



Aetna Dental presents
A Dental Benefit Summary for
Kent State University

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	\$0			
DIAGNOSTIC			CROWNS/BRIDGES		
D0120	Exam-Periodic	No Charge	D2510	Inlay, Metallic, One surface	\$220
D0150	Exam-Comprehensive	No Charge	D2530	Inlay, Metallic, Three or more surfaces	\$220
D0210	X-ray, Intraoral, Complete Series (including bitewings)	No Charge	D2543	Onlay, Metallic, Three surfaces	\$220
D0220	X-ray, Intraoral, Periapical first film	No Charge	D2740	Crown, Porcelain/Ceramic Substrate	\$260
D0230	X-ray, Intraoral, Periapical each add.	No Charge	D2750	Crown, Porcelain Fused to Metal*	\$260
D0240	X-ray, Intraoral, Occlusal	No Charge	D2790	Crown, Full Cast Metal*	\$260
D0250	X-ray, Extraoral, First Film	No Charge	D2781	Crown, ¾ Cast Metal*	\$250
D0260	X-ray, Extraoral, each additional	No Charge	D2910	Recement Inlays/Crowns	\$15
D0270	X-ray, Bitewing, Single Film	No Charge	D2930	Crown, Stainless Steel-Primary Tooth (Child)	\$45
D0272	X-ray, Bitewing, Two Films	No Charge	D2931	Crown, Prefab. Stainless Steel- Permanent Tooth	\$60
D0274	X-ray, Bitewing, Four Films	No Charge	D2950	Core Buildup, including pins	\$45
D0277	Vertical Bitewings (7-8 films)	No Charge	D2952	Cast Post and Core, in addition to Crown	\$80
D0330	X-ray, Panoramic film	No Charge	D2954	Prefab. Post and Core, in addition to Crown	\$71
D0460	Pulp Vitality Test	No Charge	D6210	Pontic, Full Cast Metal*	\$260
D0470	Diagnostic Casts	No Charge	D6240	Pontic, Porcelain Fused to Metal*	\$260
PREVENTIVE			D6750	Crown, Abutment, Porcelain Fused to Metal*	\$260
D1110	Prophylaxis-Adult (Limit-2 per Year)	No Charge	D6790	Crown, Abutment, Full Cast Metal*	\$260
D1120	Prophylaxis-Child (Limit-2 per Year)	No Charge	D6930	Recement Bridge	\$20
D1203	Topical Application of Fluoride (1 per year under age 16)	No Charge		Additional Charge per Unit for Full Mouth Rehabilitation.	\$125
D1330	Oral Hygiene Instructions	No Charge	Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.		
D1351	Sealant-per Tooth (under age 16)	\$10	ENDODONTICS		
D1510	Space Maintainers-Fixed	\$65	D3110	Pulp Cap, Direct or Indirect	No Charge
D1520	Space Maintainers- Removable (includes adjustments within 6 months of installation)	\$80	D3220	Therapeutic Pulpotomy	\$35
D1550	Recement Space Maintainer	\$15	D3310	Root Canal, Anterior	\$120
Diagnostic and Preventive services may be subject to age and frequency limitations. See your booklet for details.			D3320	Root Canal, Bicuspid	\$140
RESTORATIVE			D3330	Root Canal, Molar	\$280
PRIMARY OR PERMANENT TEETH			D3410	Apicoectomy/Periradicular Surgery, Anterior	\$130
D2140	Amalgam-1 Surface	No Charge	D3421	Apicoectomy/Periradicular Surgery, Bicuspid – 1st root	\$130
D2150	Amalgam-2 Surfaces	No Charge	D3425	Apicoectomy/Periradicular Surgery, Molar-1st Root	\$150
D2160	Amalgam-3 Surfaces	No Charge	D3426	Apicoectomy/Periradicular Surgery-each additional root	\$90
D2161	Amalgam-4 or More Surfaces	No Charge	D3430	Retrograde Filling per Root	\$65
D2330	Resin-1 Surface, Anterior	No Charge	D3450	Root Amputation per Root	\$80
D2331	Resin-2 Surfaces, Anterior	No Charge			
D2332	Resin-3 Surfaces, Anterior	No Charge			
D2335	Resin-4 or More Surfaces or Incisal Angle, Anterior	No Charge			
D2390	Resin-based composite crown, Anterior	\$60			
D2940	Sedative Filling	\$8			
D2951	Pin retention, exclusive of Restoration	\$6			
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 (*).					
"Patient Pays" applies to those procedures provided by the member's primary care dentist or approved specialty dentist.					

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
PERIODONTICS			REPAIRS TO PROSTHETICS (cont.)		
D4210	Gingivectomy or Gingivoplasty per Quadrant (limit 1 per quad every 3 years)	\$120	D5710	Rebase Complete Upper or Lower Denture	\$86
D4211	Gingivectomy or Gingivoplasty per Tooth (limit 1 per site every 3 years)	\$40	D5720	Rebase Partial Upper or Lower Denture	\$86
D4240	Gingival Flap Procedure - per quad.	\$140	D5730	Reline Complete Upper or Lower Denture (chairside)	\$50
D4241	Gingival Flap Procedure - per quad. including Root Planing, 1-3 teeth	\$84	D5740	Reline Partial Upper/Lower Denture (chair side)	\$50
D4260	Osseous Surgery per Quadrant (including flap entry and closure) (limit 1 per quad. every 3 years)	\$325	D5750	Reline Complete Upper or Lower Denture (Laboratory)	\$95
D4261	Osseous Surgery, 1-3 teeth, per quad.	\$195	D5760	Reline Partial Upper/Lower Denture (Laboratory)	\$95
D4270	Pedicle soft tissue graft	\$250	D5820	Interim Partial Upper/Lower Partial (Stayplate)	\$95
D4271	Free soft tissue graft, including Donor	\$265	D5850	Tissue Conditioning, Upper or Lower	\$25
D4273	Subepithelial connective tissue graft	\$300	ORAL SURGERY		
D4275	Soft tissue allograft	\$300	D7111	Coronal remnants – deciduous Tooth	No Charge
D4341	Periodontal scaling/root planing per quad (Limit of 4 sep. quads every 2 yrs)	\$60	D7140	Extraction, erupted tooth, exposed root	No Charge
D4342	Periodontal scaling/root planing per quad	\$36	D7210	Surgical Extraction of an Erupted Tooth	\$36
D4910	Periodontal Maintenance Procedures (limit of 2 per year following surgical therapy)	\$40	D7220	Removal of Impacted Tooth, Soft Tissue	\$60
PROSTHODONTICS-REMOVABLE*			D7230	Removal of Impacted Tooth, Partially Bony	\$72
D5110	Complete Upper or Lower Denture	\$320	D7240	Removal of Impacted Tooth, Completely Bony	\$110
D5130	Immediate Upper or Lower Denture (does not include charge for reline)	\$330	D7250	Surgical Removal of Root Tip, Root Recovery	\$35
D5211	Upper or Lower Partial Denture Resin Base-Including Clasps, Rests and Teeth	\$300	D7281	Surgical Exposure of Unerupted, Impacted Tooth to Aid Eruption	\$70
D5213	Upper or Lower Partial Cast Metal Base-Including Clasps, Rests and Teeth	\$400	D7285	Biopsy of Oral Tissue, hard	\$80
D5410	Adjust Complete Denture Upper or Lower	\$10	D7286	Biopsy of Oral tissue, soft	\$80
D5421	Adjust Partial Denture Upper or Lower	\$10	D7310	Alveoplasty in Conjunction with Extractions (per Quadrant)	\$35
REPAIRS TO PROSTHETICS			D7320	Alveoplasty Not in conjunction with Extractions (per Quadrant)	\$60
D5510	Repair Broken Acrylic, Complete Denture Upper or Lower	\$30	D7510	Incision and Drainage, Intraoral Abscess	\$30
D5520	Replace One Tooth on Complete Denture	\$25	D7960	Frenectomy	\$90
D5610	Repair Acrylic, Cast Frame, Broken Clasp	\$35	OTHER (ADJUNCTIVE) SERVICES		
D5640	Replace Broken Tooth, Partial	\$35	D9310	Consultation Appointment	No Charge
D5650	Add Tooth to Existing Partial	\$35	D9940	Occlusal Guards-for bruxism only (limit 1 every 3 years)	\$70
D5660	Add Clasp to Existing Partial	\$45	D9951	Occlusal Adjustment, Limited	\$10
D5670	Replace all teeth/acrylic metal frame Maxillary	\$86	D9952	Occlusal Adjustment, Complete	\$60
D5671	Replace all teeth/acrylic metal frame Mandibular	\$86	EMERGENCY SERVICES		
*Includes relines, adjustments, rebases within the 1 st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.			D0140	Oral Evaluation, Problem Focused	No Charge
			D0160	Detailed and extensive oral evaluation	No Charge
			D0180	Comprehensive Periodontal evaluation	No Charge
			D9110	Emergency Palliative Treatment	\$10
"Patient Pays" applies to those procedures provided by the member's primary care dentist or approved specialty dentist.					

CODE	PROCEDURE	PATIENT PAYS	PLAN EXCLUSIONS AND LIMITATIONS
ORTHODONTICS			Some of the services not covered under the plan are: 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: (a) After the end of the twelve month period starting on the date the person became a covered person; or (b) As a result of accidental injuries sustained while the person was a covered person; or (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. 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. 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. Those for services needed solely in connection with non-covered services. 21. Those for services done where there is not evidence of pathology, dysfunction, or disease other than covered preventive services.
	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:			
1. Those for services or supplies which are covered in whole or in part: (a) Under any other part of this Dental Care Plan; or (b) Under any other plan of group benefits provided by or through your employer.			
2. Those for services and supplies to diagnose or treat a disease or injury that is not: (a) A non-occupational disease; or (b) A non-occupational injury.			
3. Those for services not listed in the Dental Care Schedule that applies; unless otherwise specified in the Booklet- Certificate.			
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.			
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.			
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 correcting attrition, abrasion, or erosion.			
8. Those for any of the following services: (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. 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.			
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.			
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.			

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.

Specialty Referrals

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 opened 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. Emergency care is treatment for any traumatic injury or condition, which occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and is characterized by symptoms such as severe pain and bleeding. The benefit for certain treatment is the dentist's charge up to a \$100 limit.

*Covered emergency services may vary, based on state law.

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 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 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'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 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 has identified providers who were not accepting patients in our DMO as known to Aetna at the time this 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®.

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

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

All member care and related decisions are the sole responsibility of participating providers. Aetna 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, Advantage Plus Dental, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc.; PPO and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.

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, Certificate-booklet, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.