Dental Office Guide

www.aetnadental.com

Call our Dentist Contracting Hotline if you need assistance with your contract or this guide.
1-800-776-0537

Call the National Dentist Line to obtain eligibility or answers to claims questions.
1-800-451-7715

Preferred Provider Organization (PPO)
Participating Dental Network (PDN)
Affordable Health Choices
Exclusive Provider Plan (EPP)
Vital Savings by Aetna℠
Aetna Dental Access®
Aetna Dental® Administrators
The purpose of this *Dental Office Guide* is to provide you with an explanation of certain plan administrative procedures, plan provisions and your role as a participating dentist. Note that certain procedures may vary, depending on individual state regulatory requirements. Aetna recognizes the vital role the dental office plays in delivering a successful dental plan. We appreciate your participation and look forward to a long and mutually beneficial relationship. Please read this *Dental Office Guide* carefully. Your participating dentist agreement requires you to comply with Aetna policies and procedures, including those contained in this manual.

*Note:* The relationship between Aetna and participating dentists is that of an independent contractor. None of the provisions of this *Dental Office Guide* are intended to create, or to be construed as creating, any agency, partnership, joint venture and/or employee-employer relationships. All member care and related decisions are the sole responsibility of the dentist. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Aetna reserves the right to add, delete or change the policies and procedures described in this *Dental Office Guide* at any time.

We hope this information helps you in working with us and providing care to our members.

Important note as you review this guide: In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN).
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Quick facts

National Dentist Line
1-800-451-7715

Call us if you have a question about:

- Claims
- Member eligibility
- Fee schedule

The Aetna Voice Advantage® telephone self-service system is available 24 hours a day, 7 days a week, without a wait.

Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Dentist Contracting Hotline
1-800-776-0537

This is a dedicated Dentist Contracting Hotline.

Representatives are always available Monday through Friday, 8 a.m. to 5 p.m. (ET):

This phone number is dedicated to your use. Please do not give your patients the Dentist Contracting Hotline number; this causes unnecessary delays in answering your question(s).

NOTE: See page 8 for instructions on calling for eligibility information.

Reaching key dental management staff

Local service and support for participating dentists is furnished by our nationwide team of Provider Relations staff. Each region is headed by a dental director and staffed by network managers.

You may contact any of our field staff through the National Dentist Line.
Plan design

PPO/PDN plan features

Plan members do not all have the same coverage. Plan design and dental coverage can vary among plan sponsors, and services that are covered by some plans may not be covered by others.

However, the fundamental features of Aetna Dental PPO/PDN plans are similar to traditional fee-for-service indemnity plans and include member and family deductibles, coinsurance rates that may vary by type of procedure (for example, diagnostic procedures versus restorative versus prosthetic), contractual limitations and exclusions, and annual and lifetime limitations or maximums. Some plans also include “alternate benefit provisions.”

Plan design features may also include incentives that encourage members to use participating dentists. These incentives may include lower deductibles, lower levels of coinsurance, lower out-of-pocket costs and higher plan maximums when receiving care from participating dentists. Eligible PPO/PDN members are responsible for the cost of services that are not covered.

We encourage you to take advantage of applicable pretreatment estimate procedures and predetermine the member’s benefits (as described later in this guide). This step helps eliminate most misunderstandings regarding coverage and assists members in budgeting for the out-of-pocket expenses that will be paid directly to you.

Services that are commonly not covered in Aetna’s PPO/PDN plans include:

- Services not medically necessary or not customarily performed for an existing condition
- Services that are covered in whole or in part under any other dental or medical plan or another plan of group benefits
- Treatment performed by anyone other than a licensed dentist or licensed dental hygienist who is supervised by a dentist
- Services or supplies considered cosmetic in nature (including facings on molar crowns and pontics)
- Replacement of lost, missing or stolen appliances
- Services or supplies for orthodontic treatment, except when specifically provided in the plan
- Services/appliances/supplies for the purpose of splinting, altering vertical dimension, restoring occlusion, or correcting attrition, abrasion, or erosion
- Services for which frequency limitations apply (for example, prophylaxis, bitewing radiographs, examinations, replacement of crowns and prosthetics)
- Services to replace teeth missing and not replaced prior to the effective date of the plan, including congenitally missing teeth, as well as those removed by a dentist

EPP plan features

The EPP uses the same fee schedule and claims submission processes as the Aetna PPO/PDN. Members with ID cards that say “EPP” should be billed in accordance with the PPO/PDN fee schedule.
Vital Savings by Aetna® features
Aetna offers a dental discount program called Vital Savings by Aetna. This program enables participants to receive care in your office at the same rate as the rates listed on your negotiated PPO fee schedule.

It is important to note that this is not an insurance plan. Participants pay you 100 percent of your negotiated rate at the time of service. There are no claims to submit or forms to fill out. No benefits are payable through this program, and Aetna will not compensate you for services rendered. To verify a participant’s eligibility, you can call Aetna at the number listed on the participant’s ID card and access Aetna Voice Advantage (our 24-hour self-service telephone systems) or talk with a Member Services representative. We recommend that your office verify member eligibility with each office visit.

Aetna ValuePass℠ features
With the Aetna ValuePass card program, you can get paid at the time of service. Participants present a prepaid debit/credit card and/or certificate with the Aetna Dental Access network logo. You should charge your negotiated PPO rate for all services you provide.

This program is not insurance. There are no forms or claims to submit, and there is no need to check eligibility. Additionally, there are no limitations or exclusions. You simply swipe the card as you would any debit/credit card and get paid the full, negotiated PPO rate at the time of service. If the cost of the service is above the value amount stored on the card, the participant will be expected to pay the balance through another personal method.

Visit www.aetnadental.com to get more information about the Aetna ValuePass℠ card.

Aetna Dental Access®
The Aetna Dental Access network supports discount dental programs, such as Vital Savings by Aetna®, the Aetna ValuePass℠ card and other discount programs offered through external relationships.

Key facts:

• Anytime you see the “Aetna Dental Access” logo on a card and/or certificate, charge participants the same rate as your negotiated PPO rate.

• Programs supported by this network are not insurance, and your office will not have any claims to submit.

• Participants only need to show their card and/or certificate when they visit your office, receive dental care and pay the full, negotiated rate at the time of service.

• Call the phone number on the patient’s card with any questions.

• Visit www.aetnadental.com for more information
Aetna Dental
Preferred Dental Organization
Participating Dental Network
Affordable Health Choices
Exclusive Provider Plan
Vital Savings by Aetna
Aetna Dental Access
Aetna Dental Administrators

Aetna DentalFund® features
In most instances, an annual dental fund account is set up for the member. The benefit is coupled with a base dental PPO or indemnity plan that usually includes a deductible. The plan may include a variety of coinsurance options. The dental fund, annual plan maximum, deductible amounts and coinsurance options depend on the employer’s preference.

Aetna DentalFund members receive ID cards that list “ADF” along with the Dental PPO logo. ID cards for members with an integrated medical and dental Aetna HealthFund product will show “AHF” along with the medical plan and Dental PPO logos.

In addition to member ID cards, your office can easily verify eligibility and benefits information for Aetna DentalFund members by contacting us directly through our Aetna Voice Advantage self-service telephone system, using the number noted on the member’s ID Card.

As the member incurs covered expenses paid for by the dental fund, the member’s deductible and fund balance are simultaneously reduced. Coverage for preventive care is usually not subject to an annual deductible or deducted from the dental fund.

Claims should be submitted to Aetna as they are for our other PPO plans. For Aetna DentalFund plans, your participating PPO office generally should not collect anything from the member at the time of their visit. The Explanation of Benefits will specify if there is any amount for which the member will need to be billed.

Affordable Health Choices from Aetna® features
This Plan is administered by Strategic Resource Company (SRC), an Aetna Company.

· Call SRC at 1-888-772-9682 to verify patient eligibility.

· Submit claims to: SRC, PO Box 23759, Columbia, SC 29224.

· Look for the SRC Logo and “Dental PPO” on the ID card.

· This is a PPO dental plan and is supported by the Aetna Dental PPO Network.

· Compensation will be based on your PPO fee schedule.

· Deductible, coinsurance, annual maximums may apply.

· An Explanation of Benefits (EOB) will be issued to help you determine what to collect from the patient.
**Aetna Dental® Administrators**

- Through a variety of external relationships with insurance carriers and third-party administrators (TPAs), the Aetna Dental Administrators program provides dentists with increased opportunities for building their patient base.
- Although these relationships may vary, they all provide plan members with access to dental care from participating dentists in accordance with the contracted PPO fee schedule.
- For these PPO plans, Aetna handles claims pricing, provides network services and management, and works to resolve network contract issues.
- Contracted carriers and TPAs must agree to meet Aetna claims payment and other key standards.

**Contact information/additional resources:**

- Call the number on the member’s ID card with eligibility questions.
- Call the Dentist Contracting Hotline at **1-800-776-0537** with general questions.
- Send claims to the address on the back of the ID card.
- Visit [www.aetnadental.com](http://www.aetnadental.com) for a list of current plans that the Aetna Dental Administrators network supports.

**Dental Office Guide:** In general, most information about PPO plans in this Dental Office Guide applies to the Aetna Dental Administrators program. We have noted any significant differences in the applicable sections of the guide.
Plan administration

Fee schedules
As a participating dentist, you have agreed to accept an Aetna maximum fee as payment in full for any service rendered to eligible employees and dependents.

Compensation Schedules are calculated for specific three-digit zip code areas. If you practice in multiple locations, you can have a different Compensation Schedule for each of your locations.

The Compensation Schedule reflects the most common dental services that may be covered under the member’s plan of benefits. Inclusion of a service on the Compensation Schedule is not a guarantee that the service is covered under the member’s plan. The member must be informed in advance and agree in writing when a non-covered service is provided. You should always confirm coverage prior to providing the service.

Aetna will pay for covered dental services in accordance with the maximum fees listed in the relevant Compensation Schedule, less any applicable deductibles or member coinsurance amounts. Depending on the service(s) rendered, payment(s) can come from Aetna and/or the member. If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used to determine the patient copay.

• For covered services, the charge to the member may not exceed the maximum fee on the Compensation Schedule. You may not bill the member the balance between your usual fee and the maximum fee listed on your Compensation Schedule.

• For non-covered services, except where prohibited by state law, you may not charge an Aetna Dental PPO member more than the maximum fee, as specified on your fee schedule. If your state prohibits mandatory discounts on non-covered services, you may voluntarily agree to offer this discount.

No lab fees may be charged to the patient. Brand-name crown materials (for example, Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. Your office is not permitted to bill the member for brand-name materials.

Orthodontic aligners (for example, Invisalign®)
Ceramic, clear, lingual and Invisalign appliances are ineligible based on the cosmetic limitation; however, the plan covers up to the contracted fee for conventional orthodontic treatment plans. The member is responsible for his/her normal copayment for the conventional orthodontic treatment plan, plus the difference between your usual fees for the standard orthodontic treatment and the ceramic, clear, lingual or Invisalign appliance.

Please note: If you exclusively perform ceramic, clear, lingual and Invisalign appliances, you cannot charge an upgrade to the member.

To avoid misunderstandings, we recommend you not bill the member for out-of-pocket payments until you have received a Claim Detail Statement. You may also take advantage of the pretreatment estimate of benefits process.

For services not listed on the Compensation Schedule, Aetna will determine coverage and calculate maximum fees in a manner consistent with the formula used to develop the applicable Compensation Schedule. (This includes changes or revisions in the Current Dental Terminology published by the American Dental Association subsequent to issuance of the Compensation Schedule.) If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used for the patient copay. You should call the Dentist Contracting Hotline at 1-800-776-0537 to obtain a fee for any unlisted service.

Invisalign is a registered trademark of Align Technology, Inc.
Dental services covered under an Aetna medical plan

In certain situations, a member of an Aetna medical plan for which you do not serve as a participating dentist may receive services from you that are covered by both his/her medical plan and his/her Aetna Dental PPO/PDN plan. In that event, Aetna may apply the Aetna Dental PPO/PDN compensation terms of your participation agreement to some or all of the covered services you provide to that member.

There may also be situations where a member of an Aetna managed dental plan for which you do not serve as a participating dentist may receive services from you. In that event, we may apply the Aetna Dental PPO/PDN compensation terms to your participation agreement for some or all of the covered services you provide to the managed dental plan member.

Alternate benefit provisions

Some Aetna plan sponsors have elected to include alternate benefit provisions (ABP) in their PPO/PDN dental plans. ABP limitations and exclusions take effect when the member’s dental condition or dental problems can be treated by a less expensive, professionally acceptable service.

Alternate benefit provisions limit plan benefits to services and supplies that are customarily used for treatment and deemed by the dental profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice.

After an alternate benefit is allowed in lieu of the proposed procedure, the member may still elect to proceed with the more costly service. However, expenses for care beyond the ABP limitation remain the member’s responsibility. Written consent, signed by both the dentist and the member, should be obtained prior to rendering treatment.

In those cases, you may still bill the member for the services performed, but only up to the maximum fee shown on your Compensation Schedule. For example, if a fixed bridge is placed and Aetna allows an alternate benefit for a removable partial denture, you may balance bill the member the difference, but only up to the maximum fee for the fixed bridge as listed on your Compensation Schedule. **We strongly recommend that a pretreatment estimate be requested for any course of treatment where clarification of coverage would be helpful.**

Specialist referrals

Participating Aetna Dental PPO/PDN dentists are responsible for evaluating the member’s dental care needs, including the need for specialty care. When a specialty service is required, the proposed treatment and reason for referral should be discussed with the member.

We strongly recommend that you refer your patients to a participating specialist whenever one is available. If the member is referred to a nonparticipating dentist, he/she will usually incur higher costs.

If the member asks for a referral to a nonparticipating specialist, please inform the member that he/she will not receive the benefit of the negotiated fees and, in many instances, may receive reduced benefits. **EPP members must use participating PPO/PDN/EPP specialists, or the services will not be covered.**

You can access Aetna’s participating dentist listing, DocFind®, at [www.aetna.com](http://www.aetna.com). DocFind is a web-based application designed to put information about participating dentists at your fingertips.
Verification of eligibility

The member must be eligible on the date treatment is provided in order to qualify for benefits under the plan.

Aetna Dental PPO/PDN/EPP members have been instructed to identify themselves as participants when they call your office or arrive for an appointment. To avoid misunderstandings, we recommend confirming member eligibility prior to the scheduled appointment. You can do this via:

- **The Internet**: Online, real-time eligibility information can be obtained through [www.aetnadental.com](http://www.aetnadental.com). Once registered, your office will be able to submit preauthorization requests and query for member eligibility and detailed benefits information.

- **The automated telephone response self-service**: The Aetna Voice Advantage telephone self-service system is also available to dental offices. The system is available 24 hours a day, 7 days a week, without a wait. The number is on the member’s ID card.

More information can also be obtained by calling the National Dentist Line at **1-800-451-7715**.

Note that even if you have received a pretreatment estimate for a member’s care, it is still recommended that you verify eligibility at the time of treatment. **Benefits are only payable if the member is covered under the plan at the time services are rendered.**

For Aetna Dental Administrators members, please call the telephone number on the member’s ID card to verify eligibility.

Dental claim submission

**Aetna requires that participating dentists submit all claims on behalf of PPO/PDN/EPP members.** Claims should only be submitted for completed services (for example, after insertion of a crown, bridge or denture prosthetic, or the final fill of a root canal).

Submitting a claim for an Aetna Dental PPO/PDN/EPP member is no different than submitting a claim for a member covered by one of our traditional fee-for-service indemnity plans. Your dental office may:

- Submit electronically
- Use a standard “ADA-approved” dental claim form

The individual dentist rendering treatment must be clearly identified on the claim form. The service address and dentist’s tax ID number must also be included.

The claim form should include and clearly identify the following:

- Patient’s name and address
- Insured’s name, address, and Aetna member ID or Social Security number
- Insured’s employer
- Patient’s date of birth
- Procedure code(s) (CDT), description of service(s) and date(s)
- Tooth number(s), quadrant(s) and surface(s), where appropriate
- **Your usual and customary fee(s)** for each service
- Any additional coverage under another dental plan
The box indicating “Statement of Actual Services” should be checked. Note that we will accept “signature on file” notations for both the employee and the patient.

Claims-related questions should be referred to Aetna Member Services. The phone number is listed on the member’s ID card.

Claims should be submitted to the address listed on the member’s ID card (or as noted below) no later than 90 days after the date of service.

Aetna Dental
PO Box 14094
Lexington, KY 40512-4094

For Aetna Dental Administrators members, mail your claims to the address listed on the member’s ID card, or call the telephone number on the member’s ID card for additional information.

Electronic claims submission

We encourage you to submit your claims electronically. Claims submitted electronically are generally processed more quickly and, because manual handling is virtually eliminated, subject to very few errors. Information regarding electronic submissions can be obtained by calling the National Dentist Line at 1-800-451-7715.

For more information, visit www.aetnadental.com or see the Electronic Solutions section later in this guide.

Assignment of benefits

Members are encouraged (but not required) to assign benefits to the dentist, which facilitates payment for covered services directly to you. Permission for assignment of benefits can be obtained either on a claim-by-claim basis or through a signature on file. If the patient wishes to assign benefits, you must accept the assignment.

Explanation of Benefits (dentist version)

Your office will receive an Explanation of Benefits (EOB) statement after a claim has been processed. The EOB statement may provide detailed claims payment information on multiple members and claims.

The EOB statement includes:

- The office that processed the claim
- A Member Services phone number that can be used for questions
- The identity of the individual receiving care
- A claim identification number that can be used to identify the specific claim
- The service(s) received by the member
- Service dates
- The submitted or billed charge, which is the dentist’s usual and customary fee for each service
- Any adjustments made, based on the network negotiated amount for each service and the relevant Compensation Schedule
- Non-covered and/or not payable amounts (services not covered under the member’s plan are explained in the “Remarks” section of the EOB statement)
• Pending amounts for services rendered without adequate information to calculate payment (additional information required and what, if anything, the member or dentist needs to do is explained in “Remarks”)
• Any amount applied to the member’s deductible and coinsurance
• The amount payable by the plan and the total patient responsibility amount
• The total payment included on the EOB statement

Billing the member

You may not bill the member more than the maximum fee listed on the Compensation Schedule. If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used for the patient copay.

• For covered services, the charge to the member may not exceed the maximum fee on the Compensation Schedule. You may not bill the member the balance between your usual fee and the maximum fee listed on your Compensation Schedule. This applies whether or not the benefit maximum has been met, except where prohibited by state law.

No lab fees may be charged to the patient. Brand-name crown materials (for example, Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand-name materials.

• For non-covered services, except where prohibited by state law, you may not charge an Aetna Dental PPO member more than the maximum fee, as specified on your fee schedule. If your state prohibits mandatory discounts on non-covered services, you may voluntarily agree to offer this discount.

Providers may bill Aetna Dental PPO/PDN/EPP members for the coinsurance or deductible amounts due, but cannot bill the difference between the Aetna Dental PPO/PDN/EPP maximum fees and their usual and customary fee for any service, except as noted above.

To avoid misunderstandings, we recommend you not bill the member for out-of-pocket payments until you have received an Explanation of Benefits statement. We also recommend you take advantage of the pretreatment estimate of benefits process.

We strongly suggest that any financial arrangements between the dentist and the member be in writing and signed by both the member and the dentist prior to services being rendered.

Coordination of Benefits

When members are covered under more than one group dental plan, the Coordination of Benefits or Maintenance of Benefits provision may affect the amount of benefits paid when the Aetna plan is the secondary plan. Coverage under all plans is taken into account.

Your dental office should ask members if they, or any other family members, have coverage under another dental plan. This information should be clearly noted on the claim form.

Please note that the Coordination of Benefits or Maintenance of Benefits provision and general rules (for example, the “birthday rule”) that designate the order in which multiple carriers are to pay benefits may vary by state law or individual plan.
Regardless of the amount you collect from all plans, you are not permitted to balance bill the member for amounts in excess of the difference between the maximum fee in the Compensation Schedule and the total of the amounts paid by all plans. Information will be provided on Explanation of Benefits statements.

Pretreatment estimates and predetermination of benefits

We recommend that a pretreatment estimate be requested for any course of treatment where clarification of coverage is important to you and the patient. This is especially recommended for treatment plans involving multiple crowns/inlays, prosthodontics and periodontal surgery. This may help avoid misunderstandings concerning available benefits and enable you and the member to make financial arrangements prior to treatment being rendered.

Pretreatment estimates may be submitted on standard claims forms and should include:

- Patient’s name and address
- Insured’s name, address and Aetna member ID number
- Insured’s employer
- Patient’s date of birth
- Procedure code(s) (CDT) and description of service(s)
- Tooth number(s) and surface(s), where appropriate
- Your usual and customary fee(s) for each service

The box indicating "Pretreatment Estimate" should be checked. Note that we will accept "signature on file" for both the employee/insured and the patient.

Aetna will send both you and the member a pretreatment estimate of benefits for the proposed treatment plan, including:

- The office that processed the pretreatment estimate
- A Member Services phone number that can be used for questions
- The identity of the patient
- A claim identification number that can be used to identify the specific pretreatment estimate
- The service(s) to be received by the member
- The submitted or billed charge, which is the dentist’s usual and customary fee for each service
- Any adjustments made, based on the maximum fee for each service and the relevant Compensation Schedule
- Non-covered amounts (services not covered under the member’s plan are explained in the “Remarks” section)
- Pending amounts for services to be rendered without adequate information to calculate payment (the additional information required is explained in “Remarks”)
- Any amount that will be applied to the member’s deductible
- The amount estimated as payable by the plan and by the patient

The estimate of benefits does not guarantee payment, as benefits are only payable if the member is covered under the plan when services are rendered. It is still recommended that you verify the member’s eligibility at the time of treatment.
**Dental claim review: required radiographs and documentation**

Certain procedures and treatments, submitted either on claims or pretreatment estimates, are referred to our in-house professional staff – dental consultants – for compliance with treatment guidelines and professional standards for appropriateness.

Our dental consultants rely on the same records, radiographs and other supporting data you use to reach your diagnosis. Claim Documentation Guidelines are available on www.aetnadental.com or by calling our National Dentist Line at 1-800-451-7715.

Note that claims or pretreatment estimates submitted without required records, radiographs and/or relevant documentation will be delayed. Do not send your original radiographs; please send copies. Label all copies with the patient’s name, dentist’s name and the dates the radiographs were taken. You should identify left and right views on each radiograph.

**Updating your information**

Accurate and reliable information regarding you and your practice is essential to reimbursing you correctly and quickly for your services, and listing your name, address, telephone numbers and specialty in our directory of participating dentists.

Please inform us at 1-800-451-7715, our toll-free National Dentist Line, of any changes or errors in your:

- Name
- Office address(es) or new/additional locations
- Tax ID number
- National Provider Identifier (NPI)
- Phone number(s)
- Billing address(es)
- New associates who join your practice
- Participating dentists who leave your practice and are no longer at your location

**Grievance and appeal process**

Aetna has policies and procedures in place to address member and provider complaints. The scope of this program includes time frames and processes for the acknowledgment, evaluation, monitoring and resolution of complaints. (It should be noted that the handling of complaints may be subject to federal and state legislative requirements.)

Note: In order for the grievance and appeal process to function effectively, it is imperative that the dentist cooperates fully by submitting all requested information (for example, records, X-rays, etc.) in a timely manner. Lack of complete documentation can have an impact on the ability to meet state-mandated deadlines and can also adversely affect the final decision. You are required to comply fully with the grievance and appeal process. Non-compliance with policies and procedures may result in termination of network participation.

All complaints are documented and are routed to the appropriate area responsible for resolution. Complaints will be resolved and communicated in a timely manner depending on the urgency of the situation and requirements of specific state laws.
Electronic solutions

Visit www.aetnadental.com for more information on the available electronic solutions.

Have you been searching for an easier way to communicate with Aetna?

Using your computer, you can:

• Submit claims
• Send attachments
• Check eligibility
• Review the status of your claims
• Do much more

What are the advantages of using electronic solutions?

Submitting claims electronically can help you:

• Cut down on administrative work — telephone calls, faxes and paperwork
• Improve efficiency
• Experience fewer claims returned due to missing or incorrect information
• Receive faster reimbursement

Frequently asked questions about submitting electronic claims

Q. What is the correct payer ID for Aetna claims?
A. Use 60054 for Aetna claims.

Q. Can all claims be submitted electronically?
A. Yes. All claims can be submitted electronically.

Q. Can electronic claims be resubmitted electronically?
A. Yes, claims can be resubmitted electronically. This is especially beneficial if a claim is rejected through the vendor for missing or invalid information. Electronic claims reports identify these rejects, which can be corrected and resubmitted electronically. Duplicate claims logic is in place to reject exact duplicates of claims submitted electronically.

Q. Can old claims be submitted electronically?
A. Claims that are past timely filing limitations, often referred to as “old claims,” can be submitted electronically. Timely filing limits will be enforced appropriately during claims processing.

Q. If the dentist is having a problem with electronic claims rejecting, who do they call?
A. Call the contact number on the claims status report from the EDI vendor.

Q. Are primary payer Explanations of Benefits (EOBs) always required when Aetna is the secondary payer?
A. While Aetna does not always require the actual statement of payment or rejection from the primary carrier, we may sometimes need the actual document. Please provide the primary carrier’s payment amount in the “Remarks” field, and if we require the actual document, we will request it.
Q. What types of attachments are required for dental electronic claims?
A. Claim attachments are not always necessary. We encourage you to review our Claim Documentation Guidelines to determine which attachments, if any, are required. Or, submit claims without attachments. We will request any attachments if needed. Claim Documentation Guidelines are available on www.aetnadental.com, or by calling our National Dentist Line at 1-800-451-7715.

Q. Can I send attachments electronically?
A. You can send attachments to us electronically through the attachment vendor, National Electronic Attachment (NEA). This vendor allows you to transmit X-rays, periodontal charts, intraoral pictures, etc. via the Internet for insurance carriers to view in support of electronic claims. For more information, visit www.aetnadental.com, or contact the vendor directly at 1-800-782-5150.

Q. Can claim transactions be submitted without a CDT procedure code?
A. No, a valid CDT procedure code must be reflected, and the code must support the tooth in question, if applicable. Claims submitted with missing or invalid procedure codes will be rejected.

Q. Who should I contact if I have additional questions about electronic claims?
A. To assist you in determining whom to contact with questions on your electronic claims, please use the following as a guide:
   • If your claim is rejected at the vendor or clearinghouse level, contact your vendor.
   • If your claim is rejected at the carrier/payer level, contact your vendor.
   • If you have questions regarding claim handling (payment or denial), please call the National Dentist Line at 1-800-451-7715.

Aetna Dental has a website to provide you with tools and educational resources to help increase your efficiency while saving time and money. For additional frequently asked questions, visit www.aetnadental.com.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

What is ERA?
• ERA is an electronic communication containing claims payment information that can be easily viewed or printed.
• It is intended to replace your paper Explanation of Benefits (EOB) statement. Paper statements will be stopped after ERA enrollment.
• Since it is available online, the ERA gives you access to the information it contains sooner than with a mailed paper EOB.

What is EFT?
• When you sign up for EFT, your funds will be electronically deposited into the bank account of your choice.
• You can access your money faster — no waiting for your check to come in the mail and making trips to the bank.
• EFT eliminates the threat of lost or stolen checks.
• We have a secure process in place to perform this function. Dentists enrolling for EFT go through a 10-day test period with the financial institution where the account is held.
• Once an error-free test is performed, your EFT enrollment will become effective.
How do I enroll in ERA and/or EFT?

1. After determining which vendor best suits your needs, complete the enrollment form (please ensure you complete it in its entirety). As a security measure, we require two different signatures. You can find the form on www.aetnadental.com.

2. Mail or fax as directed on the enrollment form.

3. As part of your submission, include a voided check, or for a savings account, a preprinted deposit slip. Note this only applies for EFT enrollment.

Register for www.aetnadental.com

By registering online, you can get instant access to the secure features of aetnadental.com. This will allow you to submit claims electronically, check the status of a claim or perform real-time eligibility inquiries.

Information about www.aetnadental.com

Visit www.aetnadental.com for these benefits:

Electronic services via a secure website
  • Submit claims for multiple payers
  • Perform real-time eligibility inquiries
  • Make claims status inquiries
  • View Electronic Remittance Advice

Additional secure features
  • Access downcoding and bundling policies
  • Submit or change name, address, phone number, e-mail and NPI online
  • View dental office guides
  • Read our Dental Dialog newsletter

Information about joining the network
  • Learn about Aetna’s other dental networks
  • Request an application to join the other networks
Claim resources
• Get help with electronic transactions
• Check Claim Documentation Guidelines
• Access electronic claims processing information
• Learn about electronic attachments
• Register for Electronic Remittance Advice (ERA)/Electronic Funds Transfer (EFT)
• Download a claim form

Educational resources
• Receive continuing education credits available with access to free continuing education courses
• Use the Practice Management Coach
• Read the latest dental news and research

Other helpful tools
• DocFind provider directory — An online application designed to put information about participating providers at your fingertips. Visit DocFind for details about provider type, specialty, languages spoken, hospital affiliation, etc.
• Aetna Voice Advantage system — Our state-of-the-art interactive voice response technology makes it easy to do business with us through personalized call routing and self-service options for simple and common inquiries.
• Information on Aetna policies

And more...
We are continually adding online resources and tools to help you do business with us.

EOB statements online
Get your daily list of predeterminations and claims Explanation of Benefits (EOB) statements online through the secure section of www.aetnadental.com.

The easy-to-use, searchable format allows you to:
• Search for dental predeterminations.
• Search for any claim EOB.
• Produce an EOB statement for completed claims or predeterminations.

And, if you choose, you never have to receive paper predeterminations or EOBs again.

Aetna EDI Connect℠ (www.aetnaedi.com)
This is an electronic solution for the technically savvy — a free, direct-connect, web-based option for submitting your electronic transactions to Aetna. Best of all, with Aetna EDI Connect, there’s no third party involved and no website data entry required.
Use this website to send and receive X12-formatted files directly between you and Aetna using one of several protocols. If you are knowledgeable of X12-formatted data and HIPAA requirements, you may find this website to be appropriate for your business needs.

**Be up and running with Aetna EDI Connect in as little as 24 to 48 hours!**

Steps:
1. Read the Aetna EDI Connect Companion Guide available on [www.aetnaedi.com](http://www.aetnaedi.com). This document will help you determine if Aetna EDI Connect is the right choice for your office.
2. Register. To register, go to [www.aetnaedi.com](http://www.aetnaedi.com), select “Request an Account” and complete the screen. You will receive a confirmation e-mail.
3. Log in within 72 hours to change your password.
4. After you have logged in, you are ready to begin submitting test files.
5. Once you successfully submit your test files, you can request to move into “live” production.

**Send your claims attachments electronically to Aetna**

Attachments can be submitted to Aetna electronically. Claim attachments are not always necessary. We encourage you to review our Claim Documentation Guidelines to determine which attachments, if any, are required.

To streamline submitting claims with attachments to Aetna, you can send attachments electronically through the attachment vendor, National Electronic Attachment (NEA). This vendor allows you to transmit X-rays, periodontal charts, intraoral pictures, etc. via the Internet for us to view in support of electronic claims. For additional information, visit [www.aetnadental.com](http://www.aetnadental.com) or contact the vendor directly at 1-800-782-5150.

**Aetna Voice Advantage®**

*Aetna Voice Advantage, Aetna’s voice-recognition self-service technology, allows your dental office to:*

- Check on several patients in a single call to a single number. (Toll-free numbers can be found on member’s ID card.)
- Check coverage and benefits at the ADA code level. Choose to hear the information or have it faxed.
- Check the status of a claim(s). Choose to hear the information or have it faxed.
- Obtain a claims mailing address.
- Speak with a Member Services professional if needed.

**Other Aetna Voice Advantage features:**

**24-hour service** Automated member and dentist services are available day and night (24x7).

**Natural speech** A single automated voice uses friendly, conversational language, rather than robotic tones and instructions.

**Voice recognition** Just speak naturally, and you’ll discover how conversational the call will be.

**Voice to touch** Allows you the flexibility to switch from speaking to using the keypad.
National Provider Identifier: the one number you need for all payers

The HIPAA-regulated National Provider Identifier (NPI) number makes conducting electronic transactions with multiple payers easier.

Your NPI is the only number you need to supply to your payers on electronic claims, certifications and approvals. It replaces the many different provider numbers (Medicare and Medicaid numbers, and other payer proprietary numbers) you may have used for these transactions. (Your tax payer ID number [TIN] is an IRS requirement and is not replaced by the NPI.) The 10-digit NPI number is yours for life and does not convey information about you, such as your type of practice or your location.

Apply for your NPI now

We encourage all dentists to apply for an NPI, if you haven’t obtained one already. If you transmit dental health information by way of standard electronic transactions, as defined by HIPAA, you are required to obtain an NPI. This is true even if you use a billing agency to prepare transactions.

You can apply for an NPI by:
  • Going to https://nppes.cms.hhs.gov
  • Completing a paper application that you can download from this address
  • Calling 1-800-465-3203 to request a copy

Share it with Aetna:

Share your NPI as soon as possible and before you use it in transactions with us by:
  • Updating your personal information on www.aetnadental.com (site registration required)
  • Calling our National Dentist Line at 1-800-451-7715
  • Faxing your NPI to us at 860-754-1602

Use it in electronic transactions with Aetna

We can accept and use your NPI if it is included in a real-time transaction but only if it has been previously entered into our database. Otherwise, the transaction will reject. The NPI number must be used in all HIPAA standard electronic transactions.

For more information
  • Call the National Provider Identifier call center at 1-800-465-3203.

Resources available for you on W9 forms

Information on how to complete a W9 form, the IRS Matching Program and backup withholding can be found on the IRS website at www.irs.ustreas.gov.
Quality management

An important Aetna objective is the promotion of appropriate, affordable and timely dental care by participating dental providers to all plan members. As a result, Aetna has implemented a nationwide Dental Quality Management Program (QM Program). This QM Program is supported by various systems that tabulate, sort and analyze data collected on prospective and existing participating provider offices. Certain key components of the QM Program are summarized below.

Because the success of the QM Program depends upon the full cooperation of participating providers, network dentists are contractually required to participate in and comply with all requirements of Aetna’s QM Program, policies and procedures, whether or not they are specifically included in this Dental Office Guide. Aetna works closely with participating providers on tools that help measure dental care delivery effectiveness. We encourage you to contact us with any questions.

Aetna’s credentialing process has two major elements:

**Initial certification and credentialing**

Initial verification — Initial verification is performed on a prospective level prior to accepting a dentist into the network. Primary source verification is performed to verify or identify the following:

- Current dental licensure and expiration date
- DEA certification eligibility/licensure
- Appropriate certifications
- Highest educational level
- Current professional liability insurance
- Malpractice and disciplinary history
- Medicaid/Medicare sanctions
- Negative past professional histories

In addition, a participating dentist who renders general anesthesia and/or intravenous sedation must have a current and valid state certification or permit, if applicable.

**Periodic re-evaluation of credentials**

Ongoing verification — All existing dentists will be recredentialed every three years (or more frequently if required by state law). Primary source verification is completed to ensure current licensure and to obtain an update on past professional history.

Aetna is responsible for ensuring that all dentists participating in our dental plans are credentialed and recredentialed. **To that end, it is the participating dentist’s responsibility to notify his/her regional network support office when the dental office adds or terminates dentist associates.** The participating dentist is also responsible for notifying Aetna of any adverse action with respect to any of the credentialing and recredentialing elements noted above. Failure to do so may result in the termination of your participation agreement.

**Member satisfaction surveys**

Member satisfaction surveys assist in rating patient perception of the Aetna network. The feedback is based upon experiences of members who have had dental treatment rendered in participating dentists’ offices. The surveys address key patient issues, such as level of satisfaction with the program, access to care, utilization, perceptions of care received and interaction with your office staff. The surveys may be random or targeted to specific covered patients, certain plan sponsors or specific offices, or administered in a variety of combinations.
Member satisfaction is measured and monitored on an ongoing basis. Patient surveys are distributed on a periodic basis to a sample of members. We compile and analyze satisfaction data at the plan and network levels, and share results with customers and brokers/consultants.

**Utilization review**

Aetna employs various tools to analyze care provided to members of certain dental plans. The analysis includes treatment patterns emerging from a specific office, as well as comparing treatment patterns among peer network offices. A critical source for utilization analysis is the reporting of the treatment provided by the participating dentist. This information is received directly from your office by means of submission of claim forms. Treatment data from these forms is collected and sorted to facilitate the development of treatment pattern models and comparative benchmarks for commonly performed dental services. Reports are generated that provide a “snapshot” of the type of services delivered and the level of patient utilization. This aids in determining the impact of Aetna dental plans in a specific office. Alternative methods of reporting treatment provided to plan members must be approved by Aetna.

Members are periodically contacted to verify the services performed, to confirm the presentation of alternate treatment options, and to verify collection of appropriate and correct copayments. In addition to satisfying our oversight requirements, these periodic calls allow us to assess the need of any additional training in your office.

**Clinical policies and guidelines**

Aetna’s professional staff uses periodically updated clinical criteria and guidelines for review of coverage, medical necessity and appropriateness of treatment.

Explicit clinical policies, supported by documented technology assessments, guide utilization management (UM) and clinical decision making. The goal of these assessments is to evaluate significant new advances for availability to members as soon as appropriate, and to prevent unproven, ineffective and potentially harmful technologies from receiving coverage.

Policies are based on established and accepted professional “best practices.” The chief dental officer directs reviews of the dental literature and seeks input from Aetna’s professional staff, outside dental experts, the academic community and network dentists.

Dental review guidelines/rules are in place to identify and refer specific procedures and treatment plans to our professional staff, which reviews the case for compliance with treatment protocols and clinical policies.
Patient records
A complete patient record should be maintained for each member, documenting the member’s dental and medical history. Records should be legible, readily accessible, understandable, complete and in compliance with standards for confidentiality and dental/medical record-keeping practices.

Members’ dental records should include reports from referred-to and/or referring dentists and records of emergency care received. General information, including name, address, date of birth, sex, marital status, telephone number, member ID number, other insurance information (for example, coordination of benefits information), individual responsible for payment and emergency contact name/telephone number should be compiled and maintained.

A medical history should be completed at the initial visit and updated at each visit. The medical history, which should be signed and dated by both the member/guardian and clinician, should be comprehensive and include, without limitation, questions about allergies, medications, cardiovascular problems, other pertinent medical conditions and disease history, and such other information as Aetna may require from time to time. The member should be asked whether he/she is presently under the care of a physician, and medical alerts and drug allergies pertinent to the member’s care should be conspicuously noted in the member’s record in compliance with HIPAA privacy rules.

Examinations should include the following:

- Head and neck/soft tissue evaluation
- Dentition/periodontal evaluation
- Arch relationship and growth/development evaluation
- Appropriate radiographs
- Diagnoses

Each patient’s record should include a complete treatment plan detailing proposed treatments and alternatives. Any financial arrangements and informed consent forms should be included or cross-referenced to the treatment plan. Specialty treatment recommendations and follow-up should be documented. Progress notes must provide a clear and complete record of the member’s treatment and be signed by the clinician.

All patient records are considered confidential and should not be released to anyone without proper authorization. Please note that the enrollment forms signed by all Aetna Dental plan members contain an authorization to allow you to release necessary records to Aetna Dental, including independent dental consultants sent to your office by Aetna. In addition, the “Patient Authorization” block on all claim forms contains an authorization to release necessary records to Aetna Dental and to provide access to patient charts in order to perform reviews necessary to carry out our responsibilities under the Dental QM Program.

In addition to these authorizations, the provisions of your Participating Dentist Agreement require that such records be made available to Aetna Dental. No information obtained by Aetna Dental in the course of such reviews may be released to any other party without the express written authorization of the patient. All Aetna Dental employees, as well as the independent dentists who perform the facility/chart review, are trained in the maintenance of confidential information.
Access to care
An essential part of QM is the promotion of timely and appropriate dental care. Appropriate access to care can vary by the type of dental care needed. The following appointment availability standards are monitored via the QM Program:

I. Emergency care — patient must be seen immediately (or referred to ER, as appropriate)
   Emergency care is defined as those dental services needed to relieve pain or prevent worsening of a condition when that would be caused by delay. Coverage for emergency care is subject to state law.

II. Urgent care — must be provided same day or within 24 hours
   This care should apply to conditions involving swelling, bleeding, fever or infection.

III. Routine care — within 5 weeks (Primary Care within 10 days and Specialist within 15 days in Connecticut)
   Most routine care should be appointed within five weeks of request, provided the patient can schedule the next available appointment.

IV. Hygiene appointments — within 8 weeks
   Hygiene appointments must be scheduled within 8 weeks of the request, provided the patient can schedule the next available appointment. (It is recognized that requests for special times, such as after work hours or on weekends, may take longer to schedule for routine care and hygiene appointments.)

Access to care is monitored by our regional Provider Relations staff. Periodically, a written inquiry or phone call may be generated by an Aetna service representative to obtain information concerning your next available appointment. Member complaints regarding appointment availability are documented and investigated.

Note: Participating dentists are also required to comply with applicable state-specific requirements regarding appointment availability.

Billing practices
Aetna is committed to preventing health care fraud and inappropriate patient charges. Participating dentists must adhere to industry billing standards and avoid all forms of fraudulent billing.

Termination of participating dentist
A participating dentist may be terminated from the network for any misrepresentation(s) made on his/her application or failure to disclose any required information. Other causes for termination include, but are not limited to: fraud, failure to comply with the terms of the Participating Dentist Agreement or those outlined in this Dental Office Guide or any other supplementary material provided in writing by Aetna, failure to follow referral guidelines for specialty services, failure to meet participation criteria, failure to comply with grievance/complaint resolutions, etc.

Informed consent
Aetna expects all participating dentists to understand and comply with applicable legal requirements, as well as to adhere to the established standards of the dental community in which they practice, regarding informed consent from their patients. In general, it is the participating dentist’s duty to give patients adequate information and be reasonably sure the patient has understood it before proceeding to treat the patient. Informed consent documents should be written and signed prior to treatment being performed. This information helps members take active roles in making decisions about their dental health.
Disclosure of information

Dentists must complete and sign an application form, including responses to a series of confidential questions, in order to be credentialed and accepted for participation.

The information you provide must be complete and accurate as of the date of the application. You must update your information when changes occur. Updates should be submitted within 30 days or in accordance with your participating agreement. Failure to submit timely updates could result in your termination from the network.

Dentists are responsible for confirming the completeness and accuracy of information submitted by their staff; material omissions or inaccuracies in an application may not be excused on the grounds that the application was completed by someone other than the applicant dentist.

Claim Documentation Guidelines

We encourage you to review our Claim Documentation Guidelines, which are available on our website, www.aetnadental.com.
Conditions for participation and Participation Criteria

The Dentist Participation Criteria lists a variety of requirements that the participating dentist must meet. These requirements include standards such as your office’s physical attributes, practice coverage, patient access, office procedures, office records and insurance, and professional competence and qualifications. These criteria are used in our credentialing and recredentialing process and are attached to our current Dentist Agreements. A copy of the criteria is included below for your reference.

Primary Dentist Participation Criteria

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Primary Dentist participating in Company Plans and shall be enforced at the sole discretion of Company.¹

2. Each applicant for participation as a Primary Dentist must satisfactorily document evidence meeting the criteria listed herein for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.

3. Each participating Primary Dentist must continue to meet the following criteria for the duration of participation in the Company Plans.

4. Unless specifically permitted otherwise by Company, in its sole discretion, if Primary Dentist is part of a group practice, all dentists in the group must meet Company’s Participation Criteria and must agree to participate in all Company Plans in which Primary Dentist participates. If all dentists in the group do not meet Company’s criteria, the group cannot participate.

5. Each Primary Dentist must execute a Provider Agreement (with a footer dated 05/97 or later) or an alternative acceptable to Company, under which Primary Dentist agrees to provide services to Members of all health products, plans or programs issued, administered, or serviced by Company or one of its affiliates and specified in the Agreement.

6. Each applicant must fully complete the participation application form, and each applicant and participating Primary Dentist shall periodically supply to Company all requested information, including, but not limited to, the confidential information forms.

B. Office Standards

Each Primary Dentist’s office must:

1. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.

2. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.

3. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.

4. Be clean, presentable, and have a professional appearance.

5. Provide clean, properly equipped patient toilet and hand washing facilities.

6. Have a waiting room able to accommodate at least four (4) patients.

7. Have treatment rooms which are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.

8. Have a no-smoking policy.

¹Company refers to Aetna Health Management, LLC. and/or its affiliates.
9. Have at least one (1) staff person (in addition to Primary Dentist) on duty during normal office hours.

10. Provide evidence that Primary Dentist has a copy of current licenses for all dental hygienists and other non-dentist dental professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

11. Keep on file and make available to Company any state required practice protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in office.

12. Complete a Location Form identifying the address(es) and physical location(s) of office(s).

13. Have appropriate, safe x-ray equipment. Radiation protection devices, including, without limitation, lead aprons, should be available at all times and used according to professionally recognized guidelines (e.g., Food and Drug Administration).

   All equipment in Primary Dentist's office must comply with and maintain such certifications as may be required by Federal, state and local laws and regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association ("ADA") and the component state and local societies.

14. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; and maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association ("ADA") and the component state and local societies.

15. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.

16. Use an appointment book (or an electronic equivalent acceptable to Company) for scheduling of dental appointments. Appointments should be made in a manner which will prevent undue patient waiting time and in compliance with the access criteria in D. below.

17. Have evidence of a functional recall system in place for notifying Members of the need to schedule dental appointments.

18. Have documented emergency procedures, including procedures addressing treatment and transportation plans to provide for the safety of Members.

C. Coverage

1. Twenty-four (24) hours-a-day coverage for Members must be arranged with another Company Participating Primary Dentist except as provided in Section C.3 below.

2. The covering dentist’s office must be located within 45 minutes of the Primary Dentist’s office.

3. A Primary Dentist must submit for prior approval by Company any coverage arrangements made with a nonparticipating primary dentist. Approval of coverage by a nonparticipating primary dentist is subject to Company’s sole discretion, and such approval must be in writing. If Primary Dentist receives approval from Company for coverage by a nonparticipating primary dentist, Primary Dentist shall require such nonparticipating primary dentist to comply with applicable terms of the Agreement. Primary Dentist shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating primary dentist shall be compensated, provided, however, that Primary Dentist shall ensure that (except with respect to Reduced Fee Services) the covering dentist will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.
D. Access
1. Each Primary Dentist’s office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least three (3) days per week.

2. Each Primary Dentist or his or her covering primary dentist must respond to a Member within thirty (30) minutes after notification of an urgent call.

3. Each Primary Dentist must schedule appointments with Members within the following time frames (except as more speedily required by applicable law):
   - Emergency care: must be seen immediately (or referred to ER, as appropriate)
   - Urgent complaint: same day or within twenty-four (24) hours
   - Routine care: within five (5) weeks (eight (8) weeks in TX)
   - Routine hygiene: within eight (8) weeks (six (6) weeks in AZ and four (4) months in TX) (Ten (10) days in Connecticut)

4. Each Primary Dentist office must have adequate plans for managing an increase in patient load.

5. Each Primary Dentist must have a reliable system, twenty-four (24) hours-a-day, seven (7) days-a-week, for reaching a Primary Dentist in an emergency. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Patient Load
1. Each Primary Dentist practice must agree to and be able to demonstrate the capability to accept a minimum of two hundred and fifty (250) Members of capitated Plans, to the extent Primary Dentist participates in capitated Plans, unless otherwise approved in writing by Company. If Primary Dentist participates in Company’s dental preferred provider organization (PPO or PDN) plan(s), Primary Dentist may not close his/her practice to members of those plans.

2. Each Primary Dentist must designate by age, according to Company guidelines, those Members for whom Primary Dentist will provide care.

3. Any use of a dental hygienist or other non-dentist dental professional by a Primary Dentist must comply with Company’s then current policies and all applicable legal requirements regarding practice of such dental professionals.

F. Office Records
1. A Primary Dentist must demonstrate, at the time of application and thereafter as requested by Company, that his/her dental records are legible, reproducible and otherwise meet Company’s standards for confidentiality, and dental/medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members’ dental records shall include reports from referred and/or referring providers, records of emergency care received, a complete medical history of the Member which is updated periodically and includes, without limitation, any allergies, medications, cardiovascular problems, high blood pressure and/or diabetes of Member, and such other information as Company may require from time to time.

2. Each Member encounter must be documented in writing and signed or initialed by the Primary Dentist or as required by state law.
G. **Professional Liability Insurance**

1. During the entire term of this Agreement, Primary Dentist shall maintain insurance or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by primary dentist’s in the state or region in which the Primary Dentist operates. Primary Dentist’s insurance shall cover the acts and omissions of Primary Dentist, as well as Primary Dentist’s agents and employees. Certificates of insurance or other documentation as appropriate to show evidence of such coverage shall be delivered to Company upon request. Primary Dentist must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

H. **Philosophy**

1. A Primary Dentist must be supportive of the philosophy and concept of managed care and Company. A Primary Dentist shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.

2. Each Primary Dentist shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient’s condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

3. Primary Dentist’s obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Primary Dentist to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Primary Dentist’s legal or ethical obligations.

4. Primary Dentist is encouraged to discuss Company’s provider reimbursement methodology with Primary Dentist’s patients who are Members, subject only to Primary Dentist’s general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the reimbursement methodology under which Primary Dentist is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. **PROFESSIONAL CRITERIA**

A. **Licensure**

1. A Primary Dentist must have a valid, unencumbered license to practice dentistry in his/her state of practice, or in the case of a Primary Dentist with an encumbered license, the applicant demonstrates to the applicable peer review committee’s satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.

2. A Primary Dentist must be eligible for or possess an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification, unless otherwise approved in writing by Company.

3. A Primary Dentist who renders general anesthesia and/or intravenous sedation services must have a current and valid state certification or permit, if available in the applicable state.

B. **Education**

1. A Primary Dentist must be a graduate of a school of dentistry which is accredited by the Commission on Dental Accreditation (of the ADA) or be a graduate of a non-accredited school of dentistry and have completed a pre-licensure advanced education program at an ADA accredited school of dentistry.
C. **Continuing Education**

1. A Primary Dentist shall meet the continuing education requirements required by state law. An applicant for participation in Company must demonstrate that he/she has met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

II. **PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA**

A. **General**

1. Primary Dentist must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of dentistry.

2. Primary Dentist must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

B. **Professional Liability Claims History**

1. Primary Dentist must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

C. **History of Involuntary Termination or Restriction**

1. Primary Dentist must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, or reduction or restriction of duties or privileges, or of a contract to provide health care services, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

D. **Notification of Adverse Actions or Limitations**

1. Primary Dentist shall provide immediate notice to Company of any adverse action relating to said dentist’s: (i) hospital staff privileges (if applicable); (ii) DEA or state narcotics numbers; (iii) participation in the Medicare, Medicaid, or other governmental programs; or (iv) state licensure, certification, accreditation or other authorization required by law or the Agreement, including censure. Each applicant and Primary Dentist shall inform the Company in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, “adverse action” includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusions; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subject to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and
initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including without limitation denial, termination or other sanctions imposed pursuant to Company’s credentialing/quality improvement programs.

2. Primary Dentist shall provide immediate notice to Company of any condition or circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Primary Dentist.

3. Primary Dentist shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.

4. Primary Dentist shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Primary Dentist to report.

E. References

1. Each applicant for participation must supply references as specified in the application and as requested by the applicable peer review committee.

2. The applicable peer review committee shall have the right to act on any reference or information received from a Primary Dentist’s colleagues or other professionals. Primary Dentist waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable peer review committee.

These criteria may be modified at the sole discretion of Company.

Please refer to the California Participation Criteria for the criteria specific to California Dental Maintenance Organization (DMO®) participating providers.

Specialist Dentist Participation Criteria

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Specialist Dentist participating in Plans and shall be enforced at the sole discretion of Company.

2. Each applicant for participation as a Specialist Dentist must satisfactorily document evidence meeting the criteria listed herein for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.

3. Each participating Specialist Dentist must continue to meet the following criteria for the duration of participation in the Company Plans.

4. Unless specifically permitted otherwise by Company in its sole discretion, if Specialist Dentist is part of a group practice, all dentists in the group must meet Company’s Participation Criteria and must agree to participate in all Company Plans in which Specialist Dentist participates. If all dentists in the group do not meet Company’s criteria, the group cannot participate.

5. Each Specialist Dentist must execute a Provider Agreement (with a footer dated 05/97 or later) or an alternative acceptable to Company, under which Specialist Dentist agrees to provide services to Members of all health products, plans or programs issued, administered, or serviced by Company or one of its affiliates and specified in the Agreement.
6. Each applicant must fully complete the participation application form, and each applicant and participating Specialist Dentist shall periodically supply to Company all requested information, including, but not limited to, the confidential information forms.

B. Office Standards

Each Specialist Dentist’s office must:

1. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
2. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
3. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
4. Be clean, presentable, and have a professional appearance.
5. Provide clean, properly equipped patient toilet and hand washing facilities.
6. Have a waiting room able to accommodate at least four (4) patients.
7. Have treatment rooms which are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
8. Have a no-smoking policy.
9. Have at least one (1) staff person (in addition to Specialist Dentist) on duty during normal office hours.
10. Provide evidence that Specialist Dentist has a copy of current licenses for all dental hygienists and other non-dentist dental professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).
11. Keep on File and make available to Company any state required practice protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in office.
12. Complete a Location Form identifying the address(es) and physical location(s) of office(s).
13. Have appropriate, safe x-ray equipment. Radiation protection devices, including, without limitation, lead aprons, must be available at all times and used according to professionally recognized guidelines (e.g., Food and Drug Administration). All equipment in Specialist Dentist’s office must comply with and maintain such certifications as may be required by federal, state and local laws and regulations (including, but not limited to, laws and regulations regarding maintenance and calibration of equipment).
14. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; and maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (“ADA”) and the component state and local societies.
15. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
16. Use an appointment book (or an electronic equivalent acceptable to Company) for scheduling of dental appointments. Appointments should be made in a manner which will prevent undue patient waiting time and in compliance with the access criteria in D. below.
17. Have evidence of a functional recall system in place for notifying Members of the need to schedule dental appointments.
18. Have documented emergency procedures, including procedures addressing treatment and transportation plans to provide for the safety of Members.
C. Coverage

1. When applicable to the relevant specialty, as determined by Company in its sole discretion Specialist Dentist shall ensure that twenty-four (24) hour-a-day coverage for Members is arranged with another Company Participating Specialist Dentist, except as otherwise provided in Section C.3 below.

2. The covering dentist's office must be located within sixty (60) minutes of the Specialist Dentist's office.

3. A Specialist Dentist must submit for prior approval by Company any coverage arrangements made with a nonparticipating specialist dentist. Approval of coverage by a nonparticipating specialist dentist is subject to Company's sole discretion, and such approval must be in writing. If Specialist Dentist receives approval from Company for coverage by a nonparticipating specialist dentist, Specialist Dentist shall require such nonparticipating specialist dentist to comply with applicable terms of the Agreement. Specialist Dentist shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating specialist dentist shall be compensated, provided, however, that Specialist Dentist shall ensure that (except with respect to Reduced Fee Services) the covering dentist will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

D. Access

1. Each Specialist Dentist's office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least three (3) days per week.

2. Each Specialist Dentist or his or her covering specialist dentist must respond to a Member within thirty (30) minutes after notification of an urgent call.

3. Each Specialist Dentist must schedule appointments with Members within the following time frames (except as more speedily required by applicable law):
   - Emergency care: must be seen immediately (or referred to ER, as appropriate)
   - Urgent complaint: same day or within twenty-four (24) hours
   - Routine care: within five (5) weeks (eight (8) weeks in TX) (Fifteen (15) days in Connecticut)

4. Each Specialist Dentist office must have adequate plans for managing an increase in patient load.

5. Unless deemed inapplicable to the relevant specialty by Company, in its sole discretion, each Specialist Dentist must have a reliable system, twenty-four (24) hours-a-day, seven (7) days-a-week, for reaching a Specialist Dentist in an emergency. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Patient Load

1. Each Specialist Dentist must designate by age, according to Company guidelines, those Members for whom Specialist Dentist will provide care. If Specialist Dentist participates in Company's dental preferred provider organization (PPO or PDN) plan(s), Specialist Dentist may not close his/her practice to members of those plans.

2. Any use of a dental hygienist or other non-dentist dental professional by a Specialist Dentist must comply with Company's then current policies and all applicable legal requirements regarding practice of such dental professionals.
F. Office Records

1. A Specialist Dentist must demonstrate, at the time of application and thereafter as requested by Company, that his/her dental records are legible, reproducible and otherwise meet Company’s standards for confidentiality, and dental/medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members’ dental records shall include reports from referred and/or referring providers, records of emergency care received, a complete medical history of the Member which is updated periodically and includes, without limitation, any allergies, medications, cardiovascular problems, high blood pressure and/or diabetes of Member, and such other information as Company may require from time to time.

2. Each Member encounter must be documented in writing and signed or initialed by the Specialist Dentist or as required by state law.

G. Professional Liability Insurance

1. During the entire term of this Agreement, Specialist Dentist shall maintain insurance or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by specialist dentist’s in the state or region in which the Specialist Dentist operates. Specialist Dentist’s insurance shall cover the acts and omissions of Specialist Dentist, as well as Specialist Dentist’s agents and employees. Certificates of insurance or other documentation as appropriate to show evidence of such coverage shall be delivered to Company upon request. Specialist Dentist must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

H. Philosophy

1. A Specialist Dentist must be supportive of the philosophy and concept of managed care and Company. A Specialist Dentist shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.

2. Each Specialist Dentist shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient’s condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

3. Specialist Dentist’s obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Specialist Dentist to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Specialist Dentist’s legal or ethical obligations.

4. Specialist Dentist is encouraged to discuss Company’s provider reimbursement methodology with Specialist Dentist’s patients who are Members, subject only to Specialist Dentist’s general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the reimbursement methodology under which Specialist Dentist is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.
II. PROFESSIONAL CRITERIA

A. Licensure

1. A Specialist Dentist must have a valid, unencumbered license to practice dentistry in his/her state of practice, or in the case of a Specialist Dentist with an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.

2. A Specialist Dentist must be eligible for or possess an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification, unless otherwise approved in writing by Company.

3. A Specialist Dentist who renders general anesthesia and/or intravenous sedation services must have a current and valid state certification or permit, if available in the applicable state.

B. Education

1. A Specialist Dentist must be a graduate of a school of dentistry which is accredited by the Commission on Dental Accreditation (of the ADA) or be a graduate of a non-accredited school of dentistry and have completed a pre-licensure advanced education program at an ADA accredited school of dentistry.

2. A Specialist Dentist is required to have successfully completed a clinical postgraduate training program in a dental subspecialty (orthodontics, periodontics, etc.) which is accredited by the Commission on Dental Accreditation of the American Dental Subspecialty Board recognized by the American Dental Association (ADA), for which the provider requests to be recognized.

C. Continuing Education

1. A Specialist Dentist shall meet the continuing education requirements required by state law. An applicant for participation in Company must demonstrate that he/she has met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

III. PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA

A. General

1. Specialist Dentist must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of dentistry.

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1. Specialist Dentist must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

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E. References

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These criteria may be modified at the sole discretion of Company.

*Please refer to the California Participation Criteria for the criteria specific to California Dental Maintenance Organization (DMO®) participating providers.*
Aetna Dental
Preferred Dental Organization
Participating Dental Network
Affordable Health Choices
Exclusive Provider Plan
Vital Savings by Aetna
Aetna Dental Access
Aetna Dental Administrators

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Value Plus Program

Aetna has contracted with a number of companies to give you access to discounted products and services. Through this unique opportunity, you can save hundreds of dollars on dental supplies and laboratory services. These companies provide products and services you may use every day in your practice.

Visit www.aetnadental.com for more information.

The Value Plus Program may include access to discounts on:

- Dental supplies
- Spore testing
- Dental lab services
- Repair of hand pieces and small equipment
- Practice management software and computer hardware
- Customized telephone messages
- Charting and record-keeping systems

Aetna’s provision of access to the discounts included in the Value Plus Program does not constitute an endorsement of any vendor, product or service offered as part of the program. All vendors are independent contractors and are not employees, agents or participating providers with Aetna. Vendors, products and discounts are subject to change without notice.
Member rights and responsibilities

**Discrimination**

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, sex, age, religion, color, disability, national origin, marital status, sexual orientation or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV-positive status).

**Confidentiality policy**

Aetna’s provider participation agreements require that all dentists maintain patient information in a current, detailed, organized and comprehensive manner and in accordance with customary dental practice, applicable state and federal laws, and accreditation standards. Accordingly, participating dentists must have in place appropriate policies and procedures to implement these confidentiality requirements. In addition to complying with customary medical practice, applicable state and federal laws, and accreditation standards, these policies and procedures should include, but not be limited to, protection of patient confidentiality under the following circumstances:

- The release of information at the request of the member and in response to a legal request for information.
- The use of a release form, where applicable, is suggested.
- The storage of medical records, including restricted access and maintenance of such records, in secured files.
- Transmitting medical records electronically.
- Educating employees regarding confidentiality of medical records and patient information.

**Informed consent**

Aetna expects all participating dentists to understand and comply with applicable legal requirements, as well as to adhere to the policies of the dental community in which they practice, regarding informed consent from their patients. In general, it is the participating dentist’s duty to give patients adequate information and be reasonably sure the patient has understood it before proceeding to treat the patient. Informed consent documents should be written and signed.
Members have the following rights

**Dental members have the right to:**

- Get up-to-date information about the dentists who participate in the plan.
- Obtain necessary care from participating dentists, including participating specialty dentists (with referrals if required by the plan) or from any licensed dentist if the plan covers out-of-network services.
- Be told by the dentist office how to make appointments and get dental care during and after office hours.
- Be told how to get in touch with the dentist or a back-up dentist 24 hours a day, every day.
- Call 911 in a situation that might be life threatening.
- Receive a copy of their dental records for transfer to a new office.
- Be treated with respect for their privacy and dignity.
- Have their dental records kept private, except as otherwise required by law or with their approval.
- Have the dentist help make decisions about dental care.
- Refuse any proposed dental treatment.
- Discuss with the dentist their treatment plan and all dental care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that their dentist cannot be penalized for filing a complaint or appeal.
- Get up-to-date information about the services covered by their plan, for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about copayments and fees, if any, they must pay.
- Be told how to file a complaint or appeal with the plan.
- Receive a prompt reply when they ask plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.
Members have the following responsibilities

Dental members have the responsibility to:

• Follow the directions and advice the member and dentist have agreed upon.
• Tell their dentist promptly when they have unexpected problems or symptoms.
• Tell their dentist if they do not understand the treatment received and to ask if they do not understand how to care for their condition.
• Understand that participating dentists and any other dental care providers who care for them are not employees of Aetna.
• Promptly follow Aetna’s complaint and appeal procedures if they believe they need to submit a complaint or appeal.
• Give correct and complete information to dentists and any other health care providers who care for them.
• Treat dentists and their staffs with respect.
• Tell Aetna about other medical/dental coverage.
• Not be involved in dishonest activity directed to the plan or any dentist.
• Read and understand their plan benefits. Know what services are covered and what services are not covered.

The member may have additional rights and responsibilities depending upon the state law applicable to the plan.
The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification and Privacy (AS&P)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress and signed into law in 1996. HIPAA addresses a broad range of subjects, including a set of administrative simplification provisions (HIPAA AS&P), the purpose of which is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of data and to protect the security and privacy of member health information.

Privacy is an important topic in today’s electronic world where, with the simple touch of a key, information can be transmitted quickly to a very broad audience. Much of the public’s attention is focusing on member health information because it is sensitive in nature. Is it being properly protected? Who should have access to it, and when? Under what circumstances should we and others within the health care system share it?

Aetna has brought itself into compliance with the AS&P components of HIPAA by addressing these questions and taking steps to control information disclosure by reviewing and, where necessary, making changes to the company policies that safeguard the confidentiality of our member health information.

As part of the effort to improve the day-to-day exchange of data between dentists and payers, HIPAA AS&P includes a requirement mandating the use of certain procedure codes for standard dental transactions. HIPAA-approved code sets are present in the current version of the CDT. Therefore, nonstandard codes may not be used, and Aetna will not accept claims submissions using such codes. To remain compliant, all contracted dental providers treating Aetna members must use only HIPAA-approved code sets in claims submissions involving standard dental transactions.
Network Bulletins

- 2017-09  New CDT 2018 codes
- 2017-04  Claim administration policy changes – effective July 17, 2017
- 2017-01  Changes to the provider appeal process
- 2016-09  New CDT 2017 codes
- 2016-01  New Aetna LeapSM and Innovation Health LeapSM plans
- 2015-09  New CDT 2016 codes
- 2014-10  New CDT 2015 codes
- 2013-12  Dental card suppression
- 2013-10  New CDT 2014 codes
- 2013-09  New dental benefits embedded in Aetna medical plans
  Applies to All contracted Aetna dental PPO providers
- 2013-09  New dental benefits embedded in Aetna and Innovation Health medical plans
  Applies to All contracted Aetna dental PPO providers in DC, MD, and VA
Network Bulletin

Date: September 2017
From: Lisa Stepanian, Executive Director, Dental Network Operations
Subject: New CDT 2018 codes
Applies to: PPO*

This bulletin is part of your Dental Office Guide. After reviewing this information, please keep it with your guide for future reference.

New CDT® 2018 codes
The American Dental Association has issued new Current Dental Terminology (CDT) codes effective January 1, 2018. We've listed them below.

We’re here to help
If you have questions, call our National Dentist Line at 1-800-451-7715. Thanks for your continued participation and support of Aetna Dental® plans.

<table>
<thead>
<tr>
<th>CDT 2018 Code</th>
<th>Nomenclature</th>
<th>Contracted Fees for CDT 2018 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100 - D0999</td>
<td>I. Diagnostic</td>
<td></td>
</tr>
<tr>
<td>D0411</td>
<td>HbA1c in-office point of service testing</td>
<td>Not covered</td>
</tr>
<tr>
<td>D5000-D5899</td>
<td>VI. Prosthodontics (Removable)</td>
<td></td>
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<tr>
<td>D5511</td>
<td>repair broken complete denture base, mandibular</td>
<td>100% of negotiated fee for D5510</td>
</tr>
<tr>
<td>D5512</td>
<td>repair broken complete denture base, maxillary</td>
<td>100% of negotiated fee for D5510</td>
</tr>
<tr>
<td>D5611</td>
<td>repair resin partial denture base, mandibular</td>
<td>100% of negotiated fee for D5610</td>
</tr>
<tr>
<td>D5612</td>
<td>repair resin partial denture base, maxillary</td>
<td>100% of negotiated fee for D5610</td>
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<tr>
<td>D5621</td>
<td>repair cast partial framework, mandibular</td>
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<tr>
<td>D5622</td>
<td>repair cast partial framework, maxillary</td>
<td>100% of negotiated fee for D5620</td>
</tr>
</tbody>
</table>

CDT is a registered trademark of the American Dental Association. Used pursuant to license agreement.

* In Texas, the dental PPO is known as the participating dental network (PDN). DMO insurance plans are offered, administered and/or underwritten Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. (Aetna) Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). ©2017 Aetna Inc.

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<tr>
<td>D6000-D6999</td>
<td>VIII. Implant Services</td>
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<tr>
<td>D6096</td>
<td>remove broken implant retaining screw</td>
<td>50% of negotiated fee for D6090, with a minimum allowance of $50.00</td>
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<td>D6118</td>
<td>implant/abutment supported interim fixed denture for edentulous arch – mandibular</td>
<td>Not covered</td>
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<tr>
<td>D6119</td>
<td>implant/abutment supported interim fixed denture for edentulous arch – maxillary</td>
<td>Not covered</td>
</tr>
<tr>
<td>D7000-D7999</td>
<td>X. Oral and Maxillofacial Surgery</td>
<td></td>
</tr>
<tr>
<td>D7296</td>
<td>corticotomy - one to three teeth or tooth spaces, per quadrant</td>
<td>Not covered</td>
</tr>
<tr>
<td>D7297</td>
<td>corticotomy – four or more teeth or tooth spaces, per quadrant</td>
<td>Not covered</td>
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<tr>
<td>D7979</td>
<td>non-surgical sialolithotomy</td>
<td>50% of negotiated fee for D7980</td>
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<tr>
<td>D8000-D8999</td>
<td>XI. Orthodontics</td>
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<td>D8695</td>
<td>removal of fixed orthodontic appliances for reasons other than completion of treatment</td>
<td>Not covered</td>
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<td>D9000-D9999</td>
<td>XII. Adjunctive General Services</td>
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<td>D9222</td>
<td>deep sedation/general anesthesia – first 15 minutes</td>
<td>125% of negotiated fee for D9223</td>
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<tr>
<td>D9239</td>
<td>intravenous moderate (conscious) sedation/anesthesia – first 15 minutes</td>
<td>125% of negotiated fee for D9243</td>
</tr>
<tr>
<td>D9995</td>
<td>teledentistry – synchronous; real-time encounter</td>
<td>Inclusive to the procedure performed</td>
</tr>
<tr>
<td>D9996</td>
<td>teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review</td>
<td>Inclusive to the procedure performed</td>
</tr>
</tbody>
</table>
From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following changes that will take effect for all Aetna Dental® plans on July 17, 2017:

**D4355 - Debridement, full mouth to enable comprehensive periodontal evaluation and diagnosis**
To align with the ADA descriptor of D4355, the following changes are being made to our claim processing policies:
- D4355 will be denied when performed on the same date of service as D0120.
- D0145, D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355.
- D1110, D1120, D4910, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.

**D0210 - Intraoral - complete series of radiographic images**
To align with the ADA descriptor of D0210, additional intraoral periapical D0220 & D0230 and bitewing radiographic images D0270, D0272, D0273, D0274 and D0277 will not be separately eligible when performed on the same date of service as D0210.

**D0277 - Vertical bitewings - 7 to 8 radiographic images**
Bitewing radiographic images D0270, D0272, D0273 and D0274 will be denied when performed on the same date of service as D0277.

**D3310, D3320, D3330, D3331, D3332 and D3333 – Endodontic therapy with intraoral periapical radiographic images**
To align with the ADA nomenclature for endodontic therapy, periapical radiographic images D0230 will be denied when performed in conjunction with endodontic therapy on the same date of service. D0230 is part of the endodontic therapy. Diagnostic evaluation and images are not part of the endodontic therapy.

**D3310, D3320 and D3330 – Endodontic therapy**
Claims submitted for D3310, D3320 or D3330 will be denied if there is a history of Root Canal Therapy on the same tooth. Endodontic retreatment should be submitted under codes D3346, D3347 and D3348 for consideration.
D4910 - Periodontal maintenance and D4341/D4342 - Periodontal scaling and root planing
The descriptor for D4910 periodontal maintenance includes removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing as well as polishing where indicated.
D4341/D4342 periodontal scaling and root planing is not separately eligible when performed on the same day as a D4910.

Reminder - D2950 - Core build up, including any pins when required
To assure that benefits are being applied appropriately, and to gather data on submitted buildups to inform future plan designs, we now require pre-and post-operative radiographic images or photographs that illustrates the need for and placement of a buildup.

We’re here to help
If you have questions, call us at 1-800-451-7715. You can visit aetnadental.com to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Current Dental Terminology (CDT) (including procedure code, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association.
Network Bulletin

Date: January 2017

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: Changes to the provider appeal process

Applies to: All Aetna Dental® Plans

Starting May 1, 2017, the provider appeal policy for members enrolled in commercial plans is changing. Here are the changes:

- Elimination of Level 2 appeals for practitioner
- Require the use of a specific form when submitting appeal requests

If you want to appeal a claim
Submit it in writing using the Practitioner and Provider Complaint and Appeal Request form. There is only one opportunity to appeal, so be sure to include all supporting documentation.

The form will not be required until May 1, 2017, but we encourage you to start using it now.

Why the changes
This will eliminate unnecessary steps and help ensure that we have the information we need to do a full review of the request. These changes apply to all providers, participating and nonparticipating.

What’s not changing
You can still ask for an informal reconsideration of your claim before you file a formal appeal.

Also, the member’s appeal rights have not changed. If you are filing an appeal as a member’s designated representative, the member still has the number of appeals set forth in the member’s plan documents.

We’re here to help
If you have questions, call us at 1-800-451-7715. Thank you for your continued participation in and support of Aetna Dental plans.
Network Bulletin

Date: September 2016

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2017 codes

Applies to: PPO

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in the Network Bulletin section of your guide for future reference.

Below are the new CDT-2017 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2017 codes starting January 1, 2017.

Fee information for the new CDT-2017 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We’re here to help

If you have any questions, please call our Dentist Contracting Hotline at 1-800-776-0537. Thanks for your participation in our dental network and continued support of Aetna Dental® plans.

<table>
<thead>
<tr>
<th>CDT 2017 Code</th>
<th>Nomenclature</th>
<th>Contracted Fees for CDT 2017 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100 - D0999</td>
<td>I. Diagnostic</td>
<td></td>
</tr>
<tr>
<td>D0414</td>
<td>laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report</td>
<td>Not covered</td>
</tr>
<tr>
<td>D0600</td>
<td>non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum</td>
<td>Not covered</td>
</tr>
<tr>
<td>D1000-D1999</td>
<td>II. Preventive</td>
<td></td>
</tr>
<tr>
<td>D1575</td>
<td>distal shoe space maintainer – fixed – unilateral</td>
<td>110% of negotiated fee for D1510</td>
</tr>
<tr>
<td>D4000-D4999</td>
<td>V. Periodontics</td>
<td></td>
</tr>
<tr>
<td>D4346</td>
<td>scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation</td>
<td>115% of negotiated fee for D1110</td>
</tr>
</tbody>
</table>

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In Texas, the dental PPO is known as the Participating Dental Network (PDN).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).
<table>
<thead>
<tr>
<th>CDT 2017 Code¹</th>
<th>Nomenclature</th>
<th>Contracted Fees for CDT 2017 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6000-D6999</td>
<td>VIII. Implant Services</td>
<td></td>
</tr>
<tr>
<td>D6081</td>
<td>scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure</td>
<td>50% of negotiated fee for D4342</td>
</tr>
<tr>
<td>D6085</td>
<td>provisional implant crown</td>
<td>100% of negotiated fee for D2799</td>
</tr>
<tr>
<td>D9000-D9999</td>
<td>XII. Adjunctive General Services</td>
<td></td>
</tr>
<tr>
<td>D9311</td>
<td>consultation with a medical health care professional</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9991</td>
<td>dental case management - addressing appointment compliance barriers</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9992</td>
<td>dental case management – care coordination</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9993</td>
<td>dental case management – motivational interviewing</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9994</td>
<td>dental case management – patient education to improve oral health literacy</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Network Bulletin

Subject: New Aetna Leap℠ and Innovation Health Leap℠ plans
Applies to: All contracted Aetna dental Preferred Provider Organization (PPO) providers

This bulletin is part of your Dental Office Guide. After reviewing this, place it in your guide for future reference.

Important changes
On January 1, 2016, we began offering our new Individual plans in these areas/counties:

- AZ – Maricopa
- PA – Bucks, Chester, Delaware, Philadelphia, Montgomery
- NC – Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanley, Union
- SC – Lancaster, York
- VA – Alexandria City, Arlington County, Clarke County, Fairfax City, Fairfax County, Falls Church City, Frederick County, Fredericksburg City, Loudoun County, Manassas City, Manassas Park City, Page County, Prince William County, Shenandoah County, Spotsylvania County, Stafford County, Warren County, Winchester City

Although we offer the plans in select areas, members may still seek benefits nationally.

What this means for you
As a contracted dentist in our Dental PPO network, you may have Aetna Leap and Innovation Health Leap medical plan members coming to your office for pediatric oral services. These will be covered services for dependent children up to the age of 19 (or higher age if your state requires).

Your patients will have “Aetna Leap” or “Innovation Health Leap” in their plan name listed on their medical ID card. These pediatric benefits plans/programs use the Dental PPO fee schedule.

Digital member ID card is key to care
Members can get and print their digital member ID card from their secure member website. They can also ask for a plastic ID card. Look for the 12-digit numeric ID number beginning with “10.”

Here are sample ID cards:
Sending claims and correspondence

- For all plans except Innovation Health, keep sending claims electronically via payer ID# 60054.
- For Innovation Health claims, use payer ID# 40025.

For paper claims and correspondence, send to:

**Charlotte (NC & SC) and AZ**
Aetna
PO Box 14079
Lexington, KY 40512-4079

**Southeastern PA**
Aetna
PO Box 981106
El Paso, TX 79998-1106

**Northern VA**
Innovation Health
PO Box 981106
El Paso, TX 79998-1106

Checking eligibility and general questions

To check eligibility:

- Go to [www.aetnadental.com](http://www.aetnadental.com) and use real-time eligibility, if registered.
- Call 1-888-MDAetna (1-888-632-3862) for Aetna Leap plans.
- Call 1-844-289-4503 for Innovation Health Leap plans.

If you have general questions, just call us at the numbers above.

In Texas, the dental PPO is known as the participating dental network (PDN).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) members receive dental benefits from Aetna. Aetna and its affiliates provide certain management services for Innovation Health.

JR-418-16 (1/16)
Network Bulletin

Date: September 2015
From: Joel Hodge, Head of Dental Networks and Administration
Subject: New CDT 2016 codes
Applies to: PPO

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in the Network Bulletin section of your guide for future reference.

Below are the new CDT-2016 codes
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2016 codes effective January 1, 2016.

Fee information for the new CDT-2016 codes
Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We’re here to help
If you have any questions, please call our Dentist Contracting Hotline at 1-800-776-0537. Thanks for your participation in our dental network and continued support of Aetna Dental® plans.

| CDT 2016 Code | Nomenclature | Contracted Fees for CDT 2016 codes are based on the following:
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100 - D0999</td>
<td>I. Diagnostic</td>
<td></td>
</tr>
<tr>
<td>D0251</td>
<td>extra-oral posterior dental radiographic image</td>
<td>75% of negotiated fee for D0250</td>
</tr>
<tr>
<td>D0422</td>
<td>collection and preparation of genetic sample material for laboratory analysis and report</td>
<td>Not covered</td>
</tr>
<tr>
<td>D0423</td>
<td>genetic test for susceptibility to diseases – specimen analysis</td>
<td>Not covered</td>
</tr>
<tr>
<td>D1000-D1999</td>
<td>II. Preventive</td>
<td></td>
</tr>
<tr>
<td>D1354</td>
<td>interim caries arresting medicament application</td>
<td>100% of negotiated fee for D1351</td>
</tr>
<tr>
<td>D4000-D4999</td>
<td>V. Periodontics</td>
<td></td>
</tr>
<tr>
<td>D4283</td>
<td>autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
<td>55% of negotiated fee for D4273</td>
</tr>
</tbody>
</table>

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Contracted Fees for CDT 2016 codes are based on the following:

<table>
<thead>
<tr>
<th>CDT 2016 Code</th>
<th>Nomenclature</th>
<th>Contracted Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4285</td>
<td>non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
<td>55% of negotiated fee for D4275</td>
</tr>
<tr>
<td>D5000-D5899</td>
<td>VI. Prosthodontics (Removable)</td>
<td></td>
</tr>
<tr>
<td>D5221</td>
<td>immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)</td>
<td>115% of negotiated fee for D5211</td>
</tr>
<tr>
<td>D5222</td>
<td>immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)</td>
<td>115% of negotiated fee for D5212</td>
</tr>
<tr>
<td>D5223</td>
<td>immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) Includes limited follow-up care only; does not include future rebasing</td>
<td>115% of negotiated fee for D5213</td>
</tr>
<tr>
<td>D5224</td>
<td>immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>115% of negotiated fee for D5214</td>
</tr>
<tr>
<td>D7000-D7999</td>
<td>X. Oral and Maxillofacial Surgery</td>
<td></td>
</tr>
<tr>
<td>D7881</td>
<td>occlusal orthotic device adjustment</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8000-D8999</td>
<td>XI. Orthodontics</td>
<td></td>
</tr>
<tr>
<td>D8681</td>
<td>removable orthodontic retainer adjustment</td>
<td>100% of negotiated fee for D5421</td>
</tr>
<tr>
<td>D9000-D9999</td>
<td>XII. Adjunctive General Services</td>
<td></td>
</tr>
<tr>
<td>D9223</td>
<td>deep sedation/general anesthesia – each 15 minute increment</td>
<td>50% of negotiated fee for D9220</td>
</tr>
<tr>
<td>D9243</td>
<td>intravenous moderate (conscious) sedation/analgesia – each 15 minute increment</td>
<td>50% of negotiated fee for D9241</td>
</tr>
<tr>
<td>D9932</td>
<td>cleaning and inspection of removable complete denture, maxillary</td>
<td>100% of negotiated fee for D9931</td>
</tr>
<tr>
<td>D9933</td>
<td>cleaning and inspection of removable complete denture, mandibular</td>
<td>100% of negotiated fee for D9931</td>
</tr>
<tr>
<td>D9934</td>
<td>cleaning and inspection of removable partial denture, maxillary</td>
<td>100% of negotiated fee for D9931</td>
</tr>
<tr>
<td>D9935</td>
<td>cleaning and inspection of removable partial denture, mandibular</td>
<td>100% of negotiated fee for D9931</td>
</tr>
<tr>
<td>D9943</td>
<td>occlusal guard adjustment</td>
<td>12.5% of negotiated fee for D9940</td>
</tr>
</tbody>
</table>
Network Bulletin

Date: October 2014
From: Joel Hodge, Head of Dental Networks and Administration
Subject: New CDT 2015 Codes
Applies to: PPO, Discount Dental, Family Preventive, Basic Dental, Aetna Advantage Dental and Aetna Advantage Student Dental

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in the Network Bulletin section of your guide for future reference.

Below are the new CDT-2015 codes
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2015 codes effective January 1, 2015.

Fee information for the new CDT-2015 Codes
Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

<table>
<thead>
<tr>
<th>CDT 2015 Code</th>
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<th>Contracted Fees for CDT 2015 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100 - D0999</td>
<td>I. Diagnostic</td>
<td></td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation – post-operative visit</td>
<td>Inclusive to surgery</td>
</tr>
<tr>
<td>D0351</td>
<td>3D photographic image</td>
<td>Not covered</td>
</tr>
<tr>
<td>D1000-D1999</td>
<td>II. Preventive</td>
<td></td>
</tr>
<tr>
<td>D1353</td>
<td>Sealant repair</td>
<td>50% of negotiated fee for D1351</td>
</tr>
<tr>
<td>D6000-D6199</td>
<td>VIII. Implant Services</td>
<td></td>
</tr>
<tr>
<td>D6110</td>
<td>Implant/abutment supported removable denture for completely edentulous arch - maxillary</td>
<td>100% of negotiated fee for D6053</td>
</tr>
<tr>
<td>D6111</td>
<td>Implant/abutment supported removable denture for completely edentulous arch - mandibular</td>
<td>100% of negotiated fee for D6053</td>
</tr>
</tbody>
</table>

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2,3,4,4b – PPO
<table>
<thead>
<tr>
<th>Code</th>
<th>Nomenclature</th>
<th>Contracted Fees for CDT 2015 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6112</td>
<td>Implant/abutment supported removable denture for partially edentulous arch - maxillary</td>
<td>100% of negotiated fee for D6054</td>
</tr>
<tr>
<td>D6113</td>
<td>Implant/abutment supported removable denture for partially edentulous arch - mandibular</td>
<td>100% of negotiated fee for D6054</td>
</tr>
<tr>
<td>D6114</td>
<td>Implant/abutment supported fixed denture for completely edentulous arch - maxillary</td>
<td>100% of negotiated fee for D6078</td>
</tr>
<tr>
<td>D6115</td>
<td>Implant/abutment supported fixed denture for completely edentulous arch - mandibular</td>
<td>100% of negotiated fee for D6078</td>
</tr>
<tr>
<td>D6116</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - maxillary</td>
<td>100% of negotiated fee for D6079</td>
</tr>
<tr>
<td>D6117</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - mandibular</td>
<td>100% of negotiated fee for D6079</td>
</tr>
<tr>
<td>D6200-D6999</td>
<td>IX. Prosthodontics, fixed</td>
<td></td>
</tr>
<tr>
<td>D6549</td>
<td>Resin retainer – for resin bonded fixed prosthesis</td>
<td>50% of negotiated fee for D6722</td>
</tr>
<tr>
<td>D9000-D9999</td>
<td>XII. Adjunctive General Services</td>
<td></td>
</tr>
<tr>
<td>D9219</td>
<td>Evaluation for deep sedation or general anesthesia</td>
<td>Covered only when performed by anesthesiologist in conjunction with medically necessary deep sedation or general anesthesia</td>
</tr>
<tr>
<td>D9931</td>
<td>Cleaning and inspection of a removable appliance</td>
<td>25% of negotiated fee for D1110</td>
</tr>
<tr>
<td>D9986</td>
<td>Missed appointment</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9987</td>
<td>Cancelled appointment</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

We are here to help
If you have any questions, please contact our Dentist Contracting Hotline at 1-800-776-0537.
Thank you for your participation in our dental network and your continued support of Aetna Dental® Plans.
Network Bulletin

Date: December 2013

From: Joel Hodge, Head of Networks and Administration

Subject: Dental card suppression

Applies to: All contracted Aetna dental providers

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in your guide for future reference.

Important change
Starting January 1, 2014, as a standard practice, Aetna will stop mailing Dental PPO and DMO® only member ID cards. This will include ID cards for new and previous members of our dental plans. Instead of receiving an ID card, members may get a letter explaining that they no longer need an ID card for dental care. The letter will provide instructions on how to access or request a copy of their member ID card from Aetna Navigator®, our Aetna Mobile app and/or by calling Member Services.

What this means for you
Nothing changes. You will continue to verify benefits online, on your monthly eligibility report (DMO) or by calling our National Dentist Hotline at 1-800-451-7715.

We’re here to help
If you have questions, please call us at 1-800-451-7715. Thank you for your continued participation in and support of Aetna Dental plans.
Network Bulletin

Date: October 2013

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2014 Codes

Applies to: PPO, Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in the Network Bulletin section of your guide for future reference.

Below are the new CDT-2014 codes
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2014* codes effective January 1, 2014.

Fee information for the new CDT-2014 Codes
Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Nomenclature</th>
<th>Negotiated Rates for CDT-2014 codes are based on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100 - D0999 I. Diagnostic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0393</td>
<td>treatment simulation using 3-D image volume</td>
<td>Medical - not on fee schedule</td>
</tr>
<tr>
<td>D0394</td>
<td>digital subtraction of two or more images or image volumes of the same modality</td>
<td>Medical - not on fee schedule</td>
</tr>
<tr>
<td>D0395</td>
<td>fusion of two or more 3D image volumes of one or more modalities</td>
<td>Medical - not on fee schedule</td>
</tr>
<tr>
<td>D0601</td>
<td>caries risk assessment and documentation, with a finding of low risk</td>
<td>Inclusive to oral evaluation</td>
</tr>
<tr>
<td>D0602</td>
<td>caries risk assessment and documentation, with a finding of moderate risk</td>
<td>Inclusive to oral evaluation</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Inclusive to oral evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0603</td>
<td>caries risk assessment and documentation, with a finding of high risk</td>
<td></td>
</tr>
<tr>
<td>D1000-D1999 II. Preventive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1999</td>
<td>unspecified preventive procedure, by report</td>
<td>Not covered</td>
</tr>
<tr>
<td>D2000-D2999 III. Restorative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2921</td>
<td>reattachment of tooth fragment, incisal edge or cusp</td>
<td>10% of negotiated rate for D2335</td>
</tr>
<tr>
<td>D2941</td>
<td>interim therapeutic restoration – primary dentition</td>
<td>45% of negotiated rate for D2940</td>
</tr>
<tr>
<td>D2949</td>
<td>restorative foundation for an indirect restoration</td>
<td>Inclusive to permanent restoration.</td>
</tr>
<tr>
<td>D3000-D3999 IV. Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3355</td>
<td>pulpal regeneration - initial visit</td>
<td>50% of negotiated rate for D3354</td>
</tr>
<tr>
<td>D3356</td>
<td>pulpal regeneration – interim medication replacement</td>
<td>15% of negotiated rate for D3354</td>
</tr>
<tr>
<td>D3357</td>
<td>pulpal regeneration – completion of treatment</td>
<td>25% of negotiated rate for D3354</td>
</tr>
<tr>
<td>D3427</td>
<td>periradicular surgery without apicoectomy</td>
<td>75% of negotiated rate for D3421</td>
</tr>
<tr>
<td>D3428</td>
<td>bone graft in conjunction with periradicular surgery - per tooth, single site</td>
<td>100% of negotiated rate for D4263</td>
</tr>
<tr>
<td>D3429</td>
<td>bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site</td>
<td>100% of negotiated rate for D4264</td>
</tr>
<tr>
<td>D3431</td>
<td>biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery</td>
<td>100% of negotiated rate for D4265</td>
</tr>
<tr>
<td>D3432</td>
<td>guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery</td>
<td>100% of negotiated rate for D4266</td>
</tr>
<tr>
<td>D4000-D4999 V. Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4921</td>
<td>gingival irrigation – per quadrant</td>
<td>25% of negotiated rate for D4355</td>
</tr>
<tr>
<td>D5000-D5899 VI. Prosthodontics (Removable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5863</td>
<td>overdenture – complete maxillary</td>
<td>100% of negotiated rate for D5860</td>
</tr>
<tr>
<td>D5864</td>
<td>overdenture - partial maxillary</td>
<td>100% of negotiated rate for D5861</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Rate</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>D5865</td>
<td>overdenture - complete mandibular</td>
<td>100% of negotiated rate for D5860</td>
</tr>
<tr>
<td>D5866</td>
<td>overdenture – partial mandibular</td>
<td>100% of negotiated rate for D5861</td>
</tr>
<tr>
<td>D5900-D5999</td>
<td>VII. Maxillofacial Prosthetics</td>
<td></td>
</tr>
<tr>
<td>D5994</td>
<td>periodontal medicament carrier with peripheral seal – laboratory processed</td>
<td>Medical - not on fee schedule</td>
</tr>
<tr>
<td>D6000-D6199</td>
<td>VIII. Implant Services</td>
<td></td>
</tr>
<tr>
<td>D6011</td>
<td>second stage implant surgery</td>
<td>Inclusive to implant D6010</td>
</tr>
<tr>
<td>D6013</td>
<td>Surgical placement of mini implant</td>
<td>55% of negotiated rate for D6010</td>
</tr>
<tr>
<td>D6052</td>
<td>semi-precision attachment abutment</td>
<td>50% of negotiated rate for D6056</td>
</tr>
<tr>
<td>D8000-D8999</td>
<td>XI. Orthodontics</td>
<td></td>
</tr>
<tr>
<td>D8694</td>
<td>repair of fixed retainers, includes reattachment</td>
<td>100% of negotiated rate for D8693</td>
</tr>
<tr>
<td>D9000-D9999</td>
<td>XII. Adjunctive General Services</td>
<td></td>
</tr>
<tr>
<td>D9985</td>
<td>sales tax</td>
<td>Inclusive to service being taxed.</td>
</tr>
</tbody>
</table>

**We are here to help**

If you have any questions, please contact our Dentist Contracting Hotline at 1-800-776-0537.

Thank you for your participation in our dental network and your continued support of Aetna Dental® Plans.

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Network Bulletin

Date: September 2013

From: Bryan Geremia, Regional Manager

Subject: New dental benefits embedded in Aetna medical plans

Applies to: All contracted Aetna dental PPO providers

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in your guide for future reference.

Important changes
On January 1, 2014, major parts of the Affordable Care Act (ACA) are going to be implemented. The ACA is adding more required benefits to all new health plans. We have been certified as a Qualified Health Plan (QHP) in several states. As a part of the certification process we will be offering all 10 required Essential Health Benefits (EHB). One of these EHB requirements is pediatric oral services. We will be introducing new certified medical plans with pediatric oral services embedded into the plan designs.

What this means for you
As a contracted dentist in our Dental PPO network, you may have Aetna medical plan members coming to your office for pediatric oral services, as defined by state law. These will be covered services for dependent children up to the age of 19 (or higher age if required by your state). Patients will show you their Aetna medical identification card, which may or may not have a PD following the plan name.

Claim filing and reimbursement
Send claims for all covered services as you do normally for Aetna PPO claims. We will pay you based on your PPO fee schedule.
In order to bring your contract into compliance with applicable ACA provisions, your provider agreement will be amended to add the following:

Provider agrees to participate in the following plans/programs, as designated by Aetna from time to time:

Pediatric Dental Plans/Benefits (providing pediatric dental benefits within or in conjunction with a medical plan or as a standalone pediatric dental plan). These pediatric benefits plans/programs utilize the Dental PPO Fee Schedule.

We’re here to help
If you have questions, please call us at 1-800-451-7715. Thank you for your continued participation in and support of Aetna Dental plans.
Date: September 2013
From: Bryan Geremia, Regional Manager

Subject: New dental benefits embedded in Aetna and Innovation Health medical plans

Applies to: All contracted Aetna dental PPO providers in DC, MD, and VA

This bulletin is part of your Dental Office Guide. After reviewing this information, place it in your guide for future reference.

Important changes
On January 1, 2014, major parts of the Affordable Care Act (ACA) are going to be implemented. The ACA is adding more required benefits to all new health plans. We have been certified as a Qualified Health Plan (QHP) in several states. As a part of the certification process we will be offering all 10 required Essential Health Benefits (EHB). One of these EHB requirements is pediatric oral services. We will be introducing new certified medical plans with pediatric oral services embedded into the plan designs.

What this means for you
As a contracted dentist in our Dental PPO network, you may have Aetna and Innovation Health medical plan members coming to your office for pediatric oral services, as defined by state law. These will be covered services for dependent children up to the age of 19 (or higher age if required by your state). Patients will show you their Aetna medical identification card, which may or may not have a PD following the plan name. In addition, you may have patients that present an Innovation Health medical plan identification card. Innovation Health is an affiliate of Aetna.

Claim filing and reimbursement
Send claims for all covered services as you do normally for Aetna PPO claims. We will pay you based on your PPO fee schedule.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Inova Health System and Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.
In order to bring your contract into compliance with applicable ACA provisions, your provider agreement will be amended to add the following:

*Provider agrees to participate in the following plans/programs, as designated by Aetna from time to time:*

*Pediatric Dental Plans/Benefits (providing pediatric dental benefits within or in conjunction with a medical plan or as a standalone pediatric dental plan). These pediatric benefits plans/programs utilize the Dental PPO Fee Schedule.*

**We’re here to help**
If you have questions, please call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental plans.

For questions about Innovation Health Plan, call the phone number on the back of the member ID card. You can also call our Provider Service Center at **1-888-632-3862**.