



Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	\$0			
DIAGNOSTIC					
D0120-D0180	Oral Evaluations	No Charge	D0277	Vertical Bitewings - 7 to 8 Films	No Charge
D0210	Full mouth series Images	No Charge	D0330	Panoramic Image	No Charge
D0220-D0230	Periapicals	No Charge	D0391	Interpretation of Diagnostic Image	No Charge
D0240	Intraoral, Occlusal Image	No Charge	D0460	Pulp Vitality Test	No Charge
D0250-D0251	Extraoral Images	No Charge	D0470	Diagnostic Casts	No Charge
D0270-D0274	Bitewings	No Charge	D0472-D0474	Accession of Tissue	No Charge
PREVENTIVE					
D1110	Prophy - Adult	No Charge	D1510	Space Maintainer - Fixed Unilateral	\$75
D1120	Prophy - Child	No Charge	D1515	Space Maintainer - Fixed Bilateral	\$75
D4346	Scaling in presence of generalized moderate/severe gingival inflammation – full mouth, after oral evaluation	\$30	D1520	Space Maintainer - Removable Unilateral	\$70
D1208	Fluoride - Child	No Charge	D1525	Space Maintainer - Removable Bilateral	\$70
D1206	Application of Topical Fluoride Varnish	No Charge	D1550	Recent Space Maintainer	\$12
D1330	Oral Hygiene Instruction	No Charge	D1555	Removal of Space Maintainer	\$12
D1351, D1354	Sealant	No Charge	D1575	Distal shoe space maintainer - fixed - unilateral	\$83
D1352	Preventive Resin Restoration	No Charge	D2990	Resin Infiltration of Lesion	No Charge
D1353	Sealant Repair - Per Tooth	No Charge			
Diagnostic and Preventive services may be subject to age and frequency limitations. See your booklet for details.					
RESTORATIVE					
PRIMARY OR PERMANENT TEETH					
D2140	Amalgam - 1 Surf Primary or Permanent	\$10	D2391	Resin-Based Composite 1 Surf, Posterior	\$35
D2150	Amalgam - 2 Surf Primary or Permanent	\$12	D2392	Resin-Based Composite 2 Surf, Posterior	\$50
D2160	Amalgam - 3 Surf Primary or Permanent	\$16	D2393	Resin-Based Composite 3 Surf, Posterior	\$60
D2161	Amalgam - 4+ Surf Primary or Permanent	\$18	D2394	Resin-Based Composite 4+ Surf, Posterior	\$90
D2330	Resin-Based Composite 1 Surf, Anterior	\$15	D2921	Reattachment of tooth fragment, incisal edge or dusp	\$5
D2331	Resin-Based Composite 2 Surf, Anterior	\$21	D2940	Protective Restoration	\$3
D2332	Resin-Based Composite 3 Surf, Anterior	\$25	D2941	Interim therapeutic restoration - primary dentition	\$1
D2335	Resin-Based Composite 4+ Surf; Anterior (or involving Incisal angle)	\$45	D2951	Pin Retention - In Addition to Restoration	\$10
D2390	Resin-Based Composite Crown, Anterior	\$50			
CROWNS/BRIDGES					
D2510	Inlay - Metallic 1 Surf	\$195	D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	\$255
D2520	Inlay - Metallic 2 Surf	\$195	D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	\$255
D2530	Inlay - Metallic 3 Surf	\$195	D6094	Abutment Supported Crown - (Titanium)	\$255
D2542	Onlay - Metallic 2 Surf	\$210	D6110	Implant Abut Sup Removable Dent-MaxCom	\$275
D2543	Onlay - Metallic 3 Surf	\$210	D6111	Implant Abut Sup Removable Dent-Mand Com	\$275
D2544	Onlay, Metallic - 4 or More Surf	\$210	D6112	Implant Abut Sup Removable Dent-Max Par	\$275
D2610	Inlay, Porcelain/Ceramic - 1 Surf	\$195	D6113	Implant Abut Sup Removable Dent-Mand Par	\$275
D2620	Inlay, Porcelain/Ceramic - 2 Surf	\$195	D6114	Implant Abut Sup Fixed Dent-Max Com	\$275
D2630	Inlay, Porcelain/Ceramic - 3 or More Surf	\$195	D6115	Implant Abut Sup Fixed Dent-Mand Com	\$275
D2642	Onlay, Porcelain/Ceramic - 2 Surf	\$210	D6116	Implant Abut Sup Fixed Dent-Max Par	\$275
D2643	Onlay, Porcelain/Ceramic - 3 Surf	\$210	D6117	Implant Abut Sup Fixed Dent-Mand Par	\$275
D2644	Onlay, Porcelain/Ceramic - 4 or More Surf	\$210	D6205	Pontic - Indirect Resin Based Composite	\$255
D2650	Inlay, Composite/Resin - 1 Surf	\$195	D6210	Pontic - Cast High Noble Metal	\$255
D2651	Inlay, Composite/Resin - 2 Surf	\$195	D6211	Pontic - Cast Predominantly Base Metal	\$255
D2652	Inlay, Composite/Resin - 3 Surf	\$195	D6212	Pontic - Cast Noble Metal	\$255
D2662	Onlay, Composite/Resin - 2 Surf	\$210	D6214	Pontic - Titanium	\$255
D2663	Onlay, Composite/Resin - 3 Surf	\$210	D6240	Pontic - Porcelain Fused to High Noble Metal	\$255

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D2664	Onlay, Composite/Resin - 4 or More Surf	\$210	D6241	Pontic - Porcelain Fused to Predominantly Base	\$255
D2710	Crown - Resin-Based Composite, Indirect	\$255	D6242	Pontic - Porcelain Fused to Noble Metal	\$255
D2712	Crown - 3/4 Resin-Based Composite, Indirect	\$204	D6245	Pontic - Porcelain/Ceramic	\$255
D2720	Crown - Resin With High Noble Metal	\$255	D6250	Pontic - Resin With High Noble Metal	\$255
D2721	Crown - Resin With Predominantly Base Metal	\$255	D6251	Pontic - Resin With Predominantly Base Metal	\$255
D2722	Crown - Resin With Noble Metal	\$255	D6252	Pontic - Resin With Noble Metal	\$255
D2740	Crown - Porcelain/Ceramic Substrate	\$255	D6545	Retainer - Cast Metal for Resin-Bonded Fixed	\$195
D2750	Crown - Porcelain Fused to High Noble Metal	\$255	D6548	Retainer - Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis	\$195
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$255	D6549	Resin Retainer - Resin Bonded Prosthesis	\$128
D2752	Crown - Porcelain Fused to Noble Metal	\$255	D6600	Inlay - Porcelain/Ceramic, 2 Surf	\$195
D2780	Crown - 3/4 Cast High Noble Metal	\$255	D6601	Inlay - Porcelain/Ceramic, 3+ Surf	\$195
D2781	Crown - 3/4 Cast Predominantly Based Metal	\$255	D6602	Inlay - Cast High Noble Metal, 2 Surf	\$225
D2782	Crown - 3/4 Cast Noble Metal	\$255	D6603	Inlay - Cast High Noble Metal, 3+ Surf	\$225
D2783	Crown - 3/4 Porcelain/Ceramic	\$255	D6604	Inlay - Cast Predominantly Base Metal, 2 Surf	\$195
D2790	Crown - Full Cast High Noble Metal	\$255	D6605	Inlay - Cast Predominantly Base Metal, 3+ Surf	\$195
D2791	Crown - Full Cast Predominantly Base Metal	\$255	D6606	Inlay - Cast Noble Metal, 2 Surf	\$215
D2792	Crown - Full Cast Noble Metal	\$255	D6607	Inlay - Cast Noble Metal, 3+ Surf	\$215
D2794	Crown - Titanium	\$255	D6608	Onlay - Porcelain/Ceramic, 2 Surf	\$210
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$10	D6609	Onlay - Porcelain/Ceramic, 3+ Surf	\$210
D2915	Recement Cast or Prefab Post and Core	\$5	D6610	Onlay - Cast High Noble Metal, 2 Surf	\$240
D2920	Recement Crown	\$10	D6611	Onlay - Cast High Noble Metal, 3+ Surf	\$240
D2929	Prefab Porcelain/Ceramic Crown - Primary Tooth	\$56	D6612	Onlay - Cast Predominantly Base Metal, 2 Surf	\$210
D2930	Prefab, Stainless Steel Crown - Primary Tooth	\$40	D6613	Onlay - Cast Predominantly Base Metal, 3+ Surf	\$210
D2931	Prefab, Stainless Steel Crown - Permanent Tooth	\$50	D6614	Onlay - Cast Noble Metal, 2 Surf	\$230
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	\$40	D6615	Onlay - Cast Noble Metal, 3+ Surf	\$230
D2950	Core Buildup, Including Any Pins	\$80	D6624	Inlay - Titanium	\$225
D2952	Post & Core in Addition to Crown	\$112	D6634	Onlay - Titanium	\$240
D6058	Abutment Supported Porcelain/Ceramic Crown	\$255	D6710	Crown - Indirect Resin Based Composite	\$255
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	\$255	D6720	Crown - Resin With High Noble Metal	\$255
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	\$255	D6721	Crown - Resin With Predominantly Base Metal	\$255
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	\$255	D6722	Crown - Resin With Noble Metal	\$255
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	\$255	D6740	Crown - Porcelain/Ceramic	\$255
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	\$255	D6750	Crown - Porcelain Fused to High Noble Metal	\$255
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	\$255	D6751	Crown - Porcelain Fused to Predominantly Base Metal	\$255
D6065	Implant Supported Porcelain/Ceramic Crown	\$255	D6752	Crown - Porcelain Fused to Noble Metal	\$255
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble)	\$255	D6780	Crown - 3/4 Cast High Noble Metal	\$255
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	\$255	D6781	Crown - 3/4 Cast Predominantly Base Metal	\$255
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	\$255	D6782	Crown - 3/4 Cast Noble Metal	\$255
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	\$255	D6783	Crown - 3/4 Porcelain/Ceramic	\$255
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	\$255	D6790	Crown - Full Cast High Noble Metal	\$255

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D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	\$255	D6791	Crown - Full Cast Predominantly Base Metal	\$255
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	\$255	D6792	Crown - Full Cast Noble Metal	\$255
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	\$255	D6794	Crown - Titanium	\$255
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	\$255	D6930	Recent Fixed Partial Denture	\$15
D6075	Implant Supported Retainer for Ceramic FPD	\$255	Additional Charge per Unit for Full Mouth Rehabilitation.		\$125

Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.

Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost for gold/high noble metal.

ENDODONTICS

D3110	Pulp Cap - Direct (excluding final restoration)	\$4	D3333	Internal Root Repair of Perforation Defects	\$55
D3120	Pulp Cap - Indirect (excluding final restoration)	\$4	D3346	Retreatment of Previous Root Canal Therapy - Anterior	\$170
D3220	Therapeutic Pulpotomy (excluding final restoration)	\$22	D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$209
D3221	Pulpal Debridement, Primary and Permanent Teeth	\$10	D3348	Retreatment of Previous Root Canal Therapy - Molar	\$380
D3222	Partial Pulpotomy	\$20	D3410 (1)	Apicoectomy/Periradicular Surgery - Anterior	\$92
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	\$22	D3421 (1)	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$92
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	\$22	D3425 (1)	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$90
D3310	Root Canal Therapy - Anterior (excluding final restoration)	\$70	D3426 (1)	Apicoectomy/Periradicular Surgery- Each Additional Root	\$55
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	\$109	D3427 (1)	Periradicular surgery without apicoectomy	\$69
D3330	Root Canal Therapy - Molar (excluding final restoration)	\$280	D3430 (1)	Retrograde Filling - Per Root	\$40
D3331	Treatment of Root Canal Obstruction, Nonsurgical Access	\$70	D3450 (1)	Root Amputation - Per Root	\$70
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	\$55			

(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.

PERIODONTICS

D4210 (1)	Gingivectomy or Gingivoplasty - 4 or More Teeth - Per Quadrant	\$133	D4275 (1)	Soft Tissue Allograft	\$275
D4211 (1)	Gingivectomy or Gingivoplasty - 1-3 Teeth - Per Quadrant	\$57	D4276 (1)	Connective Tissue/Pedicle Graft, Per Tooth	\$227
D4212 (1)	Gingivectomy to allow access, per tooth	\$23	D4277 (1)	Free soft tissue graft - first tooth	\$98
D4240 (1)	Gingival Flap Procedure, Including Root Planing - 4 or More Teeth - Per Quadrant	\$134	D4278 (1)	Free soft tissue graft - each additional tooth	\$49
D4241 (1)	Gingival Flap Procedure, Including Root Planing - 1-3 Teeth - Per Quadrant	\$80	D4283 (1)	Autogenous connective tissue graft	\$76
D4245 (1)	Apically Positioned Flap	\$110	D4285 (1)	Non-autogenous connective tissue graft	\$151
D4249	Clinical Crown Lengthening, Hard Tissue	\$180	D4341	Periodontal Scaling and Root Planing - 4 or More Teeth - Per Quadrant	\$51
D4260 (1)	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Teeth - Per Quadrant	\$300	D4342	Periodontal Scaling and Root Planing - 1-3 Teeth - Per Quadrant	\$31
D4261 (1)	Osseous Surgery (Including Flap Entry and Closure) - 1-3 Teeth - Per Quadrant	\$180	D4355	Debridement	\$60
D4268 (1)	Surgical Revision Procedure, Per Tooth	\$120	D4910	Periodontal Maintenance	\$45
D4270 (1)	Pedicle Soft Tissue Graft Procedure	\$230	D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist)	\$10

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D4273 (1)	Subepithelial Connective Tissue Graft, Per Tooth	\$138	
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PROSTHODONTICS-REMOVABLE (2)					
D5110	Complete Denture - Maxillary	\$275	D5223-D5224	Immediate max/mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	\$403
D5120	Complete Denture - Mandibular	\$275	D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	\$330
D5130	Immediate Denture - Maxillary	\$315	D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	\$330
D5140	Immediate Denture - Mandibular	\$315	D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)	\$275
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	\$275	D5410	Adjust Complete Denture - Maxillary	\$10
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	\$275	D5411	Adjust Complete Denture - Mandibular	\$10
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$350	D5421	Adjust Partial Denture - Maxillary	\$10
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$350	D5422	Adjust Partial Denture - Mandibular	\$10
D5221-D5222	Immediate max/mand partial dental - resin base (including any conventional clasps, rests and teeth)	\$316			

(2) Includes relines, adjustments, rebases within the 1st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.

REPAIRS TO PROSTHETICS					
D5510	Repair Broken Complete Denture Base	\$30	D5730	Reline Complete Maxillary Denture (Chairside)	\$45
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	\$20	D5731	Reline Complete Mandibular Denture (Chairside)	\$45
D5610	Repair Resin Denture Base	\$35	D5740	Reline Maxillary Partial Denture (Chairside)	\$45
D5620	Repair Cast Framework	\$35	D5741	Reline Mandibular Partial Denture (Chairside)	\$45
D5630	Repair or Replace Broken Clasp	\$35	D5750	Reline Complete Maxillary Denture (Lab)	\$102
D5640	Replace Broken Teeth - Per Tooth	\$35	D5751	Reline Complete Mandibular Denture (Lab)	\$102
D5650	Add Tooth to Existing Partial Denture	\$35	D5760	Reline Maxillary Partial Denture (Lab)	\$102
D5660	Add Clasp to Existing Partial Denture	\$40	D5761	Reline Mandibular Partial Denture (Lab)	\$102
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	\$100	D5820	Interim Partial Denture (Maxillary) (3)	\$90
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	\$100	D5821	Interim Partial Denture (Mandibular) (3)	\$90
D5710	Rebase Complete Maxillary Denture	\$100	D5850	Tissue Conditioning, Maxillary	\$40
D5711	Rebase Complete Mandibular Denture	\$100	D5851	Tissue Conditioning, Mandibular	\$40
D5720	Rebase Maxillary Partial Denture	\$100	D5860	Overdenture - Complete, by Report	\$275
D5721	Rebase Mandibular Partial Denture	\$100			

(3) Eligible on Anterior Teeth only.

ORAL SURGERY					
D7111	Extraction, Coronal Remnants - Deciduous Tooth	\$4	D7285 (1)	Biopsy of Oral Tissue - Hard (Bone, Tooth)	\$75
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$11	D7286 (1)	Biopsy of Oral Tissue - Soft	\$75
D7210 (1)	Surgical Removal of Erupted Tooth	\$28	D7287 (1)	Cytological Sample Collection	\$38
D7220 (1)	Removal of Impacted Tooth - Soft Tissue	\$46	D7310 (1)	Alveoloplasty in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	\$25



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D7230 (1)	Removal of Impacted Tooth - Partially Bony	\$58	D7311 (1)	Alveoloplasty in Conjunction With Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	\$13
D7240 (1)	Removal of Impacted Tooth - Completely Bony	\$117	D7320 (1)	Alveoloplasty Not in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	\$40
D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	\$117	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	\$20
D7250 (1)	Surgical Removal of Residual Tooth Roots	\$25	D7510 (1)	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$20
D7251	Coronectomy - intentional partial tooth removal	\$59	D7511 (1)	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated	\$22
D7280 (1)	Surgical Access of Unerupted Tooth	\$26	D7960 (1)	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	\$34
D7282 (1)	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	\$30	D7963 (1)	Frenuloplasty	\$36
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$6			

(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.

OTHER (ADJUNCTIVE) SERVICES

D9110	Palliative (Emergency) Treatment of Dental Pain - minor procedure	\$10	D9940	Occlusal Guard, by Report	\$100
D9223	Deep sedation/general anesthesia - each 15 minute increment	\$83	D9943	Occlusal guard adjustment	\$13
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	\$83	D9942	Repair and/or Reline of Occlusal Guard	\$18
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	No Charge	D9951	Occlusal Adjustment - limited	\$20
D9311	Consultation with a medical health care professional	No Charge	D9952	Occlusal Adjustment - complete	\$80
D9932-D9935	Denture cleaning and inspection	\$25			

ORTHODONTICS

	Orthodontic Screening Exam	Not Covered			
	Diagnostic Records	Not Covered			
	Comprehensive Orthodontic Treatment				
	Adolescent (appliance must be placed prior to age 20)	Not Covered			
	Adult	Not Covered			
	Orthodontic Retention	Not Covered			

PLAN EXCLUSIONS AND LIMITATIONS*

Some Services Not Covered Under the Plan Are:

- Services or supplies that are covered in whole or in part:
 - under any other part of this Dental Care Plan; or
 - under any other plan of group benefits provided by or through your employer.
- Services and supplies to diagnose or treat a disease or injury that is not:
 - a non-occupational disease; or
 - a non-occupational injury.
- Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
- Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.

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5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. Does not apply to CA contracts.
8. Those for any of the following services (Does not apply to TX contracts): (a) An appliance or modification of one if an impression for it was made before the person became a covered person; (b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; (c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a dependent age 5 or older if that dependent becomes a covered dependent other than: (a) during the first 31 days the dependent is eligible for this coverage, or (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred: (i) after the end of the 12-month period starting on the date the dependent became a covered dependent; or (ii) as a result of accidental injuries sustained while the dependent was a covered dependent; or (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless: (a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or (b) The tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. Does not apply to CA contracts.
Any exclusion above will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Other Important Information

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

Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY and OH and for members residing in MA and OK (regardless of contract situs state).

Specialty Referrals

1. Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.



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2. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Dental has opened direct access for DMO members to orthodontic services.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

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

Replacement Rule

The replacement of; addition to; or modification of:
existing dentures;
crowns;
casts or processed restorations;
removable denture;
fixed bridgework; or
other prosthetic services
is covered only if one of the following terms is met:

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

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

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

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule (Does not apply to TX and CA contracts.)

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

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- (a) the service must be listed on the Dental Care Schedule;
- (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- (c) the service selected must meet broadly accepted national standards of dental practice.

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

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

Finding Participating Providers

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



Dental Benefits Summary

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern. In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate. All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

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

In Arizona, DMO Dental Plans are provided or administered by Aetna Health Inc.

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

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color,

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call 877-238-6200 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-238-6200. (Spanish)

欲取得繁體中文語言協助，請撥打877-238-6200，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-238-6200 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-238-6200 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-238-6200 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 877-238-6200. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-238-6200 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-238-6200. (Italian)



Dental Benefits Summary

日本語で援助をご希望の方は、877-238-6200 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-238-6200 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 6200-238-877. بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-238-6200. (Polish)

Para obter assistência linguística em português ligue para o 877-238-6200 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-238-6200. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-238-6200. (Vietnamese)