Benefit Summary for
Connecticut Business and Industry Association

This Benefit summary of the Aetna's 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.

	DMO
Annual Deductible*	
Individual	**None**
Family	**None**
Preventive Service Covered Percent	**100%**
Basic Service Covered Percent	**90%**
Major Service Covered Percent	**60%**
Annual Benefit Maximum	**None**
Office Visit Copay	**$5**

Covered Dental Services

The coverage levels for some common dental services are shown below.

	DMO
Visits and Exams	
Visit for oral examination (a)	100%
Prophylaxis, including scaling and polishing (a)	
Adult	100%
Child	100%
Fluoride (a)	100%
Oral hygiene instruction	100%
Sealants (permanent molars and bicuspids) (a)	100%
X-rays	
Bitewing X-rays (a)	100%
Full mouth series (a)	100%
Endodontics	
Pulpotomy	90%
Root canal therapy, with X-rays and cultures	90%
Anterior	90%
Bicuspid	90%
Apicoectomy	90%
Root canal therapy, molar teeth, with X-rays and cultures	60%
Minor Restorations	
Amalgam (silver) fillings	90%
Composite fillings (anterior teeth only)	90%
Stainless steel crowns	90%
Periodontics	
Scaling and root planing (a)	90%
Subgingival curettage (a)	90%
Gingivectomy (per tooth)	90%
Osseous surgery (a)	60%

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

	DMO
Oral Surgery	
Incision and drainage of abscess	90%
Uncomplicated extractions	90%
Surgical removal of erupted tooth	90%
Surgical removal of impacted tooth (soft tissue)	90%
Surgical removal of impacted tooth (partial bony)	60%
Surgical removal of impacted tooth (full bony)	60%
Prosthodontics/Major Restorations	
Inlays	60%
Onlays	60%
Crowns	60%
Full & partial dentures	60%
Denture repairs	60%
Pontics	60%
Anesthesia	
General Anesthesia/IV Sedation	60%
Space Maintainers	100%
Orthodontics	
Coinsurance	Not Covered
Orthodontic Deductible	Not Covered
Lifetime Maximum	Not Covered

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. Copayments under the DMO plan are based on the dentist's reasonable and customary fees.

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. * Coverage for emergency services may vary, based on state law.

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 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 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 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.
17. Those for pontics, crowns, cast or processed restorations made with high noble metals unless otherwise specified in the Booklet-Certificate.
18. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons unless otherwise specified in the Booklet-Certificate.
19. Those for services needed solely in connection with non-covered services.
20. Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services

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 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.

Consult Aetna's Dental 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 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 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 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, 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 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 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., Aetna U.S. Healthcare 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 either by a participating dentist, by Aetna U.S. Healthcare Dental Plan of California Inc. or by its affiliate, Prudential Health Care Plan of California, Inc. (the "Plans"). Please contact the Plan for additional details and instructions.