Aetna®

Yale Robbins, Inc.

Proposed Effective Date: 08/01/05

Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	**$5**
DIAGNOSTIC		
D0120	**Exam-Periodic**	No Charge
D0150	Exam-Comprehensive	No Charge
D0210	X-ray, Intraoral, Complete Series (including bitewings)	No Charge
D0220	X-ray, Intraoral, Periapical first film	No Charge
D0230	X-ray, Intraoral, Periapical each add.	No Charge
D0240	X-ray, Intraoral, Occlusal	No Charge
D0250	X-ray, Extraoral, First Film	No Charge
D0260	X-ray, Extraoral, each additional	No Charge
D0270	X-ray, Bitewing, Single Film	No Charge
D0272	X-ray, Bitewing, Two Films	No Charge
D0274	X-ray, Bitewing, Four Films	No Charge
D0277	Vertical Bitewings (7-8 films)	No Charge
D0330	X-ray, Panoramic film	No Charge
D0460	Pulp Vitality Test	No Charge
D0470	Diagnostic Casts	No Charge
PREVENTIVE		
D1110	Prophylaxis-Adult (Limit-2 per Year)	$12
D1120	Prophylaxis-Child (Limit-2 per Year)	$10
D1203-D1204	Topical Application of Fluoride (1 per year under age 16)	No Charge
D1330	Oral Hygiene Instructions	No Charge
D1351	Sealant-per Tooth (under age 16)	$10
D1510-D1515	Space Maintainers-Fixed	$100
D1520-D1525	Space Maintainers- Removable (includes adjustments within 6 months of installation)	$100
D1550	Recement Space Maintainer	$15
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 Surface	$22
D2150	Amalgam-2 Surfaces	$32
D2160	Amalgam-3 Surfaces	$43
D2161	Amalgam-4 or More Surfaces	$53
D2330	Resin-1 Surface, Anterior	$40
D2331	Resin-2 Surfaces, Anterior	$55
D2332	Resin-3 Surfaces, Anterior	$60
D2335	Resin-4 or More Surfaces or Incisal Angle, Anterior	$70
D2390	Resin-based composite crown, Anterior	$80
D2391	Resin-based composite-1 Surf, Posterior	$22
D2392	Resin-based composite-2 Surf, Posterior	$32
D2393	Resin-based composite-3 Surf, Posterior	$43
D2394	Resin-based composite-4+ Surf, Posterior	$53
D2940	Sedative Filling	$15
D2951	Pin retention, exclusive of Restoration	$15
CROWNS/BRIDGES		
D2510-D2520	Inlay, Metallic, One surface	$275
D2530	Inlay, Metallic, Three or more surfaces	$275
D2543-D2544	Onlay, Metallic, Three surfaces	$275
D2740	Crown, Porcelain/Ceramic Substrate	$325
D2750-D2752	Crown, Porcelain Fused to Metal*	$325
D2781	Crown, ¾ Cast Metal*	$300
D2790-D2792	Crown, Full Cast Metal*	$325
D2910-D2920	Recement Inlays/Crowns	$18
D2930	Crown, Stainless Steel-Primary Tooth (Child)	$65
D2931	Crown, Prefab. Stainless Steel-Permanent Tooth	$80
D2950	Core Buildup, including pins	$55
D2952	Cast Post and Core, in addition to Crown	$95
D2954	Prefab. Post and Core, in addition to Crown	$90
D6210-D6212	Pontic, Full Cast Metal*	$325
D6240-D6242	Pontic, Porcelain Fused to Metal*	$325
D6750-D6752	Crown, Abutment, Porcelain Fused to Metal*	$325
D6790-D6792	Crown, Abutment, Full Cast Metal*	$325
D6930	Recement Bridge	$20
	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.		
ENDODONTICS		
D3110-D3120	Pulp Cap, Direct or Indirect	$8
D3220	Therapeutic Pulpotomy	$50
D3310	Root Canal, Anterior	$150
D3320	Root Canal, Bicuspid	$195
D3330	Root Canal, Molar	$295
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$250
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	$295
D3348	Retreatment of Previous Root Canal Therapy – Molar	$395
D3410	Apicoectomy/Periradicular Surgery, Anterior	$156
D3421	Apicoectomy/Periradicular Surgery, Bicuspid – 1st root	$156
D3425	Apicoectomy/Periradicular Surgery, Molar-1st Root	$190
D3426	Apicoectomy/Periradicular Surgery-each additional root	$130
D3430	Retrograde Filling per Root	$75
D3450	Root Amputation per Root	$100

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.

Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS
PERIODONTICS		
D4210	Gingivectomy or Gingivoplasty per Quadrant (limit 1 per quad every 3 years)	$160
D4211	Gingivectomy or Gingivoplasty per Tooth (limit 1 per site every 3 years)	$43
D4240	Gingival Flap Procedure - per quad.	$200
D4241	Gingival Flap Procedure - per quad. including Root Planning, 1-3 teeth	$120
D4260	Osseous Surgery per Quadrant (including flap entry and closure) (limit 1 per quad. every 3 years)	$340
D4261	Osseous Surgery, 1-3 teeth, per quad.	$204
D4270	Pedicle soft tissue graft	$260
D4271	Free soft tissue graft, including Donor	$275
D4273	Subepithelial connective tissue graft	$310
D4275	Soft tissue allograft	$310
D4276	Combined Commective Tissue and Double Pedicle Graft	$341
D4341	Periodontal scaling/root planning per quad (Limit of 4 sep. quads every 2 yrs)	$65
D4342	Periodontal scaling/root planning per quad	$39
D4910	Periodontal Maintenance Procedures (limit of 2 per year following surgical therapy)	$60
PROSTHODONTICS-REMOVABLE*		
D5110-D5120	Complete Upper or Lower Denture	$350
D5130-D5140	Immediate Upper or Lower Denture (does not include charge for reline)	$400
D5211-D5212	Upper or Lower Partial Denture Resin Base-Including Clasps, Rests and Teeth	$375
D5213-D5214	Upper or Lower Partial Cast Metal Base-Including Clasps, Rests and Teeth	$475
D5410-D5411	Adjust Complete Denture Upper or Lower	$15
D5421-D5422	Adjust Partial Denture Upper or Lower	$15
REPAIRS TO PROSTHETICS		
D5510	Repair Broken Acrylic, Complete Denture Upper or Lower	$35
D5520	Replace One Tooth on Complete Denture	$25
D5610-D5630	Repair Acrylic, Cast Frame, Broken Clasp	$45
D5640	Replace Broken Tooth, Partial	$45
D5650	Add Tooth to Existing Partial	$45
D5660	Add Clasp to Existing Partial	$50
D5670	Replace all teeth/acrylic metal frame Maxillary	$95
D5671	Replace all teeth/acrylic metal frame Mandibular	$95

CODE	PROCEDURE	PATIENT PAYS
REPAIRS TO PROSTHETICS (cont.)		
D5710-D5711	Rebase Complete Upper or Lower Denture	$95
D5720-D5721	Rebase Partial Upper or Lower Denture	$95
D5730-D5731	Reline Complete Upper or Lower Denture (chairside)	$65
D5740-D5741	Reline Partial Upper/Lower Denture (chair side)	$65
D5750-D5751	Reline Complete Upper or Lower Denture (Laboratory)	$110
D5760-D5761	Reline Partial Upper/Lower Denture (Laboratory)	$110
D5820-D5821	Interim Partial Upper/Lower Partial (Stayplate)	$110
D5850-D5851	Tissue Conditioning, Upper or Lower	$35
ORAL SURGERY		
D7111	Coronal remnants – deciduous Tooth	$15
D7140	Extraction, erupted tooth, exposed root	$30
D7210	Surgical Extraction of an Erupted Tooth	$60
D7220	Removal of Impacted Tooth, Soft Tissue	$80
D7230	Removal of Impacted Tooth, Partially Bony	$100
D7240-D7241	Removal of Impacted Tooth, Completely Bony	$150
D7250	Surgical Removal of Root Tip, Root Recovery	$55
D7281	Surgical Exposure of Unerupted, Impacted Tooth to Aid Eruption	$90
D7285	Biopsy of Oral Tissue, hard	$100
D7286	Biopsy of Oral tissue, soft	$100
D7310	Alveoplasty in Conjunction with Extractions (per Quadrant)	$55
D7320	Alveoplasty Not in conjunction with Extractions (per Quadrant)	$75
D7510	Incision and Drainage, Intraoral Abscess	$50
D7960	Frenectomy	$128
OTHER (ADJUNCTIVE) SERVICES		
D9310	Consultation Appointment	No Charge
D9940	Occlusal Guards-for bruxism only (limit 1 every 3 years)	$90
D9951	Occlusal Adjustment, Limited	$25
D9952	Occlusal Adjustment, Complete	$90
EMERGENCY SERVICES		
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

***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.**

Dental Benefits Summary

"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:**
	Orthodontic Screening Exam	$30	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.
	Diagnostic Records	$150	
	Comprehensive Orthodontic Treatment		
	Adolescent	$1,845	
	Adult	Not Covered	
	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 benefits summary of the Aetna Dental DMO (Dental Maintenance Organization) 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.
*In some states, limited coverage may be available for non-emergency services referred by a nonparticipating provider.

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.
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, or you are more than 50 miles from your home address, you should contact Member Services for assistance in locating a dentist. If you receive treatment from a non-participating dentist more than 50 miles away from your home, then the emergency services will be covered up to a maximum of $100. You must submit a claim to Aetna in order to receive benefits. *

*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.

Tooth Missing But Not Replaced Rule
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 ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

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 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, Advantage Plus Dental, Advantage Dental, Basic Dental and Family Preventive 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,

Dental Benefits Summary

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