in full, although some care may require a copayment. There are no claim forms to complete. When you enroll in the BCN HMO plan, you must select and use a Primary Care Physician (PCP) who is your first line of defense and the person to refer to in time of medical needs (except for an emergency). In some cases, your PCP may refer you to another provider within the network for treatment, which will be covered by your HMO. In order to see a specialist, you must receive a referral from your PCP. Female members can visit an OB/GYN participating in the BCN network for routine/preventative care without a referral. You may change your PCP at any time simply by calling the Member Services Department at BCN. To see what providers are in the BCN HMO, please access the BCN directory available through [www.mibcn.com](http://www.mibcn.com). Select BCN when asked to select your plan. Below is a brief highlight of all three medical options. A more comprehensive benefits comparison can be found on the following two pages.

- **RTC Enhanced BCBSM PPO.** This is a “rich” PPO plan. It has a low annual deductible of \$250 for single coverage/\$500 for family coverage, and most services are covered at 75% provided services are rendered within the network.
- **RTC Standard BCBSM PPO.** This PPO plan has an annual deductible of \$500 for single coverage/\$1,000 for family coverage, and most services are covered at 75% provided services are rendered within the network.
- **BCN HMO.** This is a comprehensive HMO. Most services are covered at 100% after a \$20 office visit copay and/or a \$250 inpatient hospital copay. Benefits are payable in-network only, except in the case of life-threatening injury.

Both the Enhanced and Standard PPO plans and the HMO plan offer the same three-tier prescription drug design which covers most medically necessary Federal Legend prescription drugs. Generics have the same active ingredients and dosage amounts of their brand name counterpart whose patent has expired. Below is a listing of the copay tiers.

- \$10 Generic Drugs
- \$20 Preferred Brand Drugs Brand (*brand name drugs that have been given a preferred status by BCBSM/BCN*)
- \$40 Non-Preferred Brand Drugs (*typically more expensive brand & lifestyle drugs*)

In addition to the retail prescription drug benefit, you are eligible for mail order prescription service from Medco. This benefit allows you to get a 90-day supply of your approved maintenance medication for two copays instead of three! Using the mail order service is easy; just complete a mail order form (available on [www.bcbsm.com](http://www.bcbsm.com)) and send it in along with your prescription for a 90 day supply (with refill options). Your medications will usually be sent 7 to 11 days after you mail your order. Refills are easy too; simply go online to [www.medco.com](http://www.medco.com) or call the 800 number on your prescription. In addition to the mail order service, all three of our plans include the 90 Day Retail Prescription Program. With this program you have the ability to get a 90-day supply of your *approved maintenance medication* at most pharmacies for two copayments instead of three. To see if your maintenance medication is an *approved maintenance medication*, log onto [www.bcbsm.com](http://www.bcbsm.com) for PPO members, or [www.mibcn.com](http://www.mibcn.com) for HMO members.



	ENHANCED		STANDARD		BCN
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
<b>MAJOR MEDICAL</b>					
Deductible- Single Family	\$250 \$500	\$500 \$1,000	\$500 \$1,000	\$2,000 \$4,000	\$0 \$0
Co-Insurance	75%	50%	75%	50%	50%
Annual Out of Pocket Maximum Single Family	\$1,500 \$3,000	\$6,500 \$13,000	\$2,500 \$5,000	\$5,000 \$10,000	\$250 \$750
Maximum-Lifetime	\$5 million per member lifetime for all covered services with a separate \$1 million per member lifetime per covered specified human organ transplant type.				None
<b>PREVENTATIVE CARE SERVICES (Limited to a combined maximum \$500 per member per calendar year for the Enhanced and Standard Plans)</b>					
Health Maintenance Exam- includes chest X-Ray, EKG, and select lab	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay
Gynecological Exam	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay
Pap Smear- lab and pathology	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay
Well Baby and Child Care	100% - Birth-12 Mon.: 6 Visits - 13-23 Mon.: 6 Visits - 24-35 Mon.: 2 Visits - 36-47 Mon.: 2 Visits -48 Mon.-15 Yrs: 1/ yr	Not covered	100% - Birth-12 Mon.: 6 Visits - 13-23 Mon.: 6 Visits - 24-35 Mon.: 2 Visits - 36-47 Mon.: 2 Visits -48 Mon.-15 Yrs: 1/ yr	Not covered	100% through age 6, \$20 copay over age 6
Childhood Immunizations	100%	Not covered	100%	Not covered	\$20 copay (adult also)
Fecal Occult Blood Screening	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay may apply
Flexible Sigmoidoscopy	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay may apply
Prostate Specific Antigen (PSA)	100%; 1/calendar year	Not covered	100%; 1/calendar year	Not covered	\$20 copay may apply
<b>MAMMOGRAPHY (One per calendar year, no age restrictions for the Enhanced and Standard Plans)</b>					
Mammography Screening	75% after deductible	50% after deductible	75% after deductible	50% after deductible	\$20 copay may apply
<b>PHYSICIAN OFFICE SERVICES</b>					
Office Visits	\$25 copay	50% after deductible*	\$30 copay	50% after deductible*	\$20 copay (PCP and Consulting Specialist Care when Referred)
Outpatient and Home Visits	75% after deductible	50% after deductible*	75% after deductible	50% after deductible*	\$20 copay
Urgent Care Visits	\$25 copay	50% after deductible*	\$30 copay	50% after deductible*	\$30 copay
<b>EMERGENCY MEDICAL CARE</b>					
Hospital E.R.- <i>Waived if admitted</i>	\$75 copay		\$100 copay		\$75 copay
Ambulance Services	75% after deductible*		75% after deductible*		100%*
<b>DIAGNOSTIC SERVICES</b>					
Laboratory and Pathology	75% after deductible	50% after deductible	75% after deductible	50% after deductible	\$20 copay
Diagnostic Tests and X-Rays	75% after deductible	50% after deductible	75% after deductible	50% after deductible	\$20 copay
Therapeutic Radiology	75% after deductible	50% after deductible	75% after deductible	50% after deductible	\$20 copay
<b>MATERNITY SERVICES PROVIDED BY A PHYSICIAN (Includes care and delivery by a certified nurse midwife)</b>					
Prenatal and Postnatal Care	100%	50% after deductible	100%	50% after deductible	\$20 copay first visit only
Delivery and Nursery Care	75% after deductible	50% after deductible	75% after deductible	50% after deductible	100%
<b>HOSPITAL CARE (Non-Emergency services must be rendered in a participating hospital for the Enhanced and Standard Plans)</b>					
Semiprivate Room, Inpatient Physician Care/Consultations, Chemotherapy, General Nursing, Hospital Services/Supplies- unlimited	75% after deductible	50% after deductible	75% after deductible	50% after deductible	\$250 copay per admission up to \$750 per member, \$1,000 per family per calendar year
<b>ALTERNATIVES TO HOSPITAL CARE</b>					
Skilled Nursing Care	75% after deductible		75% after deductible		100%
	Up to 120 days per calendar year		Up to 120 days per calendar year		Up to 45 per calendar year
Hospice Care	100%		100%		100%
	Limited to dollar maximum that is reviewed and adjusted periodically		Limited to dollar maximum that is reviewed and adjusted periodically		
Home Health Care/Infusion Therapy	75% after deductible		75% after deductible		100%

\*Must be medically necessary. This comparison is only a brief summary of your benefits. If there is any discrepancy, the BCBSM/BCN documents will rule.



	ENHANCED		STANDARD		BCN
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
<b>SURGICAL SERVICES</b>					
Surgery-includes regulated surgical services and anesthesia	75% after deductible	50% after deductible	75% after deductible	50% after deductible	100%
Presurgical consultation- with a doctor of medicine, osteopathy, podiatry, or an oral surgeon	100%	50% after deductible	100%	50% after deductible	100%
Voluntary Sterilization	75% after deductible	50% after deductible	75% after deductible	50% after deductible	100%
<b>HUMAN ORGAN TRANSPLANTS</b>					
Specified Human Organ Transplants	100%, <b>in designated facilities only</b> , when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)		100%, <b>in designated facilities only</b> , when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)		100%
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital, and pharmacy services		Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital, and pharmacy services		Subject to medical criteria
Bone Marrow	75% after deductible	50% after deductible	75% after deductible	50% after deductible	100%
	When coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)		When coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)		Subject to medical criteria
Kidney, Cornea, and Skin	75% after deductible	50% after deductible	75% after deductible	50% after deductible	100%
<b>MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT</b>					
Inpatient Mental Health	50% after deductible		50% after deductible		100%
	Limited Days		Limited Days		Up to 30 days per calendar year
Inpatient Substance Abuse Treatment	50% after deductible		50% after deductible		50%
	Limited Days		Limited Days		Limited to 1 program per 12 month period
Outpatient Mental Health Care -Facility and Clinic -Physician's Office	50% after deductible	50% after deductible	50% after deductible	50% after deductible	\$15 copay Up to 20 visits per calendar year
	50%	50% after deductible	50%	50% after deductible	
Outpatient Substance Abuse Treatment	50% after deductible		50% after deductible		\$15 copay
	In approved facilities only; up to the state dollar amount that is adjusted annually		In approved facilities only; up to the state dollar amount that is adjusted annually		Up to 20 visits per calendar year
<b>OTHER SERVICES</b>					
Allergy Testing and Therapy	100%	50% after deductible	100%	50% after deductible	\$20 copay may apply
Chiropractic Spinal Manipulation	\$25 copay	50% after deductible	\$30 copay	50% after deductible	\$20 copay
	Up to 24 visits per calendar year		Up to 24 visits per calendar year		Must be referred
Outpatient Physical, Speech, and Occupational Therapy -Facility and Clinic -Physicians Office- excludes speech and occupational therapy	75% after deductible		75% after deductible		100%
	100%	50% after deductible	100%	50% after deductible	Limited to 60 consecutive days per episode per year for a combination of therapies; subject to significant improvement within 60 days
	Combined 60 visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physicians office		Combined 60 visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physicians office		
Durable Medical Equipment	75% after deductible		75% after deductible		50%
Prosthetic and Orthotic Appliances	75% after deductible		75% after deductible		50%
Prescription Drugs- 30 day supply -Generic -Preferred Brand -Non-Formulary	\$10		\$10		\$10
	\$20		\$20		\$20
	\$40		\$40		\$40
Prescription Drugs- 90 day supply -Generic -Preferred Brand -Non-Formulary	\$20		\$20		\$20
	\$40		\$40		\$40
	\$80		\$80		\$80

\*Must be medically necessary. This comparison is only a brief summary of your benefits. If there is any discrepancy, the BCBSM/BCN documents will rule.

## Dental Options

Resource offers our employees a choice of two dental plan options, both of which are insured by Aetna. We offer a DMO plan, a PPO plan, or the ability to opt out.

**DMO stands for “Dental Maintenance Organization”.** To participate in the DMO, each employee and eligible dependant must choose a Primary Care Dentist (PCD). You can change your PCD as often as once a month. If you receive care from a dentist in the DMO network, there is no deductible to satisfy, no annual dollar maximums, and no claim forms. DMO dentists cannot balance bill you for amounts over allowed fees.

**Our dental PPO gives you choices.** You have the option of using a dentist who participates in the network or a dentist that does not participate in their network. If you use a non-participating provider you will have a larger cost-share for some services and you may be billed the difference between the provider's charges and Aetna's reasonable and customary fee schedule. Below is a summary of the PPO plan and a brief summary of the DMO plan. The complete fee schedule for the DMO plan is located on page 9 of this booklet.

Dental Options	DMO	PPO	
		In-Network	Out-of-Network
<b>Annual Deductible</b> ( <i>waived for preventative</i> )			
Single	\$0	\$50	\$50
Family	\$0	\$150	\$150
<b>Preventative</b> ( <i>Oral exams, cleanings, X-Rays</i> )	100% after \$5 copay	100%	90%
<b>Basic</b> ( <i>Oral surgery, minor restorative, endodontics</i> )	Subject to copay schedule	80%	70%
<b>Major</b> ( <i>Prosthetics, major restorative</i> )	Subject to copay schedule	50%	50%
<b>Orthodontia</b> ( <i>Adult and child</i> )	100% after a \$2,000 copay	50%	50%
<b>Plan Year Maximum</b> ( <i>Includes Preventative</i> )	Unlimited	\$1,000	
<b>Orthodontia Lifetime Maximum</b>	Unlimited	\$1,000	

## Vision Options

Resource offers our employees a vision plan insured through Spectera. When you participate in the voluntary vision plan, you are eligible for the following benefits when you visit a participating provider:

- Annual comprehensive eye examination for a copay of just \$10.
- New eyeglass lenses (annually) and frames (every 24 months) for a copay of just \$25 (Contact lenses can be elected in lieu of eye glasses).

The frame allowance at network retail providers is a minimum of \$130. At network private practice providers a \$50 wholesale allowance is available. The only lense option covered in full is standard scratch resistant coating. Other lens options are available at a discount. You can locate a Spectera provider by calling (800) 638-3120 or logging onto [www.spectera.com](http://www.spectera.com).

## Legal Options

Resource offers our employees the opportunity to elect participation in a pre-paid legal service. The Basic Plan is available at \$3.45 per week and the Expanded Plan is available at \$5.52 per week (both after-tax). *In addition to these plans, there is also a service that you can purchase which assists with identity theft.* Some of the highlights of the program are:

- Unlimited telephone consultations.
- Legal document review (including Will preparation and annual updates).
- Legal representation for defense (limited type).

# Flexible Spending Options

Flexible Spending Accounts give you a way to pay for health care and day care expenses with tax-free dollars. Resource offers two types of accounts under these plans: a Health Care Reimbursement Account and a Dependent Care Reimbursement Account. You may choose to participate in one or both of these options, depending on your individual needs. Here's how the plans work:

- You decide, in advance, how much to contribute to each account each plan year.
- Your contributions are automatically withheld pre-tax—in equal amounts—from your paychecks throughout the plan year.
- You pay for eligible expenses as you normally would. Then you submit your receipts with a claim form for reimbursement.

**The Health Care Reimbursement Account** is designed to help you pay for health expenses that are not covered by your basic medical, dental, or vision plans, including any deductible amounts you have to pay and copayments required by your insurance plan. Eligible expenses also include many expenses that may not be covered by your basic plans. Generally, health care expenses that would qualify as a deduction on your personal federal income tax form will qualify for reimbursements as long as the expense is paid by you out-of-pocket. The maximum annual election for the Health Care Reimbursement Account is \$2,500 and the minimum annual election is \$260.

**The Dependent Care Reimbursement Account** allows you to pay for eligible dependent care expenses with pre-tax dollars. To decide whether a dependent care spending account is right for you, determine if you will incur eligible expenses. Generally, child and elder care and companion services are eligible expenses, as are Social Security and other taxes you pay a caregiver. Your dependents must be:

- Under age 13 or mentally or physically unable to care for him/herself.
- Spending at least 8 hours a day in your home.
- Eligible to be claimed as a dependent on your federal income tax.
- Receiving care when you are at work and your spouse (if you are married) is at work or is searching for work, is in school full-time, or is mentally or physically disabled and unable to provide the care.

The maximum annual election for the Dependent Care Reimbursement Account is \$5,000. However, if you and your spouse both work, the IRS currently limits your maximum contribution to a Dependent Account as follows:

- If you file separate personal income tax returns, the annual contribution amount is limited to \$2,500 each for you and your spouse.
- If you file a joint income tax return and your spouse also contributes to a Dependent Care Reimbursement Account, your family combined limit is \$5,000.
- If your spouse is disabled or a full-time student, special limits apply.
- If you or your spouse earns less than \$5,000, the maximum is limited to the earnings under \$5,000.

**Important Note:** The IRS requires that money in the accounts not used for eligible expenses incurred in the same plan year be forfeited, however the risk of forfeiture can be reduced significantly. For example, many out-of-pocket expenses are predictable; dependent care expenses can be budgeted ahead of time; and finally, your tax savings act as a cushion. You must leave a balance of more than your tax savings to “lose”. For example, if you deposit \$1,000 in your accounts, you will save approximately \$250 in taxes (with the assumption of a 25% tax rate). If you leave no more than \$250 in your accounts, you break even because you would have paid \$250 in taxes.



## 401(k) Options

Resource offers our employees the opportunity to elect participation in a 401(k) savings plan through Citizens Bank. This plan allows you to set aside up to 100% of your pay to a maximum of \$15,500 for 2007 (adjusted annually). The company will match \$0.10 on every dollar that you contribute to the plan, up to 5% of your gross compensation with a maximum \$104. You may increase or decrease your contributions at any time, and have the flexibility to direct your funds into numerous interest bearing accounts.

## Employee Managed Time Off

Resource offers our employees a generous managed time off policy which (depending on your contract) includes the following:

- 6 Holidays paid retroactively after 13 weeks of employment (New Years Day, Memorial Day, July 4<sup>th</sup>, Labor Day, Thanksgiving, and Christmas Day)
- Any Additional paid time off will accrue annually on a monthly basis (e.g. If you are eligible for an additional 12 days of paid time off, these days will accrue at a rate of 1 paid day off per month). Paid time off days may be used at any time once accrued.
- Employees must cash out any unused earned paid time off at year-end; paid time off will not be carried over into the new year.

## Enrollment Information

Your complete enrollment form must be returned to Human Resources within one week of your hire date. If you are electing coverage, you will receive an ID card and welcome package in the mail within the next month. You will also receive a notice from our benefits department advising you of your rights under COBRA. If you have any questions about any of this information (or the information contained in this packet), please contact Jaime Radick in the Benefits Department at 248-577-1812. The chart below lists your required weekly contributions to participate in our plans.

Weekly Employee Contributions	BCBSM	BCBSM	BCN HMO	Aetna Dental		Spectera Vision
	Enhanced PPO	Standard PPO		PPO	DMO	
Single	\$47.00	\$32.00	\$39.00	\$6.90	\$3.10	\$1.55
Employee + 1	\$102.00	\$76.00	\$84.00	\$12.90	\$5.60	\$2.45
Family	\$117.00	\$95.00	\$99.00	\$21.35	\$7.95	\$3.75
FCR (Child age 19-	\$25.00	\$20.00	N/A	N/A	N/A	N/A

If your benefit level should change during the plan year (i.e. from zero coverage to single; single to couple, etc.) the following premium contributions would apply:

Original Benefit Level	New Benefit Level	Blue Cross Blue Shield Enhanced Plan Weekly Deduction	Blue Cross Blue Shield Standard Plan Weekly Deduction	Blue Care Network HMO Weekly Deduction
No Insurance	Single	\$85.00	\$70.00	\$77.00
	Couple	\$182.00	\$156.00	\$175.00
	Family	\$214.20	\$192.20	\$196.20
Single Coverage	Couple	\$144.00	\$118.00	\$126.00
	Family	\$176.20	\$154.20	\$158.20
Couple Coverage	Family	\$134.20	\$112.20	\$116.20

## Dental Benefits Summary

Resource

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	<b>\$5</b>	D2391	Resin-based composite-1 Surf, Posterior	\$35
<b>DIAGNOSTIC</b>			D2392	Resin-based composite-2 Surf, Posterior	\$45
D0120	Exam-Periodic		D2393	Resin-based composite-3 Surf, Posterior	\$55
D0145	Exam-Patient under 3 years of		D2940	Sedative Filling	\$0
D0150	Exam-Comprehensive		D2951	Pin retention, exclusive of Restoration	\$10
D0210	X-ray, Intraoral, Complete Series (including bitewings)		<b>CROWNS/BRIDGES</b>		
D0220	X-ray, Intraoral, Periapical first		D2510	Inlay, Metallic, One surface	\$190
D0230	X-ray, Intraoral, Periapical each		D2530	Inlay, Metallic, Three or more surfaces	\$190
D0240	X-ray, Intraoral, Occlusal		D2543	Onlay, Metallic, Three surfaces	\$200
D0250	X-ray, Extraoral, First Film		D2740	Crown, Porcelain/Ceramic Substrate	\$225
D0260	X-ray, Extraoral, each additional		D2750	Crown, Porcelain Fused to Metal*	\$225
D0270	X-ray, Bitewing, Single Film		D2790	Crown, Full Cast Metal*	\$225
D0272	X-ray, Bitewing, Two Films		D2781	Crown, ¾ Cast Metal*	\$225
D0273	X-ray, Bitewing, Three Films		D2910	Recement Inlays/Crowns	\$5
D0274	X-ray, Bitewing, Four Films		D2930	Crown, Stainless Steel-Primary Tooth (Child)	\$0
D0277	Vertical Bitewings (7-8 films)		D2931	Crown, Prefab. Stainless Steel-Permanent Tooth	
D0330	X-ray, Panoramic film		D2950	Core Buildup, including pins	\$60
D0460	Pulp Vitality Test		D2952	Cast Post and Core, in addition to Crown	\$80
D0470	Diagnostic Casts		D2954	Prefab. Post and Core, in addition to Crown	
<b>PREVENTIVE</b>			D6210	Pontic, Full Cast Metal*	\$225
D1110	Prophylaxis-Adult (Limit-2 per		D6240	Pontic, Porcelain Fused to Metal*	\$225
D1120	Prophylaxis-Child (Limit-2 per		D6750	Crown, Abutment, Porcelain Fused to Metal*	\$225
D1203	Topical Application of Fluoride (1 per year under age 16)		D6790	Crown, Abutment, Full Cast Metal*	\$225
D1206	Topical Fluoride Varnish (Moderate to High risk patients)		D6930	Recement Bridge	\$15
D1330	Oral Hygiene Instructions			Additional Charge per Unit for Full Mouth Rehabilitation.	\$125
D1351	Sealant-per Tooth (under age 16)	\$0	Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.		
D1510	Space Maintainers-Fixed	\$0	<b>ENDODONTICS</b>		
D1520	Space Maintainers- Removable (includes adjustments within 6 of installation)	\$0	D3110	Pulp Cap, Direct or Indirect	\$0
D1550	Recement Space Maintainer	\$12	D3220	Therapeutic Pulpotomy	\$0
D1555	Removal of Fixed Space	\$12	D3310	Root Canal, Anterior	\$50
Diagnostic and Preventive services may be subject to age and frequency limitations. See your booklet for details.			D3320	Root Canal, Bicuspid	\$70
<b>RESTORATIVE</b>			D3330	Root Canal, Molar	\$175
<b>PRIMARY OR PERMANENT TEETH</b>			D3410	Apicoectomy/Periradicular Surgery, Anterior	\$65
D2140	Amalgam-1 Surface	\$0	D3421	Apicoectomy/Periradicular Surgery, Bicuspid – 1st root	\$65
D2150	Amalgam-2 Surfaces	\$0	D3425	Apicoectomy/Periradicular Surgery, Molar-1st Root	\$80
D2160	Amalgam-3 Surfaces	\$0	D3426	Apicoectomy/Periradicular Surgery-each additional root	
D2161	Amalgam-4 or More Surfaces		D3430	Retrograde Filling per Root	\$20
D2330	Resin-1 Surface, Anterior	\$0	D3450	Root Amputation per Root	\$60
D2331	Resin-2 Surfaces, Anterior		All charges for crown and bridge are per unit. There will be an additional patient charge for the actual cost for gold/high noble metal for the procedures identified by an asterisk (*). <b>“Patient Pays” applies to those procedures provided by the member’s primary care dentist or approved specialty dentist.</b>		
D2332	Resin-3 Surfaces, Anterior	\$0			
D2335	Resin-4 or More Surfaces or Angle, Anterior	\$40			
D2390	Resin-based composite crown,	\$40			

## Dental Benefits Summary

**Resource**

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
<b>PERIODONTICS</b>			<b>REPAIRS TO PROSTHETICS (cont.)</b>		
D4211	Quadrant (limit 1 per quad every 3 Gingivectomy or Gingivoplasty per (limit 1 per site every 3 years)	\$30	D5710	Rebase Complete Upper or Lower	\$100
D4240	Gingival Flap Procedure - per quad.	\$110	D5720	Rebase Partial Upper or Lower Denture	\$100
D4241	Gingival Flap Procedure - per quad. including Root Planing, 1-3 teeth	\$66	D5730	Reline Complete Upper or Lower Denture (chairside)	\$40
D4249	Clinical Crown Lengthening, Hard	\$150	D5740	Reline Partial Upper/Lower Denture (chair side)	\$40
D4260	Osseous Surgery per Quadrant (including flap entry and closure) (limit 1 per quad. every 3 years)	\$250	D5750	Reline Complete Upper or Lower Denture (Laboratory)	
D4261	Osseous Surgery, 1-3 teeth, per quad.	\$150	D5760	Reline Partial Upper/Lower Denture (Laboratory)	\$90
D4270	Pedicle soft tissue graft	\$190	D5820	Interim Partial Upper/Lower Partial	\$90
D4271	Free soft tissue graft, including Donor	\$205	D5850	Tissue Conditioning, Upper or Lower	\$40
D4273	Subepithelial connective tissue graft	\$115	<b>ORAL SURGERY</b>		
D4275	Soft tissue allograft	\$230	D7140	Coronal remnants – deciduous Extraction, erupted tooth, exposed	\$0
D4341	Periodontal scaling/root planing per quad (Limit of 4 sep. quads every 2 yrs)		D7210	Surgical Extraction of an Erupted Tooth	\$0
D4342	Periodontal scaling/root planing per quad		D7220	Removal of Impacted Tooth, Soft Tissue	\$0
D4910	Periodontal Maintenance Procedures (limit of 2 per year following surgical therapy)		D7230	Removal of Impacted Tooth, Partially	\$45
<b>PROSTHODONTICS-REMOVABLE*</b>			D7240	Removal of Impacted Tooth, Completely	\$70
D5110	Complete Upper or Lower Denture	\$275	D7250	Surgical Removal of Root Tip, Root	\$15
D5130	Immediate Upper or Lower Denture (does not include charge for reline)	\$325	D7285	Biopsy of Oral Tissue, hard	\$50
D5211	Upper or Lower Partial Denture Resin Base-Including Clasps, Rests and Teeth	\$275	D7286	Biopsy of Oral tissue, soft	\$50
D5213	Upper or Lower Partial Cast Metal Base-Including Clasps, Rests and Teeth	\$325	D7310	Alveoplasty in Conjunction with Extractions (per Quadrant)	\$18
D5410	Adjust Complete Denture Upper or Lower	\$10	D7320	Alveoplasty Not in conjunction with Extractions (per Quadrant)	\$25
D5421	Adjust Partial Denture Upper or Lower		D7510	Incision and Drainage, Intraoral Abscess	\$10
<b>REPAIRS TO PROSTHETICS</b>			D7960	Frenectomy	\$24
D5510	Repair Broken Acrylic, Complete Denture Upper or Lower		<b>OTHER (ADJUNCTIVE) SERVICES</b>		
D5520	Replace One Tooth on Complete Denture	\$35	D9310	Consultation Appointment	No Charge
D5610	Repair Acrylic, Cast Frame, Broken Clasp		D9940	Occlusal Guards-for bruxism only (limit 1 every 3 years)	\$100
D5640	Replace Broken Tooth, Partial	\$35	D9951	Occlusal Adjustment, Limited	\$20
D5660	Add Clasp to Existing Partial	\$40	D9952	Occlusal Adjustment, Complete	\$80
D5670	Replace all teeth/acrylic metal frame Maxillary	\$100	<b>EMERGENCY SERVICES</b>		
D5671	Replace all teeth/acrylic metal frame Mandibular	\$100	D0140	Oral Evaluation, Problem Focused	No Charge
			D0160	Detailed and extensive oral evaluation	No Charge
			D0180	Comprehensive Periodontal evaluation	No Charge
			D9110	Emergency Palliative Treatment	\$10

**\*Includes relines, adjustments, rebases within the 1<sup>st</sup> six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.**

**“Patient Pays” applies to those procedures provided by the member’s primary care dentist or approved specialty dentist.**

## Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS	PLAN EXCLUSIONS AND LIMITATIONS
<b>ORTHODONTICS</b>			<p><b>Some of the services not covered under the plan are:</b></p> <p>15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than: (a) during the first 31 days the person is eligible for this coverage; or (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:</p> <p>(a) After the end of the twelve month period starting on the date the person became a covered person; or</p> <p>(b) As a result of accidental injuries sustained while the person was a covered person; or</p> <p>(c) For a primary care service in the Dental Care Schedule that applies shown under the headings Visits and Exams, and X-rays and Pathology.</p> <p>16. Those for services given by a non-participating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.</p> <p>17. Those for a crown, cast or processed restoration unless:</p> <p>(a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or</p> <p>(b) The tooth is an abutment to a covered partial denture or fixed bridge.</p> <p>18. Those for pontics, crowns, cast or processed restorations made with high noble metals unless otherwise specified in the Booklet-Certificate.</p> <p>19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons unless otherwise specified in the Booklet-Certificate.</p> <p>20. Those for services needed solely in connection with non-covered services.</p> <p>21. Those for services done where there is not evidence of pathology, dysfunction, or disease other than covered preventive services.</p>
	Orthodontic Screening Exam	\$30	
	Diagnostic Records	\$150	
	<i>Comprehensive Orthodontic Treatment</i>		
	Adolescent	\$1,545	
	Adult	\$1,545	
	Orthodontic Retention	\$275	
<b>PLAN EXCLUSIONS AND LIMITATIONS</b>			
<p><b>Some of the services not covered under the plan are:</b></p> <p><b>1. Those for services or supplies which are covered in whole or in part:</b></p> <p>(a) Under any other part of this Dental Care Plan; or</p> <p>(b) Under any other plan of group benefits provided by or through your employer.</p> <p>2. Those for services and supplies to diagnose or treat a disease or injury that is not:</p> <p>(a) A non-occupational disease; or</p> <p>(b) A non-occupational injury.</p> <p>3. Those for services not listed in the Dental Care Schedule that applies; unless otherwise specified in the Booklet- Certificate.</p> <p>4. Those for replacement of a lost, missing, or stolen appliance; and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.</p> <p>5. Those for: plastic, reconstructive, cosmetic surgery, or other dental services or supplies which are primarily intended to improve, alter, or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.</p> <p>6. Those for or in connection with: services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.</p> <p>7. Those for: dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion or correcting attrition, abrasion, or erosion.</p> <p>8. Those for any of the following services:</p> <p>(a) An appliance or modification of one if an impression for it was made before the person became a covered person;</p> <p>(b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;</p> <p>(c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.</p> <p>9. Those for services that Aetna defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.</p> <p>10. Those for services intended for treatment of any Jaw Joint Disorder; unless otherwise specified in the Booklet-Certificate.</p> <p>11. Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.</p> <p>12. Those for orthodontic treatment unless otherwise specified in the Booklet-Certificate.</p> <p>13. Those for general anesthesia and intravenous sedation.</p> <p>14. Those for treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.</p>			

## **Aetna Dental Benefits Summary**

### **Other Important Information**

This benefits summary of the Aetna Dental DMO (Dental Maintenance Organization) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists.

In some states, limited coverage may be available for non-emergency services referred by a nonparticipating provider.

### **Specialty Referrals**

1. Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.
2. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Dental has opened direct access for DMO members to orthodontic services.

### **Emergency Dental Care**

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, or you are more than 50 miles from your home address, you should contact Member Services for assistance in locating a dentist. If you receive treatment from a non-participating dentist more than 50 miles away from your home, then the emergency services will be covered up to a maximum of \$100. You must submit a claim to Aetna in order to receive benefits.

Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

### **Your Dental Care Plan Coverage Is Subject to the Following Rules:**

#### Replacement Rule

The replacement of; addition to; or modification of:

- existing dentures;
- crowns;
- casts or processed restorations;
- removable denture;
- fixed bridgework; or
- other prosthetic services

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

## **Aetna Dental Benefits Summary**

### *Tooth Missing But Not Replaced Rule*

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

**Alternate Treatment Rule:** If more than one service can be used to treat a covered person's dental condition, Aetna 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 of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- (a) the copayment for the approved less costly service; plus
- (b) the difference in cost between the approved less costly service and the more costly covered service.

### **Finding Participating Providers**

Consult Aetna Dental's online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at [www.aetna.com](http://www.aetna.com).

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Arizona, DMO, Advantage Plus Dental, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.