

Cuyahoga Community College
Aetna U.S. Healthcare Dental Maintenance Organization (DMO®)

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copy	\$0			
DIAGNOSTIC			RESTORATIVE		
0120	Exam-Periodic**	No Charge	2330	Resin-1 Surface, Anterior	No Charge
0150	Exam-Comprehensive**	No Charge	2331	Resin-2 Surfaces, Anterior	No Charge
0210	X-ray, Intraoral, Complete Series (including bitewings)**	No Charge	2332	Resin-3 Surfaces, Anterior	No Charge
0220	X-ray, Intraoral, First Film	No Charge	2335	Resin-4 or More Surfaces or Incisal Angle, Anterior	No Charge
0230	X-ray, Intraoral, Additional	No Charge	2940	Sedative Filling	No Charge
0240	X-ray, Intraoral, Occlusal	No Charge	2951	Pin retention, exclusive of Restoration	\$6
0250	X-ray, Extraoral, First Film	No Charge	All charges for crown and bridge are per unit. There will be an additional patient charge for the actual cost for gold/high noble metal for the procedures identified by an asterisk (*).		
0260	X-ray, Extraoral, Additional	No Charge	CROWNS/BRIDGES		
0270	X-ray, Bitewing-Single Film**	No Charge	2510/2520	Inlay or Onlay, Metallic*	\$160
0272	X-ray, Bitewing-Two Films**	No Charge	2530	Inlay or Onlay, Metallic*	\$160
0274	X-ray, Bitewing-Four Films**	No Charge	2543-2544	Inlay or Onlay, Metallic*	\$160
0330	X-ray, Panoramic	No Charge	2740	Crown, Porcelain/Ceramic Substrate	\$185
0460	Pulp Vitality Test	No Charge	2750-2752	Crown, Porcelain Fused to Metal*	\$185
0470	Diagnostic Casts	No Charge	2790-2792	Crown, Full Cast Metal*	\$185
PREVENTIVE			2810	Crown, 3/4 Cast Metal*	\$178
1110	Prophylaxis-Adult (Limit-2 per Year)	No Charge	2910-2920	Recement Inlays/Crowns	\$5
1120	Prophylaxis-Child (Limit-2 per Year)	No Charge	2930	Crown, Stainless Steel-Primary Tooth (Child)	No Charge
1203/1204	Topical Application of Fluoride (1 per year under age 16)	No Charge	2931	Crown, Prefab. Stainless Steel-Permanent Tooth	\$40
1330	Oral Hygiene Instructions	No Charge	2950	Core Buildup, including pins	\$30
1351	Sealant-per Tooth (under age 16)**	No Charge	2952	Cast Post and Core, in addition to Crown	\$50
1510/1515	Space Maintainers-Fixed	No Charge	2954	Prefab. Post and Core, in addition to Crown	\$60
1520/1525	Space Maintainers- Removable (includes adjustments within 6 months of installation)	No Charge	6210-6212	Pontic, Full Cast Metal*	\$185
1550	Recement Space Maintainer	\$12	6240-6242	Pontic, Porcelain Fused to Metal*	\$185
RESTORATIVE			6750-6752	Crown, Abutment, Porcelain Fused to Metal*	\$185
PRIMARY TEETH			6790-6792	Crown, Abutment, Full Cast Metal*	\$185
2110	Amalgam-1 Surface	No Charge	6930	Recement Bridge	\$15
2120	Amalgam-2 Surfaces	No Charge	Additional Charge per Unit for Full Mouth Rehabilitation.		
2130	Amalgam-3 Surfaces	No Charge	Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.		
2131	Amalgam-4 or More Surfaces	No Charge			
PERMANENT TEETH					
2140	Amalgam-1 Surface	No Charge			
2150	Amalgam-2 Surfaces	No Charge			
2160	Amalgam-3 Surfaces	No Charge			
2161	Amalgam-4 or More Surfaces	No Charge			

"Patient Pays" applies to those procedures provided by the member's primary care dentist or approved specialty dentist.

(**) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate or evidence of coverage.

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
ENDODONTICS			PROSTHODONTICS-REMOVABLE		
3110-3120	Pulp Cap, Direct or Indirect	No Charge	5410-5411	Adjust Complete Denture Upper or Lower	\$10
3220	Therapeutic Pulpotomy	No Charge	5421-5422	Adjust Partial Denture Upper or Lower	\$10
3310	Root Canal, Anterior	\$50	REPAIRS TO PROSTHETICS		
3320	Root Canal, Bicuspid	\$70	5510	Repair Broken Acrylic, Complete Denture Upper or Lower	\$25
3330	Root Canal, Molar	\$150	5520	Replace One Tooth on Complete Denture	\$35
3410	Apicoectomy/Periradicular Surgery, Anterior	\$60	5610-5630	Repair Acrylic, Cast Frame, Broken Clasp	\$35
3421	Apicoectomy/Periradicular Surgery, Bicuspid - 1st root	\$60	5640	Replace Broken Tooth, Partial	\$35
3425	Apicoectomy/Periradicular Surgery, Molar-1st Root	\$80	5650	Add Tooth to Existing Partial	\$35
3426	Apicoectomy/Periradicular Surgery-each additional root	\$40	5660	Add Clasp to Existing Partial	\$40
3430	Retrograde Filling per Root	\$20	5710-5711	Rebase Complete Upper or Lower Denture	\$86
3450	Root Amputation per Root	\$60	5720-5721	Rebase Partial Upper or Lower Denture	\$86
PERIODONTICS			5730-5731	Reline Complete Upper or Lower Denture (chairside)	\$40
4210	Gingivectomy or Gingivoplasty per Quadrant (limit 1 per quad every 3 years)	\$75	5740-5741	Reline Partial Upper/Lower Denture (Chairside)	\$40
4211	Gingivectomy or Gingivoplasty per Tooth (limit 1 per site every 3 years)	\$20	5750-5751	Reline Complete Upper or Lower Denture (Laboratory)	\$75
4220	Gingival Curettage, Surgical per Quadrant (Limit of 4 separate quadrants every 2 years)	\$25	5760-5761	Reline Partial Upper/Lower Denture (Laboratory)	\$75
4240	Gingival Flap Procedure - per quad.	\$90	5820-5821	Interim Partial Upper/Lower Partial (Stayplate)	\$60
4260	Osseous Surgery per Quadrant (including flap entry and closure) (limit 1 per quad. every 3 years)	\$250	5850-5851	Tissue Conditioning, Upper or Lower	\$20
4341	Periodontal Scaling & Root Planing per Quadrant (Limit of 4 separate quadrants every 2 years)	\$40	ORAL SURGERY		
4910	Periodontal Maintenance Procedures (1 in 12 months- following active therapy)	\$20	7110	Extraction, Single Tooth	No Charge
PROSTHODONTICS-REMOVABLE*			7120	Extraction, Each Additional Tooth	No Charge
5110-5120	Complete Upper or Lower Denture	\$250	7130	Root Removal, Exposed Root	No Charge
5130-5140	Immediate Upper or Lower Denture (does not include charge for reline)	\$300	7210	Surgical Extraction of an Erupted Tooth	No Charge
5211-5212	Upper or Lower Partial Denture Resin Base-Including Clasps, Rests and Teeth	\$250	7220	Removal of Impacted Tooth, Soft Tissue	No Charge
5213-5214	Upper or Lower Partial Cast Metal Base-Including Clasps, Rests and Teeth	\$300	7230	Removal of Impacted Tooth, Partially Bony	\$45
			7240-7241	Removal of Impacted Tooth, Completely Bony	\$60
			7250	Surgical Removal of Root Tip, Root Recovery	\$15
			7281	Surgical Exposure of Unerrupted, Impacted Tooth to Aid Eruption	\$30

*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.

CODE	PROCEDURE	PATIENT PAYS	PLAN EXCLUSIONS AND LIMITATIONS
ORAL SURGERY			<p>Some of the services not covered under the plan are:</p> <p>7. Those for: dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion or correcting attrition, abrasion, or erosion.</p> <p>8. Those for any of the following services:</p> <p>(a) An appliance or modification of one if an impression for it was made before the person became a covered person;</p> <p>(b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;</p> <p>(c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.</p> <p>9. Those for services that Aetna defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician or dentist.</p> <p>10. Those for services intended for treatment of any Jaw Joint Disorder unless otherwise specified in the Booklet-Certificate.</p> <p>11. Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.</p> <p>12. Those for orthodontic treatment unless otherwise specified in the Booklet-Certificate.</p> <p>13. Those for general anesthesia and intravenous sedation.</p> <p>14. Those for treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.</p> <p>15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than: (a) during the first 31 days the person is eligible for this coverage; or (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:</p> <p>(a) After the end of the twelve month period starting on the date the person became a covered person; or</p> <p>(b) As a result of accidental injuries sustained while the person was a covered person; or</p> <p>(c) For a primary care service in the Dental Care Schedule that applies shown under the headings Visits and Exams, and X-rays and Pathology.</p> <p>16. Those for services given by a non-participating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.</p> <p>17. Those for a crown, cast or processed restoration unless:</p> <p>(a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or</p> <p>(b) The tooth is an abutment to a covered partial denture or fixed bridge.</p> <p>18. Those for pontics, crowns, cast or processed restorations made with high noble metals unless otherwise specified in the Booklet-Certificate.</p> <p>19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons unless otherwise specified in the Booklet-Certificate.</p> <p>20. Those for services needed solely in connection with non-covered services.</p> <p>21. Those for services done where there is not evidence of pathology, dysfunction, or disease other than covered preventive services.</p>
7285-7286	Biopsy of Hard or Soft Tissue	\$20	
7310	Alveoplasty in Conjunction with Extractions (per Quadrant)	\$18	
7320	Alveoplasty Not in Conjunction with Extractions (per Quadrant)	\$25	
7510	Incision and Drainage, Intraoral Abscess	\$10	
7960	Frenectomy	\$24	
OTHER (ADJUNCTIVE) SERVICES			
9310	Consultation Appointment	No Charge	
9940	Occlusal Guards-for bruxism only (limit 1 every 3 years)	\$70	
9951	Occlusal Adjustment, Limited	\$10	
9952	Occlusal Adjustment, Complete	\$60	
EMERGENCY SERVICES			
0140/0160	Oral Evaluation, Problem Focused	No Charge	
9110	Emergency Palliative Treatment	\$10	
ORTHODONTICS			
	Orthodontic Screening Exam	\$30	
	Diagnostic Records	\$150	
	Comprehensive Orthodontic Treatment		
	Adolescent	\$1,045	
	Adult	\$1,045	
	Orthodontic Retention	\$275	
PLAN EXCLUSIONS AND LIMITATIONS			
Some of the services not covered under the plan are:			
<p>1. Those for services or supplies which are covered in whole or in part:</p> <p>(a) Under any other part of this Dental Care Plan; or</p> <p>(b) Under any other plan of group benefits provided by or through your employer.</p> <p>2. Those for services and supplies to diagnose or treat a disease or injury that is not:</p> <p>(a) A non-occupational disease; or</p> <p>(b) A non-occupational injury.</p> <p>3. Those for services not listed in the Dental Care Schedule that applies; unless otherwise specified in the Booklet-Certificate.</p> <p>4. Those for replacement of a lost, missing, or stolen appliance; and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.</p> <p>5. Those for: plastic, reconstructive, cosmetic surgery, or other dental services or supplies which are primarily intended to improve, alter, or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.</p> <p>6. Those for or in connection with: services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.</p>			

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Dental Maintenance Organization (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 established direct access for DMO members to orthodontic services.

Emergency Dental Care*

DMO participating dentists will arrange for treatment for your dental emergencies at the DMO level of benefits. If the emergency occurs more than 50 miles from home, you have limited coverage for certain treatment by a non-participating dentist. The services must be needed to relieve pain or prevent the worsening of a condition that would be caused by delay of treatment. The benefit for certain treatment is the dentist's charge up to a \$100 limit. *Covered emergency services may vary, based on state law.

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 bridges, or fixed bridgework is covered only if one of the following terms is met: (a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental Care Plan coverage must have been in force for the covered person when the extraction took place. (b) The existing denture, crown, cast or processed restoration, removable bridge, or bridgework cannot be made serviceable; and was installed at least 5 years under the DMO Dental Plan before its replacement. (c) 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.

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures, removable bridges, and fixed bridgework is subject to the requirements that such dentures, removable bridges, and fixed bridgework 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 under the DMO Dental Plan. (This exclusion does not apply for TX regulations under the DMO).

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 must be deemed by the dental profession to be an appropriate method of treatment; and (c) The service 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.

Consult Aetna U.S. Healthcare's on-line provider directory for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna U.S. Healthcare or its affiliates. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna U.S. Healthcare has identified providers who were not accepting patients as known to Aetna U.S. Healthcare 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 member services at the toll-free number on your ID card or use our Internet based provider directory DocFind®.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract or any part of one. For a complete description of the benefits available to you, including procedures, exclusions and limitations, please request a copy of your specific plan documents which may include the Group Insurance Certificate or Booklet, Group Insurance Policy and any applicable riders to your plan. All the terms and conditions of your plan or program are subject to and governed by applicable contracts, laws, and regulations and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available in all areas. All benefits are subject to coordination of benefits.

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 you and your plan documents and this information, the plan documents will govern.

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

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

Dental benefits are provided or administered by: Aetna Life Insurance Company, Aetna U.S. Healthcare Dental Plan of California, Inc., Aetna U.S. Healthcare Dental Plan Inc. (NJ), Aetna U.S. Healthcare Dental Plan Inc. (TX) and the following Aetna U.S. Healthcare affiliates: Prudential Dental Maintenance Organization, Inc., Prudential Health Care Plan of California, Inc, and Prudential Health Care Plan of Georgia, Inc. and Aetna U.S. Healthcare, Inc. (AZ).

Georgia residents may contact us at Aetna U.S. Healthcare, 11675 Great Oaks Way, Alpharetta, GA 30022, (770) 346-4300.

Enrollees on their own behalf or on behalf of their covered family members may request an independent medical review when the enrollee believes that health care services have been improperly denied, modified or delayed by a participating dentist, by Aetna U.S. Healthcare Dental Plan of California Inc. or its affiliates, Prudential Health Care Plan of California, Inc. (the "Plans"). Please contact the Plan for additional details and instructions.