THE LORAL BENEFITS NEWSLETTER

September, 1993

This is the first in a series of newsletters we will be issuing concerning your benefits program. This newsletter is intended to address several key issues you may need to be aware of regarding the new Choices Health Care Plan, and will supplement the information you have already received.

TOPICS IN THIS NEWSLETTER

- The Dental Program
- Prescription Drug Programs
- Durable Medical Equipment
- Vision Care Benefits
- Employee Assistance Program

THE DENTAL PROGRAM

There have been a number of questions raised regarding the benefits and administration of the dental program that became effective May 1, 1993. The following guidelines should assist each participant in receiving the appropriate benefit from the dental program in a timely manner.

- **Course of Treatment**

A "course of treatment" is a planned treatment program of one or more services or supplies rendered by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination.

If you go to your dentist and an exam is performed, he/she should advise you of <u>all</u> the problems with your teeth. For example, if the dentist determines your need for 5 cavities filled, 2 root canals and one bridge, this would be considered a course of treatment. Whether you choose to have all the work done at once or over a period of time, is your decision. What you need to know is that if <u>correcting all</u> the problems will exceed $300 for that course of treatment, you must obtain pre-treatment authorization in order for benefits to be paid.

- **Pre-Treatment Authorizations**

To obtain benefits from the dental program, any course of treatment that is anticipated to exceed $300 <u>must</u> be submitted to Aetna for pre-treatment authorization.

Attached to your request for pre-treatment authorization should be as much diagnostic and applicable historical information as possible. Based on the procedure, the supporting documentation could include pre-treatment x-rays, photographs, models which view the extent of the disease or injury; clinical exam information; a copy of historical information substantiating the original placement date of a filling, crown, inlay, denture, partial denture or bridge including the details supporting the need for the replacement; and periodontal soft tissue records when required.

If the appropriate documentation is not attached to your pre-treatment authorization request, the Aetna review and determination will be delayed until the documentation is received. If you or your dentist are uncertain about the types of supporting documentation required for your pre-treatment authorization, contact Aetna Member Services at 1-800-345-5839 for a detailed description.

- **Fillings (Amalgams and Composites)**

Multiple fillings in a course of treatment whose total cost exceeds $300 in a year require pre-treatment authorization. **This is true even if they are filled at different times. If the cumulative cost in one year exceeds $300, a pre-treatment authorization is required in order to receive benefits from the dental program.**

- **Claims Recently Denied for Failure to Obtain Pre-Treatment Approval for Fillings**

If a claim for multiple fillings was incurred between May 1, 1993 and September 15, 1993, and was denied by Aetna because there was no pre-treatment approval, the claim will be reconsidered if you or your dentist submit all of the following to Aetna:

1. A photocopy of your denial (which is the Explanation of Benefit statement (EOB))
2. Pre-treatment objective diagnostic aids such as x-rays, photos, or models which show the extent of the disease or injury.
3. Historical documentation in the event these are replacement fillings.

This is a limited exception only for claims incurred between May 1, 1993 and September 15, 1993. Beginning with claims incurred September 16, 1993, benefits will be payable only if the course of treatment exceeding $300 has been pre-approved by Aetna.

- **Replacement Fillings/Inlays/Crowns/Bridges Partial Dentures and Dentures**

The dental program requires that the replacement of an existing filling, inlay, crown, bridge, partial denture or denture be irreparable and meet certain requirements.

Fillings (silver and tooth colored) customarily last for 7 years. If a filling needs replacement, you need to provide evidence that the old filling was at least 7 years old.

Inlays, crowns and bridges customarily last for 10 years. If an inlay, crown or bridge needs replacement, you need to provide evidence that the prior inlay, crown or bridge was cemented at least 10 years ago.

Dentures and partial dentures customarily last for 5 years. If your denture or partial denture needs replacement, you need to provide evidence that the prior denture or partial denture was delivered at least 5 years ago.

If you do not meet the above replacement guidelines, no benefits are payable from the dental program.

Your dental treatment records provide the most easily duplicated proof of the prior placement dates of fillings, inlays, crowns, bridges, partial dentures and dentures. If you cannot obtain this information, you or your dentist need to submit all of the following to Aetna:

1. The date you first became a patient under the care of your current dentist.
2. A photocopy of your current examination and treatment planning records.
3. The approximate date of prior placement of fillings, inlays, crowns, bridges, partial dentures or dentures.
4. Your dentist's description of the restoration and the clinical information which leads him/her to believe this restoration was done originally on "x" date.
5. The pre-treatment diagnostic aids such as x-rays, photos, or study models which view the extent of disease or decay.

- **Denied Claims for Replacement Fillings/Inlays /Crowns/Bridges/Partial Dentures and Dentures**

If a claim for a replacement filling, inlay, crown, bridge, partial or full denture was incurred between May 1, 1993 and September 15, 1993 and was denied based on the replacement rules above, you can have the claim reconsidered if you meet the replacement rules by submitting the denied claim (copy of the EOB), together with the applicable documentation outlined above, to Aetna.

- **Emergency Oral Examinations/Treatments**

You will receive benefits for one oral examination in a calendar year. Emergency oral examinations are not covered under the dental program. Claim submissions for emergency oral examinations will be denied if you've already been reimbursed for one non-emergency oral exam in the calendar year. If you have not already had an oral examination, the emergency examination will count as the annual oral examination.

In emergencies, any of the covered procedures which will cost under $300 can be completed without pre-treatment authorization.

Should your dentist indicate there is absolutely nothing he/she can do for you that is under $300 for your immediate emergency situation, you should have the dental office contact Aetna Member Services at 1-800-345-5839 with all the clinical and historical information at hand for an emergency pre-treatment authorization. For emergency endodontic treatment (root canals), see below.

Any **subsequent** dental services or procedures identified at the emergency dental appointment are subject to pre-treatment authorization by Aetna in order to obtain reimbursement under the dental program.

- **Denied Claims for Emergency Oral Examinations/Treatments**

If a claim for an emergency oral examination/treatment was incurred between May 1, 1993 and September 15, 1993 and was denied, you can have the claim reconsidered by submitting the denied claim (copy of the EOB), along with any supporting documentation, to Aetna. This will count as your annual oral examination if you have not already had one.

- **Emergency Endodontic Therapy (Root Canal Treatment)**

Emergency root canal treatment that is necessary for the relief of pain will not require pre-treatment authorization. However, the patient or dentist is required to submit to Aetna, along with the claim, the pre- and post-treatment x-rays and details of the emergency treatment. This claim will not be processed for payment until the required documentation is received by Aetna.

- **Claims Denied for Failure to Obtain Pre-Treatment Approval for Emergency Root Canals**

If you had a claim denied by Aetna for emergency root canal incurred between May 1, 1993 and September 15, 1993, you may resubmit the claim with the above-requested information and it will be reconsidered by Aetna for payment. This is a limited exception and will be applicable only for services incurred between May 1, 1993 and September 15, 1993.

- **Missing and Unreplaced Tooth Rule**

There is no coverage for dental work performed to replace a tooth that was removed and not replaced prior to the effective date of your coverage under Loral's dental program. This rule applies to charges related to inlays, bridges, crowns, partial dentures and dentures.

- **Wisdom Teeth**

Extraction of an impacted wisdom tooth is covered only if there is associated pathology. Pathology (disease) may be determined from a pre-treatment x-ray. Evidence of associated pathology may require submission of photocopies of your general dental treatment records where the clinical findings and treatment of the problem tooth would be noted. Pain and discomfort, along with a threat to adjacent teeth, are considered pathology.

- **Periodontal Maintenance**

Under the dental program, there is no coverage for periodontal maintenance procedures.

However, for services incurred after September 15, 1993, Aetna will apply any available (unused) benefits for routine prophylaxis (cleaning) toward the charges of a periodontal maintenance procedure. This allowance will be counted toward the maximum of two cleanings per calendar year under the plan. You will be reimbursed up to the reasonable and customary cost of a routine cleaning.

- **Claims Recently Denied for Periodontal Maintenance Procedures**

If you had a claim denied by Aetna for periodontal maintenance incurred between May 1, 1993 and September 15, 1993, you may resubmit the denial (EOB) with a note requesting that the procedure count toward one of the two cleanings per year.

All of the provisions of the dental program will be described in detail in the Summary Plan Description (SPD) which is scheduled to be distributed in November.

PRESCRIPTION DRUG PROGRAMS

- **Generic Equivalent Rule**

Prescription drugs, whether dispensed by a network pharmacy or by mail order, are administered according to the Generic Equivalent Rule. Basically, the Generic Equivalent Rule states that if your doctor requests to have a prescription filled with a brand name drug when a generic equivalent exists, you will be required to pay the $5 co-pay (20% co-pay for out-of-area Plan participants) plus the difference in cost between the generic and brand name drug. Keep in mind that different reimbursement rules apply if you use a non-network pharmacy.

- **Mail Order RX Drug Claims**

When using America's Pharmacy Mail Order Drug Program, unless your doctor indicates on the brand name prescription "dispense as written" or you specifically request the brand name drug on the order form alongside of the "Amount of co-payment enclosed" line or above the certification statement on the re-order form, America's Pharmacy will fill the prescription with a generic, if available. If you receive the generic equivalent either because your doctor did not write "dispense as written" or you did not specifically request the brand name and you return it to America's Pharmacy to receive the brand name, you will pay the entire cost of the brand name drug plus a $25 processing charge, since the original generic equivalent prescription you returned must be discarded.

- **Filling a Prescription**

You can get up to a 30-day supply of prescription drugs from a network pharmacy. You can get up to a 90-day supply of prescription drugs through the mail order program. These limits apply even if the prescription designates a larger supply.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is not covered under the Prescription Drug Card Program. Durable medical equipment which includes crutches, wheel chairs, commodes, colostomy supplies, pumps, ostomy and ileostomy supplies, surgical support stockings, may or may not require a doctor's order before purchasing. Participants purchasing durable medical equipment should submit a claim for reimbursement under the medical program.

If you have questions about the reimbursement of durable medical equipment prior to purchasing the equipment, call Member Services at 1-800-345-5839.

VISION PLAN

Under the new Vision Plan, the copayments applicable to the exams, lenses and frames apply whether you go to a participating VSP provider or non-VSP provider. When using a non-VSP provider, you will be reimbursed up to the maximum allowable amount, after the copayment.

EMPLOYEE ASSISTANCE PROGRAM

Until now, we had contracted with National Employee Assistance Services (NEAS) to offer short term counseling in addition to their standard problem assessment and referral services. The short term counseling was made available only in those cases where NEAS determined that a person's issue could be successfully resolved in eight or less counseling sessions. On May 1, we introduced Human Affairs International (HAI) as the mental health and substance abuse provider under the new Choices Health Care Plan. With HAI's network of providers in place, we have determined that the short term counseling services offered by NEAS are duplicative and will be discontinued as of October 1, 1993. NEAS will continue to provide problem assessment and referral services for all employees and their families. We have arranged with NEAS to follow through on short term counseling for anyone undergoing that treatment on October 1.

If you have questions about the Employee Assistance Program, call NEAS at 1-800-634-6433. If you have questions about mental health and substance abuse benefits under the Choices Health Care Plan, call HAI at 1-800-424-1817.■