Specialty Dental Office Guide

Dental Maintenance Organization (DMO®)

Aetna Advantage™ Student Dental

Aetna Advantage™ Dental

Basic Dental

Family Preventive

Discount Dental

aetna™

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I. Introduction

Aetna managed dental plans are offered as a benefit to employers and other groups nationwide. They provide covered individuals with comprehensive and flexible dental benefits. Your primary role in this plan is to render appropriate Specialty Dental Services to those patients who have been referred to you by their Primary Care Dentist.

The purpose of the Specialty Dental Office Guide is to provide you with an explanation of certain plan administrative procedures, plan provisions and your role as a Specialty Dentist. The Guide includes information on all Aetna managed dental plans/programs (Aetna Advantage™ Student Dental, Aetna Advantage™ Dental, Basic Dental, Family Preventive, Discount Dental and DMO®).

Aetna recognizes the vital role the specialty dental office plays in delivering a successful dental plan. We appreciate your participation and look forward to a long relationship.

The relationship between Aetna and Specialty Dentists is that of independent contractor. None of the provisions of this Specialty Dental Office Guide are intended to create, or to be construed as creating, any agency, partnership, joint venture and/or employee-employer relationships. All member care and related decisions are the sole responsibility of participating Primary Care Dentists and Specialty Dentists. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Aetna reserves the right to add, delete or change the policies and procedures described in this Specialty Dental Office Guide at any time. Please read the Specialty Dental Office Guide carefully. Your participating dentist agreement requires you to comply with Aetna policies and procedures including those contained in this manual.

Quick Facts

Plan Feature	Discount Dental	Family Preventive	Basic Dental (Stand-Alone Dental)	Aetna Advantage™ Dental	Aetna Advantage™ Student Dental	DMO® Plans
Eligibility Verification	Call number on member ID card	1-800-451-7715	1-800-451-7715	1-800-451-7715	1-800-451-7715	1-800-451-7715
Member Copayments for Individual Procedures	Yes — See Relevant Compensation Schedule (All Services Not Listed as NCS)	Yes — See Relevant Compensation Schedule (All Services Not Listed as NCS)	Yes — See Relevant Compensation Schedule (All Services Not Listed as NCS)	Yes — See Relevant Compensation Schedule (All Services Not Listed as NCS)	Yes — See Relevant Compensation Schedule (Most Services Not Listed as NCS)	Yes — See Dental Procedure Guidelines
Member "Per-Visit" Copayments	None	$2/visit when a prepaid service is provided for commercial business, $5 when a prepaid service is supplied to Medicare members	$2/visit when a prepaid service is provided for commercial business, $5 when a prepaid service is supplied to Medicare members	$5/visit when a prepaid service is provided	$5/visit when a prepaid service is provided	Some plans — Check member ID card for office visit copay amount. Note: Does not apply to orthodontic services.
Orthodontia Coverage	Yes (Direct Member Payment of Reduced Fee)	Yes (Direct Member Payment of Reduced Fee)	Yes (Direct Member Payment of Reduced Fee)	Yes (Direct Member Payment of Reduced Fee)	Yes (Direct Member Payment of Reduced Fee)	To verify coverage call 1-800-451-7715.
Out-of-Area Emergency Benefit	Yes (Only at participating offices)	Yes (May be limited)	Yes (May be limited)	Yes (May be limited)	Yes (May be limited)	Yes (May be limited)
Request Specialist Referral Forms	No	No	No	No	No	National Dentist Line 1-800-451-7715
Specialist Referral Approval	No	No	No	No	No	(See **Specialty Referrals**) Not Required for Orthodontia

Important Addresses and Telephone Numbers

National Dentist Line

1-800-451-7715

All Claims and Specialist Approvals

Aetna Dental
PO Box 14094
Lexington, KY 40512-4094

Pennsylvania CHIP Claims

Aetna Dental
PO Box 981106
El Paso, TX 79998-1106

II. Plan Administration

General Overview

This section provides an overview of the Specialty Services of each of Aetna's Managed Dental Plans. These currently include ***DMO®, Aetna Advantage™ Dental, Aetna Advantage™ Student Dental, Basic Dental, Family Preventive, and Discount Dental***. As you review this Guide, you will note that procedures and administrative policies occasionally differ between the various plans. These differences are clearly noted.

In All Plans

- There are no deductibles or waiting periods.
- To receive benefits, members of all plans, except Discount Dental, must receive specialty care from participating Specialty Dentists (this may differ in some states). Discount Dental members can seek treatment from any participating Specialty Dentist, regardless of whether the treatment is routine or specialty.

Discount Dental

- There are no prepaid services.
- All dental services, including **all** services provided by participating specialists, are charged by the dentist **to the member,** based on the applicable fee schedule.
- **Discount Dental does not require prior approval of specialty care.** However, if specialty care is required, the Primary Care Dentist must refer the member to a participating specialist, if one is available, in order for the member to receive access to negotiated discounts.

Family Preventive

- Certain diagnostic and preventive services are fully prepaid (The Primary Care Dentist provides these services to the covered member).
- Commercially insured members have a $2 per-visit copayment when a prepaid service is provided. Medicare members have a $5 copayment. Federal members also have a $5 copayment.
- All other primary care dental services and **all** services provided by participating specialists are charged by the dentist to the member, based on the relevant fee schedule.
- **Family Preventive does not require prior approval of specialty care.** However, if specialty care is required, the Primary Care Dentist must refer the member to a participating specialist, if one is available, in order for the member to receive the plan discount.

Basic Dental (Stand-Alone Dental)

- Diagnostic, preventive, and certain routine restorative services (i.e., amalgam restorations) are fully prepaid (The Primary Care Dentist provides these services to the covered member).
- Members have either a $2 or $5 office visit copayment when prepaid services are provided.
- All other primary care dental services and **all** services provided by participating specialists are charged by the dentist to the member, based on the relevant fee schedule.
- **Basic Dental does not require prior approval of specialty care.** However, if specialty care is required, the Primary Care Dentist must refer the member to a participating specialist, if one is available, in order for the member to receive the plan discount.

Aetna Advantage™ Dental

- Diagnostic, preventive, routine restorative services (i.e., intracoronal amalgams and composites), certain basic repairs, scaling and root planing, and nonsurgical extractions are fully prepaid (The Primary Care Dentist provides these services to the covered member).
- Members have $5 office visit copayment when prepaid services are provided.
- All other primary care dental services and **all** services provided by participating specialists are charged by the dentist **to the member,** based on the relevant fee schedule.
- **Aetna Advantage™ Dental does not require prior approval of specialty care.** However, if specialty care is required, the Primary Care Dentist must refer the member to a participating specialist, if one is available, in order for the member to receive the plan discount.

Aetna Advantage™ Student Dental

The Aetna Advantage Student Dental plan is identical to the Aetna Advantage Dental plan with the exception that the plan year is written on a school year basis rather than a calendar year. This will be important to remember when applying frequencies. If you require information as to the plan year dates for a particular member, please call the National Dentist Line at 1-800-451-7715.

Dental Maintenance Organization (DMO®)

- Diagnostic and preventive services are fully prepaid (The Primary Care Dentist provides these services to the covered member).
- Member copayments, paid by the member directly to the participating dentist, are in place for partially prepaid covered services, including some specialty services. Copayments may take several forms depending on the patient's plan:
  a) Percentage Copayments: These are determined by applying the plan's copayment percentage to your Aetna-approved fee to each service provided. (See **Fee Schedules**.)
  b) Fixed Dollar Copayments: These copayments are determined as a specified dollar amount for each different procedure. These may vary from plan to plan.
  c) Office Visit Copayments: Some plans may also provide for an Office Visit Copayment, which is in addition to the copayments described above. These may vary but are usually either $5 or $10 per office visit. Office Visit Copay does not apply to Orthodontic visits.
- Coverage for Orthodontia is optional.
- In the event that specialty care is required, members must be referred by the Primary Care Dentist to a participating Specialty Dentist. For Orthodontics only, a referral is not required.
- **DMO plans require prior approval of some care provided by Specialty Dentists.** See **Specialty Referrals** for specific instructions.

DMO Plan 42 (DMO Access®)

- Does not cover certain *specific* specialty services when performed by a specialist. These non-covered services are considered reduced fee services. You may bill the patient your DMO negotiated rate for these services.
- In addition to the DMO network, this plan also offers the member use of the Aetna Dental Access network.
- If you are participating in both the Aetna Dental Access® network and the DMO network, the DMO negotiated fee should be charged.

Compensation

As indicated above, under Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage Student Dental, the member is responsible for full payment of the fee specified in the fee schedule applicable to the plan and attached to your Specialty Dentist Agreement. **You may not balance bill the patient for any amounts in excess of the fee schedule.**

Under DMO plans, compensation is based on the fee schedule attached to the Specialty Dentist Agreement. For services with no member copayment, Aetna will pay the full amount of the fee shown in the schedule. For services with a member copayment, Aetna will pay the difference, if any, between the copayment specified in the member's plan and the scheduled fee.

Copayments

Member copayments are determined by the patient's plan. Under the DMO fixed copayment plans, the copayment will be a specified dollar amount for each service covered under the plan. Under the DMO coinsurance plans, the copayment is a specified percentage of the fee schedule. **You may not bill the patient for any amounts other than the copayments specified in these plans.**

Patients are financially responsible for all copayments required by the above plans. It is the responsibility of the Specialty Dentist to make arrangements with patients for collection of the copayments. Aetna will not reimburse the Specialty Dentist for any uncollected copayments.

Noncovered Services

You are free to provide any service not covered under the plan. However, before doing so, you **must** inform the patient that the service is not covered and advise the patient of his/her financial responsibility for your fee. This must be confirmed in writing (see the **Informed Consent** form later in this Guide). The following guidelines must be followed in charging patients for noncovered services:

- **Discount Dental:** All services are Reduced Fee Services and should be provided at the rate shown in the relevant Compensation Schedule attached to your Specialty Dentist Agreement. **Note**: If a procedure is not listed, you are required to provide the member a 20% discount off your usual fee.
- **Family Preventive:** All specialist services are Reduced Fee Services and should be provided at the rate shown in the relevant Compensation Schedule attached to your Specialty Dentist Agreement. **Note**: If a procedure is not listed, you are required to provide the member a 20% discount off your usual fee.
- **Basic Dental:** All specialist services are Reduced Fee Services and should be provided at the rate shown in the relevant Compensation Schedule attached to your Specialty Dentist Agreement. **Note**: If a procedure is not listed, you are required to provide the member a 20% discount off your usual fee.
- **Aetna Advantage™ Dental and Aetna Advantage Student Dental:** All specialist services are Reduced Fee Services and should be provided at the rate shown in the relevant Compensation Schedule attached to your Specialty Dentist Agreement. **Note**: If a procedure is not listed, you are required to provide the member a 20% discount off your usual fee.
- **DMO®:** You may charge the full amount of your usual fee to the patient for any noncovered services.
- **DMO Access®**: Does not cover specific specialty services when performed by a specialist. These non-covered services are considered reduced fee services. You may bill the patient your DMO negotiated rate for these services.

Appointments

Aetna Managed Dental Plan members are entitled to the same appointment availability as all other patients. No additional charges may be assessed to covered members. However, if a patient misses appointments without complying with your office's cancellation policy, you may bill the patient for broken appointments, consistent with your existing office policy for all other patients. Similarly, if it is your standard office policy to charge extra for an after-hours office visit, you may also bill the patient for this charge consistent with your existing policy for all other patients.

Second Opinions

As outlined in the Professional Standards section of the Guide, you should discuss all aspects of the patient's treatment plan with the patient prior to beginning treatment. You should address all concerns and questions that the patient may have. Occasionally, however, a patient may indicate that he/she wishes to have a second opinion before commencing treatment. If this should happen, the member should contact Customer Service. They will arrange for the patient to consult with another participating dentist. You should provide copies of your chart and radiographs, and any other pertinent information, to the other dentist upon request. You may bill the patient a reasonable charge for duplicating records.

Eligibility

Verification of patient eligibility

Members have been instructed to identify themselves as participants in an Aetna managed dental plan when they call for an appointment. In addition, members covered under all plans are provided with an Aetna ID card. Whether or not the patient presents an ID card at the time of their appointment, eligibility should be verified for each member each time he/she visits your office to avoid possible misunderstandings on the day of his/her appointment.

If a patient is found to be ineligible for benefits, you must seek payment from the patient. If members require assistance, they can call Aetna Customer Service at the toll-free number shown on their ID card.

Eligibility verification for each managed dental plan is outlined in the Quick Facts chart at the front of the Guide. When contacting the National Dentist Line for eligibility verification, you should be prepared to supply the employee's member ID number, date of birth and other validation requirements and be able to identify the member as an employee, spouse or child.

- Discount Dental
  You may obtain eligibility for these cases by calling the number shown on the member's ID card.
- Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental
  These plans do not require a Specialty Referral approval to receive specialty treatment. Call the National Dentist Line to ensure the member is covered.
- DMO® Plans
  For these plans, the Primary Care Dentist can directly refer certain services or problem-focused examination requests to you. In addition, members may access orthodontic care directly without a referral. See the Specialty Referral section for additional information. To ensure the member is eligible for benefits at the time treatment is provided, call the National Dentist Line.
- The National Dentist Line is 1-800-451-7715

Dental/Medical Integration

Periodontal disease has been associated with diabetes, premature births and low birth weight babies, heart disease and stroke. Aetna has taken a leadership position in adopting an evidence-based approach to help you and our members use tools and services which will promote concepts of prevention and improve oral and overall health.

- We conducted a pilot study to determine if certain interventions can change a member's behavior to seek dental care. By educating members about the importance and value of dental care as part of the overall treatment of their medical conditions, we hope to encourage them to visit their dentists regularly.
- We will continue to review opportunities to increase member education and respond to emerging evidence of connections between oral and systemic health conditions.
- We have developed benefit plans that contain enhanced benefits to allow and encourage eligible members with certain conditions and/or diseases to take advantage of these early interventions. Compensation for these enhanced benefits will be administered as follows:
  - For any services that are currently covered at less than 100%, Aetna will pay the member's copayment or coinsurance amount.
  - For services that are not covered, or are covered but have exceeded the frequency limit, reimbursement from Aetna will be based on the following fee schedule:

Procedure Code	Reimbursement Amount
D1110	$50
D4341	$90
D4342	$54
D4355	$60
D4910	$50
D4381	$80

  - **The compensation listed above only applies to benefit plans that contain the enhanced benefits. Not all plans will include these enhanced benefits.**

Electronic Services

Have you been searching for an easier way to communicate with Aetna?

Using your computer, you can:

- Submit claims
- Send attachments
- Check eligibility
- Review the status of your claims
- Do much more

What are the advantages of using electronic solutions?

Submitting claims electronically can help you:

- Cut down on administrative work — telephone calls, faxes and paperwork
- Improve efficiency
- Experience fewer claims returned due to missing or incorrect information
- Receive faster reimbursement

Choose the solution that's right for you.

Visit www.aetnadental.com for more information on the available electronic solutions.

Frequently Asked Questions About Submitting Electronic Claims

Q. What are the correct payer IDs for Aetna claims?

A. Use 60054 for Aetna claims.

Q. Can all claims be submitted electronically?

A. Yes. All claims can be submitted electronically.

Q. Can electronic claims be resubmitted electronically?

A. Yes, claims can be resubmitted electronically. This is especially beneficial if a claim is rejected through the vendor for missing or invalid information. Electronic claim reports identify these rejects, which can be corrected and resubmitted electronically. Duplicate claim logic is in place to reject exact duplicates of claims submitted electronically within 180 days of the original claim.

Q. Can old claims be submitted electronically?

A. Claims that are past timely filing limitations, often referred to as "old claims," can be submitted electronically. Timely filing limits will be enforced appropriately during claim processing.

Q. If the dentist is having a problem with electronic claims rejecting, who do they call?

A. Call the contact number on the claim status report from the EDI vendor.

Q. What types of attachments are required for dental electronic claims?

A. Claim attachments are not always necessary. We encourage you to review our Claim Documentation Guidelines to determine which attachments, if any, are required. Or, submit claims without attachments. We will request any attachments if needed.

Claim Documentation Guidelines are available in Appendix I of this DMO Specialty Dental Office Guide, on www.aetnadental.com, or by calling our National Dentist Line at 1-800-451-7715.

Q. Are primary payer explanations of benefits always required when Aetna is the secondary payer?

A. While Aetna does not always require the actual statement of payment or rejection from the primary carrier, we may sometimes need the actual document. Please provide the primary carrier's payment amount in the remarks field, and if we require the actual document, we will request it.

Q. Can I send attachments electronically?

A. You can send attachments to us electronically through the attachment vendor, National Electronic Attachment (NEA). These services allow you to transmit X-rays, periodontal charts, intraoral pictures, etc., via the Internet for insurance carriers to view in support of electronic claims. For more information, visit www.aetnadental.com or contact the vendor directly at 1-800-782-5150.

Q. For DMO specialty procedures, are copies of specialty referrals required along with my claim for payment?

A. While an actual copy of the referral is not required, specialists will need to indicate in the remarks field that a patient has been referred.

Q. Can orthodontia claims be submitted electronically?

A. Yes, orthodontic claims should be submitted electronically for all products. Send only the Initial Claim for Orthodontic Treatment Plans — Our system has been enhanced to automatically set up a regular payment schedule for most orthodontic treatment plans. Once we receive the initial claim indicating the banding date, total case fee, length of treatment and all other required claim details, our system will automatically release the appropriate monthly/quarterly installment payment for the member's treatment plan, as long as he/she remains eligible for benefits. **Please Note:** Orthodontic claims do not routinely require models or X-rays.

Q. How can I submit a pre-determination/pre-treatment estimate electronically?

A. Submit the pre-treatment estimate electronically simply by omitting the dates of service. This will reflect that the treatment has not been completed. Please follow the same procedures as outlined above for X-rays, charting and narratives. Aetna will contact the member or dentist if additional information is required.

Q. Can claim transactions be submitted without a CDT procedure code?

A. No, a valid CDT procedure code must be reflected and the code must support the tooth in question, if applicable. Claims submitted with missing or invalid procedure codes will be rejected.

Q. Who should I contact if I have additional questions about electronic claims?

A. To assist you in determining whom to contact with questions on your electronic claims, please use the following as a guide:

- If your claim is rejected at the vendor or clearinghouse level, contact your vendor.
- If your claim is rejecting at the carrier/payer level, contact your vendor.
- If you have questions regarding claim handling (payment or denial), contact Aetna using the toll-free number listed on the remittance advice and/or the number on the patient's ID card.

Aetna Dental has a website to provide you with tools and educational resources to help increase your efficiency while saving time and money. For additional Frequently Asked Questions about Electronic Services, visit www.aetnadental.com.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

What is ERA?

- ERA is an electronic communication containing claim payment information that can be easily viewed or printed.
- It is intended to replace your paper Explanation of Benefits (EOB) statement. Paper statements will be stopped within 60 days of enrollment.
- Since it is available online, the ERA gives you access to the information it contains sooner than with a mailed paper EOB.

What is EFT?

- When you sign up for EFT, your funds will be electronically deposited into the bank account of your choice.
- You can access your money faster — no waiting for your check to come in the mail and making trips to the bank.
- EFT eliminates the threat of lost or stolen checks.
- We have a secure process in place to perform this function. Dentists enrolling for EFT go through a 10-day test period with the financial institution where the account is held.
- Once an error-free test is performed, your EFT enrollment will become effective.

How do I enroll in EFT and/or ERA?

1. After determining which vendor best suits your needs; complete the enrollment form (please ensure you complete it in its entirety). You can find the form on www.aetnadental.com.
2. Mail or fax as directed on the enrollment form.
3. As part of your submission, include a voided check, or for savings accounts, a preprinted deposit slip. ***Note this only applies for EFT enrollment.***

www.aetnadental.com

Register for aetnadental.com now

By registering online, you can get instant access to the secure features of aetnadental.com. This will allow you to submit claims electronically, check the status of a claim or perform real-time eligibility inquiries.

Visit www.aetnadental.com for these benefits:

Electronic Services via a Secure Website

- Receive EOB information
- Submit claims for multiple payers
- Perform real-time eligibility inquiries
- Make claim status inquiries
- View Electronic Remittance Advice

Additional Secure Features

- Access downcoding and bundling policies
- Submit or change name, address, phone number, e-mail and NPI online
- View dental office guides
- Read our *Dental Dialog* Newsletter

Information About Joining Our Network

- Learn about our other dental networks
- Request an application to join our other networks

Claim Resources

- Get help with electronic transactions
- Check claim documentation guidelines
- Access electronic claims processing information
- Learn about electronic attachments
- Register for Electronic Remittance Advice (ERA)/Electronic Funds Transfer (EFT)
- Download a claim form

Educational Resources

- Receive continuing education credits available with access to free continuing education courses
- Use the Practice Management Coach
- View or find out how to order free patient education brochures
- Read the latest dental news and research

Other Helpful Tools

- DocFind® Provider Directory — A Web-based application designed to put information about participating providers at your fingertips. Visit DocFind for individual details about provider type, specialty, languages spoken, hospital affiliation, etc.
- Aetna Voice Advantage® System — Our state-of-the-art interactive voice response technology makes it easy to do business with Aetna through personalized call-routing and self-service options for simple and common inquiries.

Information on Aetna Policies

- Read our Appeals Policy

And More…

- We are continually adding online resources and tools to help you do business with us.

EOB statements online

Get your daily list of predeterminations and claim Explanation of Benefits (EOB) statements online through the secure section of aetnadental.com

The easy-to-use, searchable format allows you to:

- Search for dental predeterminations.
- Search for any claim EOB.
- Produce an EOB statement for completed claims or predeterminations.

And, if you choose, you never have to receive paper predeterminations or EOBs again.

Benefits of electronic EOB - Claim Inquiry Tool

This tool, which is located on the secure dental website, enables your dental office to receive your daily list of EOB statements online in PDF format, 24 hours a day, 7 days a week. You can either print the statements or save them to your computer. In addition, you can perform searches by:

- Claim (including predeterminations)
- Claim status (including finalized, in process, pended, denied, rejected)
- Patient (including name, date of birth, member ID, patient account number, service code)
- Payment (including date, check number/EFT trace number)
- Provider ID

With this tool you will have access to:

- A "View Claim Details" screen
- View a PDF format of your paper EOB
- Submitting claim reconsiderations (day-to-day rework/appeals) online

Send your claim attachments electronically to Aetna

Attachments can be submitted to Aetna electronically. Claim attachments are not always necessary. We encourage you to review the claim documentation guidelines to determine which attachments, if any, are required.

To streamline submitting claims with attachments to Aetna, send attachments electronically through an electronic attachment vendor. For additional information on attachment vendors and submitting attachments electronically, visit www.aetnadental.com.

An electronic attachment vendor enables dentists to transmit attachments, in support of electronic claims, to payers via the Internet. Attachments include X-rays, perio charts, intraoral pictures, EOBs, lab reports and narratives.

Aetna Voice Advantage®

Aetna Voice Advantage, Aetna's voice recognition self-service technology, allows your dental office to:

- Check on several patients in a single call to a single number. (Toll-free numbers can be found on member's ID card.)
- Check coverage and benefits at the ADA code level. Choose to hear the information or have it faxed.
- Check the status of a claim(s). Choose to hear the information or have it faxed.
- Obtain a claim mailing address.
- Speak with a customer service professional if needed.

Other Aetna Voice Advantage features

- **24-hour Service** — Automated member and dentist services are available day and night (24x7).
- **Natural Speech** — A single automated voice uses friendly, conversational language, rather than robotic tones and instructions.
- **Voice Recognition** — Just speak naturally and you'll discover how conversational the call will be.
- **Voice to Touch** — Allows you the flexibility to switch from speaking to using the keypad.

National Provider Identifier: The One Number You Will Need for All Payers

The days of remembering an identification number for each payer you do business with electronically is coming to an end. The HIPAA-regulated National Provider Identifier (NPI) number makes conducting electronic transactions with multiple payers easier.

Your NPI will be the only number you will need to supply to your payers on electronic claims, certifications and approvals. It replaces the many different provider numbers (Medicare and Medicaid numbers, and other payer proprietary numbers) you currently use for these transactions. (Your tax payer ID number [TIN] is an IRS requirement, and will not be replaced by the NPI.) The 10-digit NPI number is yours for life and does not convey information about you, such as your type of practice or your location.

You can apply for your NPI now

If you transmit dental health information by way of standard electronic transaction, as defined by HIPAA, you are required to obtain an NPI. This is true even if you use a billing agency to prepare transactions.

You can apply for an NPI:

- Online at https://nppes.cms.hhs.gov.
- By completing a paper application. You can download a copy through https://nppes.cms.hhs.gov
- By calling 1-800-465-3203 to request a copy.

Share It with Aetna:

Share your NPI as soon as possible and before you use it in transactions with us. You can:

- Update your Personal Information on www.aetnadental.com (site registration required).
- Call our National Dentist Line at 1-800-451-7715.
- Fax your NPI to us at 860-754-1602.

Use It in electronic transactions with Aetna

We can accept and use your NPI if it is included in a real-time transaction but only if it has been previously entered into our database. Otherwise, the transaction will reject. The NPI number must be used in all HIPAA standard electronic transactions.

For More Information

Visit http://www.cms.hhs.gov/hipaa/hipaa2.

Call the National Provider Identifier number — 1-800-465-3203.

Resources available for you on W9 forms.

- Information on how to complete a W9 form, IRS Matching Program and backup withholding can be found on the IRS website at **www.irs.ustreas.gov**.
- Refer to the following IRS alerts for additional information.

IRS Alerts

Department of the Treasury
Internal Revenue Service

IRS ALERT FOR MEDICAL SERVICE PROVIDERS

Notify Payers of Your Correct Name and Identification Number Combination

High Rate of Errors for Medical Service Providers

The Internal Revenue Service ("IRS") says that medical service providers have a higher than average error rate for name/taxpayer identification number ("Name/TIN") combinations reported on **Form 1099-MISC,** Miscellaneous Income. Payers, such as insurance companies, are required by law to report to the IRS a payee's: name, TIN, total payments, and any tax withholding for each calendar year on Form 1099-MISC. **Form 1099-MISC recipients should review the name and TIN that they provide to organizations ("payers") paying them for services.**

Mistakes May Cause Withholdings From Your Payments

When there is an error in the Name/TIN combination that is reported to the IRS, the IRS will notify the payer; and the payer will attempt to correct the information, as required by law. The payer will send a **Form W-9**, Request for Taxpayer Identification Number and Certification, or similar form, to verify the payee's correct name and TIN. If the payee fails to respond, or supply the correct information, the payer is required to withhold Federal income tax at a rate of 28 percent ("backup withholding") from future payments. Backup withholding is not a failure to pay you. It is an advance Federal income tax payment on your behalf. You should report all backup withholding as "Federal income tax withheld" on your federal income tax return.

Avoid Backup Withholding By Providing Correct Name/TIN Combinations To Payers

For an individual operating as a sole proprietor (and a single-member limited liability company ("LLC"), disregarded as an entity separate from its owner), the name is the individual's name as recorded with the Social Security Administration and the TIN is the social security number ("SSN") for that individual. For a corporation, partnership, or similar entity, the correct name is the name used on its income tax returns, payroll returns and similar filings. The TIN for a corporation, partnership, or similar entity is its employer identification number ("EIN").
Review your medical service invoice and Form W-9 for the name and TIN that is being used. Unless advised to the contrary on Form W-9, payers generally use the information on a payee's invoice in their reports to the IRS.

Common Name/TIN Combination Mistakes

- You are a sole proprietor using a "doing business as" (DBA) name, and your individual SSN or the EIN of the sole proprietorship. ***A sole proprietor must always use his/her individual name as the legal name of the business.***
- You are an individual medical provider (sole proprietor) using the EIN of the partnership, corporation, hospital, or clinic of which you are a member. ***You should always use your SSN in combination with your individual legal name.***
- You change your business name and fail to notify the IRS. For example, you change your business name Johnson, McCleary & Reed, P.C. to JMC Medical Group, P.C. but fail to notify the IRS. Invoices or Form W-9, disclosing your old EIN with your new name, will cause a mismatch with IRS records. ***You must notify the IRS of any name changes by writing to the "Entity Section" of the IRS Service Center handling your Federal tax returns.***
- You are identifying your business name with initials instead of your complete name as recognized by the IRS. For example, you originally obtained your EIN under the business name Immediate Care Clinic, P.C. By filling out Form W-9 using ICC, P.C. as the name with your correct EIN, a mismatch will occur with IRS records. ***You should always use your complete name when notifying payers of your Name/TIN combination.***
- You are an operating unit of a large entity. Using your operating unit's name with the EIN of the entity will cause a mismatch with IRS records. For example, you are Meadowbrook Nursing Home, an operating unit of Healthcare, Inc. ***You must use the name Healthcare, Inc., with the correct EIN, to avoid an IRS mismatch.***
- You are an employee who performs services for a practice, clinic, or facility. Frequently, medical service providers submit claims seeking payments in the name of the employee who performed the services, to track the source of funds. ***If you are an employee of an entity, the entity's name should appear as the payee on the check and on Form 1099-MISC.***

Help is Available

If you think you may be using an incorrect Name/TIN combination, call the IRS at 1-800-829-3676 to order **Pub. 1635**, Understanding Your TIN, **Form W-9, Instructions for the Requester of Form W-9,** or **Circular E**, Employer's Tax Guide (Pub. 15). You may also visit the IRS Web-Site at www.irs.gov to order the above referenced forms and publications; or to obtain additional information.

Department of the Treasury
Internal Revenue Service

IRS ALERT FOR SOLE PROPRIETORS

Notify Payers of Your Correct Name and Identification Number Combination

High Rate of Errors for Sole Proprietor Businesses

The Internal Revenue Service (IRS) says that sole proprietor service providers have a higher than average error rate for name/taxpayer identification number ("Name/TIN") combinations reported on **Form 1099-MISC,** Miscellaneous Income. Payers are required by law to report to the IRS a payee's: name, TIN, total payments, and any tax withholding, for each calendar year on Form 1099-MISC. **Form 1099-MISC recipients should review the name and TIN that they provide to organizations ("payers") paying them for services.**

Mistakes May Cause Withholdings From Your Payments

When there is an error in the Name/TIN combination that is reported to the IRS, the IRS will notify the payer; and the payer will attempt to correct the information, as required by law. The payer will send a **Form W-9**, Request for Taxpayer Identification Number and Certification, or similar form, to verify the payee's correct name and TIN. If the payee fails to respond, or supply the correct information, the payer is required to withhold Federal income tax at a rate of 28 percent ("backup withholding") from future payments.
Backup withholding is not a failure to pay you. It is an advance Federal income tax payment on your behalf. You should report all backup withholding as "Federal income tax withheld" on your federal income tax return.

Avoid Backup Withholding By Providing Correct Name/TIN Combinations To Payers

For an individual operating as a sole proprietor (and a single-member limited liability company ("LLC"), disregarded as an entity separate from its owner), the name is the individual's name as recorded with the Social Security Administration and the TIN is the social security number ("SSN") for that individual. For a corporation, partnership, or similar entity that is reportable for information return purposes, the correct name is the name used on its income tax returns, payroll returns, and similar filings. The TIN for a corporation, partnership, or similar entity is its employer identification number ("EIN") Review your service invoice and Form W-9 for the name and TIN that is being used. Unless advised to the contrary on Form W-9, payers generally use the information on a payee's invoice in their reports to the IRS.

If you receive a Form 1099-MISC that shows an incorrect Name/TIN combination, immediately notify the payer. If you receive a B-Notice letter from the payer, please respond immediately; failure to correct problems as they arise increases the likelihood that your payments may become subject to backup withholding.

Common Name/EIN Combination Mistakes

You are a sole proprietor using your "doing business as (DBA)" name, and your individual SSN or the EIN of your sole proprietorship. The IRS can match your individual name with your SSN or EIN, but cannot match your DBA name or trade name with either your SSN or EIN. ***Do not use your DBA name or your trade name with either your SSN or EIN. A sole proprietor must always use his/her individual name as the main legal name of the business.***
. For a corporation, partnership or similar entity that is reportable for information return purposes, you are identifying your business name with initials instead of your complete name as recognized by the IRS. For example, you originally obtained your EIN under the business name Immediate Care Clinic, P.C. By filling out Form W-9 using ICC, P.C. as the name with your correct EIN, a mismatch will occur with IRS records. ***You should always use your complete name when notifying payers of your Name/EIN combination.***
. You are a sole proprietor operating as a single-member LLC that is disregarded as an entity separate from its owner and provide only the LLC name to the payer. Because your LLC will not be filing its own tax return, the IRS will need your individual name to match with either your SSN or pre-LLC EIN. ***Provide your individual name and SSN (or "pre-LLC" EIN, if desired) to the payer.***

Help is Available

If you think you may be using an incorrect Name/EIN combination, call the IRS at 1-800-829-3676 to order **Pub. 1635**, Understanding Your TIN, **Form W-9, Instructions for the Requester of Form W-9,** or **Circular E**, Employer's Tax Guide (Pub. 15). You may also visit the IRS Web-Site at www.irs.gov to order the above referenced forms and publications; or to obtain additional information.

Coordination With Other Plans

Occasionally members covered under Aetna's managed dental plans will have coverage under another dental plan or will have coverage for some procedures under a medical plan. The other coverage may be primary or secondary, depending on the member's status under the other plan. The exact rules applying to each situation will differ, depending on whether or not the other plan is a dental plan or a medical plan. In addition, some of the rules may vary depending on whether the other dental or medical plan is a managed care plan or a traditional insurance plan. The material on the following pages describes how benefits and copayments are determined in each situation. In addition, in situations where the Specialty Dentist determines that the patient requires prescription drugs, there may be special rules to follow to assure the patient is able to obtain full coverage for the prescription.

Coordination of Benefits (Applies to Dental Plans)

Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental
These plans do not have a Coordination of Benefits provision. Therefore, they are always treated as primary. (See examples below for instructions on handling when coverage is primary.)

DMO® Plans
Aetna DMO plans include a Coordination of Benefits (COB) provision. This provision allows benefits available to members to be reduced when benefits from the Aetna plan and all other plans exceed the total allowable expenses. This provides an effective way to reduce the possibility of over insurance, while also allowing the member to reduce or eliminate out-of-pocket expenses without profiting from duplicate coverage. The guidelines provided below follow the standards established jointly by the National Association of Insurance Commissioners and the National Association of HMO Regulators.

Allowable expenses are those usual and prevailing charges for a service that are covered, at least in part, by one or more plans covering the patient receiving the treatment. However, when a plan provides benefits in the form of services (such as a prepaid plan), the reasonable cash value for each service rendered will be considered both an allowable expense and a benefit paid. Refer to Examples for a further explanation.

Before you can apply the Coordination of Benefits provision, the following rules are used to determine which plan is primary (the plan that determines benefits first) and which is secondary. The rules define the "order of benefit determination." These rules can be somewhat complicated, so you are encouraged to call the National Dentist Line when you need assistance.

Order of Benefit Determination Rules
(Note: These rules apply to standard plans. They may not be applicable in certain states, on older contracts or when coordinating benefits with certain other carriers. If you have any questions, call the National Dentist Line for your location.)

- **Employee or Spouse**
  (a) The patient may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the patient as an employee has primary responsibility.
  (b) The benefits of a plan that covers a person as an active employee is considered primary over the plan that covers a person as a laid-off or retired employee.
- **Dependent Children**
  (a) Parents not separated or divorced

  If a child is covered as a dependent under both parents' coverage, the plan of the parent whose birthday falls earlier in the year is considered primary. This is called the Birthday Rule. For example: If the mother's birth date is February 8th and the father's birth date is May 15th, the mother's plan would have primary responsibility.

(b) Parents are separated or divorced

If two or more programs cover a dependent child of divorced or separated parents, benefits are determined in this order:

First: the plan of the parent with custody of the child
Second: the plan of the spouse, if applicable, of the parent with custody of the child
Third: the plan of the parent not having custody of the child

The Birthday Rule does **not** apply in the above.

(c) One of the plans does not have a Coordination of Benefits provision

Whenever a plan does not have a Coordination of Benefits provision, that plan is always considered primary when coordinating with a plan that does have a Coordination of Benefits provision.**

(Special Note for Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental:** These plans do <u>not</u> have a Coordination of Benefits provision. Therefore, they are <u>always primary</u>.)

(d) If none of the above rules determine the order of benefits, the plan that covered the person the longest is considered primary.

Aetna Managed Dental Is Both Primary and Secondary
When the patient has coverage under two different Aetna managed dental plans (such as the case of a husband and wife working for two different employers who each have Aetna coverage), use the Order of Benefit Determination Rules to determine which plan is primary and which is secondary.

Coordination With Medical Plans

There may be some instances where dental procedures are covered under both a medical plan and a dental plan. This happens most frequently in cases involving accidental injuries to natural teeth. Additionally, there are also some medical plans that cover some oral surgery procedures, as well as some endodontic and periodontic procedures. (Members who have both medical and dental coverage with Aetna may be eligible for benefits for some of these procedures under their medical plans.) In these instances, it may be necessary to refer patients to their Primary Care Physician to determine if a referral is necessary. **Family Preventive, Basic Dental, Aetna Advantage Dental, Aetna Advantage Plus Dental and Standard DMO Plans.** These plans have a provision that excludes coverage for any service covered in whole or in part under the employer's medical plan. **In the event that a member of an Aetna medical plan for which you do not serve as a participating provider is referred to you for specialty care by a primary care dentist participating in one of our managed dental plans, and you treat that member, the compensation terms of your participation agreement may be applied by Aetna to all covered services you provide to that member.**

Prescription Drug Coverage

It is sometimes necessary for the Specialty Dentist to prescribe medication for pain or antibiotics to counter the effects of an infection, etc. Aetna's managed dental plans do not normally cover the cost of prescription drugs. However, many employer groups cover charges for prescription drugs under either their medical plans or a separate drug plan.

If the patient has prescription drug coverage under a traditional medical insurance plan or a separate prescription drug plan (i.e., independent of the medical plan), then usually all that is necessary is to write the prescription in the usual manner and give it to the patient to have filled.

However, if the patient's prescription drug coverage is provided through an HMO or other managed care plan or a prescription drug plan affiliated with or contracted by the managed care plan, the patient may not be able to obtain full coverage unless the plan's rules are followed (e.g., the plan may not cover prescriptions unless written by or authorized by the patient's primary care physician). When this situation arises, it is suggested that you contact the patient's primary care physician to obtain approval for the prescription or, if necessary, to have the physician write the prescription for the patient.

Optional Treatment Plans

Aetna's managed dental plans cover a full range of preventive and restorative services to treat most aspects of dental disease. Benefits are available for a specific list of covered services, subject to plan provisions, including all limitations and exclusions.

Due to the continued development of new dental materials and equipment/technology, there are often many ways to treat dental conditions. Additionally, there are now alternative and enhanced techniques to render certain services with new technology, although the underlying procedure remains unchanged. Often, these techniques are not addressed in the ADA Procedure Codes and Nomenclature. This section provides guidance for determining benefits in situations where the Specialty Dentist and the patient are considering optional treatment plans involving elective services.

Whenever cosmetic procedures or enhanced technology are employed, the patient must be fully advised as to those procedures that are covered by the plan and those that are optional, so that an informed choice can be made. As with other noncovered services, if the patient elects to receive the services, then the patient is responsible for the cost of the additional procedures or materials. The total amount due from the patient is determined by establishing the copayment, if any, for the underlying covered service plus the incremental charge for the cosmetic procedures/materials or enhanced technology.

An "Informed Consent" form has been designed for your use (see the form later in this section). This form, or an equivalent, **must** be completed and signed by the patient and the dentist **prior to beginning treatment** for optional treatment plans involving cosmetic services or enhanced technology/materials.

Note: If any dental service/material is required due to dental necessity (even though it may coincidentally provide a cosmetic result) and addresses a pathologic or functional need, then it may not be considered as a cosmetic service. You may only collect the normal copayment based on your Aetna-approved fee schedule.

The incremental fee for a cosmetic enhancement must reflect the true additional costs of providing the service (e.g., unit cost difference in material or lab bill, difference in usual fees, etc.). At all times, you must be able to demonstrate the basis for an incremental fee. Since the incremental fee is intended to directly offset the additional cost of cosmetic-enhanced service, it is not necessary to report incremental charges on claims forms.

Enhanced Technological Methods/Equipment

Purpose: Aetna recognizes that there is increasing dental technology that allows for alternative and enhanced techniques to render certain dental services compared to traditional methods. The intent of this policy is to identify those new technologies that represent a significant increase in dental practice resources and which were never included in the original compensation model to the dentist.

An incremental fee may be charged to the member for enhanced technological methods and materials as set forth in this policy. However, before a fee can be charged, the patient must be presented with a choice of methods/materials and be able to choose between the traditional and enhanced technology with full disclosure.

Policy and Procedures: All covered dental procedures must be made available to members. As applicable, a choice of the basic covered service with and without the enhanced technology must be offered to the member. If no choice is given to the member, the service rendered is covered per the applicable copayment schedule with no additional fee allowed. Treatment options involving enhanced technology must be documented on the "Informed Consent" form at the end of this section (or an equivalent form). If patient consent is not documented by signature on the form, you may not charge the incremental fee.

This policy only applies to technology that has received clearance from the Food and Drug Administration for appropriate clinical applications defined therein.

The incremental fee for enhanced technological methods and materials must reflect the true additional costs of providing the service versus the traditional method. For example, the purchase price of a computerized delivery system for local anesthesia should be amortized over the number of years of expected useful life and total procedural visits. Variable costs can also be incorporated into the cost accounting. You must be able to demonstrate the basis of an incremental fee. It is not necessary to report incremental charges.

Example #1

Use of computerized delivery system for local anesthesia:

■ Variable expense per injection (e.g., handpiece, etc.)	$1.50
■ Amortized expense of unit ($1,000/5000 procedures)	.20
■ **Incremental fee per visit**	**$1.70**

Example #2

Use of microabrasion unit for sealant application

■ Variable expense per use	$ .10
■ Amortized expense of unit ($5,000/4 yrs/ 250 procedures per year	5.00
■ **Incremental fee per visit**	**$5.10**

Approved List of Cosmetic Services/Enhanced Technology or Materials

A full list of approved cosmetic services and enhanced technological methods/equipment for which the patient may be charged is shown below. If a service is on this list, provide this service to the patient at an additional charge in accordance with the policies outlined on the previous pages. If a service is not included on this list, do not charge the patient without approval from the Dental Director.

Enhanced Technology/Materials:

- Computerized delivery of local anesthetic
- Use of laser technology for applicable and appropriate dental procedures (e.g., frenectomy)
- Use of microabrasion (e.g., Kinetic Cavity Preparation – KCP) for applicable and appropriate dental procedures

Patient Noncompliance — Orthodontic Services

This policy addresses those situations where, due to patient non-compliance, additional dental services may be needed to complete an orthodontic procedure (i.e., repetitive replacements or recementations).

A prorated fee may be charged to the member for documented orthodontic services that must be repeated due to member noncompliance reasons.

Policy and Procedures

This policy applies only to covered orthodontic services. The Specialty Dentist should document in the patient record those incomplete orthodontic procedures that require retreatment and/or an unplanned additional service due to patient non-compliance. The retreatment or unplanned service is considered a new dental service, and a prorated fee may be charged to the member for the prior uncompleted service.

The prorated fee should be based on your usual fee and strictly reflect the time and/or direct costs of the prior uncompleted procedure. Determining factors include the percentage of total treatment time for the uncompleted procedure. At all times, you must be able to demonstrate the basis for the prorated fee. It is not necessary to report these pro-rated charges since the patient is responsible for the entire amount.

DMO® Plans — Examples of Orthodontic Cosmetic Upgrades

Ceramic, clear, and lingual fixed brackets and clear, removable orthodontic aligners are considered cosmetic upgrades. The plan will consider benefits based on the contracted fee for a conventional orthodontic treatment plan. If the member agrees in writing to an upgrade for ceramic, clear, or lingual fixed brackets or clear, removable orthodontic aligners, the member will be responsible for his/her normal copayment for the conventional orthodontic treatment plus the difference between the orthodontist's usual fees for conventional orthodontics and the upgrade option selected.

Clear, removable orthodontic aligners (e.g. Invisalign)

The starting date of service for clear, removable orthodontic aligners is the date the first aligner is delivered.
01/28/2020 thru 05/17/2021 – If the starting date of service is during this time period, an upgrade may not be charged for clear, removable orthodontic aligners (e.g. Invisalign).
Effective 05/18/2021 - The Plan reversed this guideline. If the starting date is on or after 05/18/2021, an upgrade is allowed contingent upon the financial informed consent guidelines outlined above.

The example below illustrates how the member's out-of-pocket would be calculated:

Contracted fee for conventional orthodontic treatment plan		$2,000
Plan Coinsurance	*	50 percent
Member usual copayment	=	$1,000
Usual fee for clear brackets		$4,500
Usual fee for conventional fixed brackets		($3,000)
Difference between usual fees	=	$1,500
The member's usual copayment		$1,000
Difference between usual fees	+	$1,500
Member responsibility	=	$2,500

Replacement or recementation of an appliance due to patient abuse or non-compliance is not covered after the third retreatment. The member is responsible for these charges.

Replacement or repair of broken bands or brackets is considered a covered service under DMO unless due to patient neglect or non-compliance. This should be considered as included in the orthodontist's contracted fee. The orthodontist should specify that such repair or replacement is the responsibility of the patient when caused by non-compliance or neglect on the part of the patient.

Alternate Benefits Provision (DMO® plans only)

This section does NOT apply to Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental. (These plans incorporate the alternate benefit by reflecting higher levels of copayments for the costlier procedures in the applicable fee schedules.)

Aetna DMO plans contain a provision known as the Alternate Benefit Provision. This provision can operate in several ways in situations where (a) the service requested is not covered, but alternate covered service(s) are available, or (b) more than one covered service is available, all of which are suitable for the condition being treated.

DMO plans contain a "closed" list of dental services, sometimes referred to as the Dental Care Schedule. This means that only those services that are specifically listed are covered under the plan. If a service is not in the Dental Care Schedule, it is not covered. However, if the Dental Care Schedule does provide coverage for another service that is a suitable alternative for the condition being treated, then the plan will provide coverage for that alternate service in lieu of the noncovered service. If the patient elects to receive the noncovered service, then the patient is responsible for the copayment, if any, for the alternate service, plus the difference, if any, between the negotiated fees for the alternate service and the noncovered service.

A service may be included in the Dental Care Schedule but may not be covered due to a plan limitation or exclusion. However, the list may also include an alternate service, that is not excluded and that would be suitable for the condition being treated. If the patient elects to receive the noncovered service, then the patient is responsible for the copayment, if any, for the alternate service, plus the difference, if any, between the negotiated fees for the alternate service and the noncovered service.

Two or more services may be included in the Dental Care Schedule that are suitable for the condition being treated. In this situation, the plan generally provides coverage for the least expensive treatment that would produce a professionally acceptable result. However, in applying the Alternate Benefit provision in these situations, it is important to note that the alternate procedure must be reasonably equivalent in terms of results and must satisfy generally accepted professional standards. If the patient opts for the more expensive service, then the patient is responsible for the copayment, if any, for the alternate service, plus the difference, if any, between your Aetna-approved fees for the alternate service and the noncovered service.

Whenever any of these situations arise, it is important that the Specialty Dentist fully discusses all optional treatment plans with the patient in advance and fully advises the patient of all additional fees for which the patient may be responsible. If the optional plans and fees are not discussed in advance with the patient, no additional charges may be billed to the patient beyond the normal copayments for the covered service. The "Informed Consent" form (or an equivalent) used for enhanced technology/materials must be used in these situations to document the patient's file in Alternate Benefits situations (the form is included on the next page).

Examples of Optional Treatment Plans

- A patient requires local anesthesia for a covered restorative procedure. Local anesthesia is covered as part of the underlying service and may not be billed to the patient. However, the patient is offered the choice of having the anesthetic delivered via traditional means versus a computerized delivery system and opts for the latter. If the patient is informed in advance that the optional means of delivery will require an additional charge, you may bill the patient the incremental cost of using the enhanced technology.
- A patient elects and agrees in writing to an upgrade to ceramic, clear, or lingual fixed brackets or clear, removable orthodontic aligners (e.g. Invisalign). The plan will consider benefits based on the contracted fee for a conventional comprehensive orthodontic treatment plan. The member must be informed in advance that in addition to their normal copayment for the conventional comprehensive orthodontic treatment, the member will be responsible for the difference between your usual fees for the conventional fixed brackets and the upgrade for ceramic, clear, or lingual fixed brackets or clear, removable orthodontic aligners.
  If the covered benefits, options, and fees are not discussed with the patient in advance and agreed to in writing, no additional charges may be billed to the patient beyond their normal copayment for the covered service.
  If you exclusively perform ceramic, clear, lingual fixed brackets or clear, removable orthodontic aligners, you cannot charge an upgrade to the member.
  Clear, removable orthodontic aligners (e.g. Invisalign)
  The starting date of service for clear, removable orthodontic aligners is the date the first aligner is delivered.
  01/28/2020 thru 05/17/2021 – If the starting date of service is during this time period, an upgrade may not be charged for clear, removable orthodontic aligners (e.g. Invisalign).
  Effective 05/18/2021 - The Plan reversed this guideline. If the starting date is on or after 05/18/2021, an upgrade is allowed contingent upon the financial informed consent guidelines outlined above.

Patient Informed Consent for Elective/Optional Treatment

Patient's Name		
First	Middle	Last
Employee Name (if different than patient)		
First	Middle	Last
Employer Group Number	**Employee ID Number**	
Dentist Name and Office ID Number		

Covered Services				Enhanced/Non-covered Services		
ADA Code	Procedure Description	UCR Fee	Patient Copay	ADA Code	Procedure Description	Additional Charge

I have been given the option of selecting a non-covered and/or enhanced service. I request that my dentist perform those elective services listed above. I acknowledge all of the following: (a) The elective (Enhanced/Non-covered) services listed above, including all associated costs, have been fully explained to me; (b) The elective services are not covered by Aetna; and, (c) I am liable for payment of any such costs.

Patient Signature_____ Date_____
(Parent or Guardian if Patient is Minor)

Dentist Signature_____ Date_____

Value Plus℠ Program

We have contracted with a number of companies to develop an exciting Value Plus Program that gives Aetna Network Dentists access to discounts on products and services you use every day. You can save hundreds of dollars on dental supplies and services. By participating with Aetna you can take advantage of this Value Plus Program free of charge. It's that easy! Read more about it on www.aetnadental.com.

III. Specialty Referrals (Applies to DMO® Plans Only)

Introduction

Aetna managed dental plans provide a full range of covered services to treat the dental needs of its covered members. Services are divided into Primary Care Dentist Services and Specialty Dentist Services categories. Specialty Services are provided by Specialty Dentists under the terms of the agreements they have signed with Aetna. Aetna recommends that you have a process in place to monitor specialty referrals so that continuity of care is maintained between referring and treating practitioners. These include such services as osseous surgery, extraction of bony impacted teeth, molar root canals and orthodontics.

For patients covered under Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental, and Aetna Advantage™ Student Dental dental plans, patients are simply referred to a participating Specialty Dentist so the member may obtain the plan discount. No specialty pre-approval by Aetna is required.

MEMBERS WHO HAVE BOTH DENTAL AND MEDICAL COVERAGE WITH AETNA MAY BE ELIGIBLE FOR CERTAIN ORAL SURGERY BENEFITS (INCLUDING SURGICAL PERIODONTICS AND ENDODONTICS) UNDER THEIR MEDICAL PLAN.

IN THE EVENT A MEMBER OF AN AETNA MEDICAL PLAN FOR WHICH YOU DO NOT SERVE AS A PARTICIPATING PROVIDER IS REFERRED TO YOU FOR SPECIALTY CARE BY A PRIMARY CARE DENTIST PARTICIPATING IN ONE OF OUR MANAGED DENTAL PLANS, AND YOU TREAT THAT MEMBER, THE COMPENSATION TERMS OF YOUR PARTICIPATION AGREEMENT MAY BE APPLIED BY AETNA TO ALL COVERED SERVICES YOU PROVIDE TO THAT MEMBER.

IF THE MEDICAL PLAN IS A NON-AETNA MANAGED CARE PLAN, MEMBERS REQUIRING THESE SERVICES MUST BE SENT TO THEIR PRIMARY CARE PHYSICIAN FOR REFERRAL TO A PARTICIPATING ORAL SURGEON, I.E., ANY ORAL SURGERY COVERED BY A NON-AETNA MANAGED MEDICAL PLAN MAY REQUIRE A MEDICAL, NOT DENTAL, REFERRAL.

IF THE MEMBER IS COVERED UNDER A NON-AETNA MEDICAL PARTICIPATING PROVIDER ORGANIZATION (PPO) PLAN THAT COVERS ORAL SURGICAL PROCEDURES, THEY MUST RECEIVE SERVICES FROM A PARTICIPATING PROVIDER IN THE MEDICAL PPO NETWORK IN ORDER TO RECEIVE MAXIMUM BENEFITS.

Under DMO plans, all referrals to Specialty Dentists must be arranged by the patient's Primary Care Dentist in accordance with the procedures outlined below.

(**NOTE:** — This requirement does **not** apply to the DMO Orthodontic Direct Access Program. Members may seek care from a participating orthodontist without obtaining a referral from their Primary Care Dentist.)

Aetna utilizes various processes to facilitate specialty care and determine benefits available for Specialty Services. This section defines the key elements and the processes for referral and delivery of specialty care.

Specialty Referral Form — This form is used to submit a Specialty Referral Request or to directly refer a member to a Specialty Dentist. Regardless of the purpose, parts 1-3 of the form are completed by the Primary Care Dentist.

The Specialty Dentist is required to complete the proposed or completed treatment portion of the form. If you opt to submit a standard ADA claim form for prospective or retrospective review or for payment, the Specialty Referral Form must be attached. (The form is included at the end of this section.)

- For Direct Referral, the form and diagnostic material is sent with the patient (or mailed) to the Specialty Dentist's office. **It is the Specialty Dentist's responsibility to return all diagnostic material to the Primary Care Dentist.**
- For a Specialty Referral Request, the Primary Care Dentist sends the form to the appropriate Aetna office. (See the **Quick Facts** chart.)

Direct Referral — This process enables the Primary Care Dentist to "directly refer" a member for certain services to a participating Specialty Dentist. A pre-approval request is not required. The following is an overview of this process.

1. The Primary Care Dentist determines that a Specialty Dentist should perform a problem-focused examination and/or provide a Specialty Service.

2. The Primary Care Dentist checks the patient roster to ensure that the patient is covered.
3. The Primary Care Dentist reviews the list of services and/or conditions to identify if the service is eligible for "direct referral." (See the **Direct Referral and Specialty Review Protocols** section that follows.)
4. If eligible for direct referral, the Primary Care Dentist selects a participating Specialty Dentist to whom the patient is to be referred and completes the Specialty Referral Form. The Primary Care Dentist must complete parts 1-3 of the form, including the Office Code, as well as the member's copayment for the consultation/problem-focused examination and for the service being referred. The Primary Care Dentist should also include the diagnosis and check off the specific clinical indications/rationale for the treatment and any specific procedures that should be performed. The form and any relevant diagnostic material should be given to the member with instructions to call the Specialty Dentist for an appointment. (The Primary Care Dentist may facilitate this process by calling the Specialty Dentist's office to discuss the situation and reserve an appointment for the member.)
5. If the service and/or condition is not listed, the Primary Care Dentist completes the Specialty Referral Form (parts 1-3) to request a problem-focused examination for the specific tooth/condition. The form and all supporting diagnostic materials are sent to Aetna for consideration. (See the **Quick Facts** section for more information.)
6. For problem-focused examinations — The Specialty Dentist may complete the exam and submit a treatment plan to Aetna for prospective review and a pretreatment estimate. (See the **Direct Referral and Specialty Review Protocols** section that follows.)

For treatment of a specific condition or tooth – The Specialty Dentist may complete the treatment and submit for payment. Services subject to retrospective review should be submitted with supporting diagnostic materials. (See the **Direct Referral and Specialty Review Protocols** section that follows.)

Specialty Referral Request — Certain procedures may require that the Primary Care Dentist first submit a request for referral to a specialist via a Specialty Referral Form. Based on the information and diagnostic materials submitted, Aetna will determine if the service meets the referral criteria.

- An approval may be required when a Primary Care Dentist is referring services for which he/she has been contracted to perform (i.e., a Primary Care Dentist Service). Services and/or conditions that are exempt from requiring approval in advance are listed under the Direct Referral protocols that follow. Certain services may be prospectively reviewed.
- The Specialty Dentist will receive a copy of the predetermination identifying the procedures approved for treatment.

Note that even if you have received a pretreatment estimate for a member's care, it is still recommended that you verify eligibility at the time of treatment. **Benefits are payable only if the member is covered under the plan at the time services are rendered. (National Dentist Line 1-800-451-7715)**

Prospective Review — Clinical review conducted prior to commencing treatment. For certain Specialty Services, the Specialty Dentist is required to submit a proposed treatment plan with supporting documentation that may include radiographs, narratives, charting and/or study models (see **Claims Documentation Guidelines** later in this Guide). The purpose of a prospective review is to determine if the services are covered under the member's plan, the plan's benefits and the member's out-of-pocket costs.

Retrospective Review — Clinical review conducted after treatment has been rendered and the services have been submitted for benefits consideration. This review includes determining if the member was eligible for coverage at the time services were provided and assessing the level of care provided. (Note: In the event a procedure was directly referred to you by the Primary Care Dentist and it is determined that the service was the Primary Care Dentist's responsibility to perform, the Specialty Dentist will still receive the plan's benefit for that service.)

The following section addresses the Direct Referral and Specialty Review protocols and procedures, and contains a list of services and/or conditions eligible for Direct Referral. In addition, it includes those services subject to prospective or retrospective review.

California Participating Dentists
Please refer to the Network Bulletin Section
Date: December 2018
Subject: Pre-Determination of Benefits for All Aetna California DMO® Providers
.
No More Pre-Determinations for Aetna California DMO® plans
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

Direct Referral and Specialty Review Protocols

Endodontic Protocols

Endodontic specialty services eligible for direct referral

The Primary Care Dentist may directly refer a member to a participating Specialty Dentist for the following conditions or treatment, and the Specialty Dentist may render treatment without approval:

1. Consultation or problem-focused examinations
2. Severely dilacerated and/or sclerosed roots (with conclusive radiographic evidence)*
3. Tortuous and/or convoluted roots (with conclusive radiographic evidence)*
4. Calcified/inaccessible canals (with conclusive radiographic evidence)*
5. Complications encountered during treatment
6. Molar root canal therapy
7. Hemisection
8. Root amputation
9. Root canal retreatments
10. Retrograde fillings/apicoectomies
11. Apexification/recalcification

*Note: Refers to anterior and bicuspid root canal therapy since molar root canal therapy is eligible for direct referral.

All other endodontic conditions or procedures not indicated above must be approved in advance by Aetna.

Primary Care Dentist responsibilities include, but are not limited to:

1. Initial and emergency examinations
2. Appropriate radiographs
3. Emergency treatment (i.e., pain control, palliative treatment, infection management)
4. Pulp capping, pulpotomies and pulpectomies on all teeth
5. Root canal therapy on anterior and premolar teeth

Specialty review protocols

Prospective review

1. The Specialty Dentist should submit for prospective review for any anterior or bicuspid root canal that does not meet the conditions noted above.
2. Any other treatment that does not appear under the Direct Referral list of services/conditions.

Retrospective review

Anterior or bicuspid root canal therapy services for teeth with the following conditions are subject to retrospective review. Services submitted for treatment due to these conditions should include all pre- and post-op radiographs.

1. Severely dilacerated and/or sclerosed roots (with conclusive radiographic evidence)
2. Tortuous and/or convoluted roots (with conclusive radiographic evidence)
3. Calcified/inaccessible canals (with conclusive radiographic evidence)

California Participating Dentists - Refer to Network Bulletin Section
Date: December 2018
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

Oral Surgery Protocols

MEMBERS WHO HAVE BOTH DENTAL AND MEDICAL COVERAGE WITH AETNA MAY BE ELIGIBLE FOR CERTAIN ORAL SURGERY BENEFITS (INCLUDING SURGICAL PERIODONTICS AND ENDODONTICS) UNDER THEIR MEDICAL PLAN.

IN THE EVENT THAT A MEMBER OF AN AETNA MEDICAL PLAN FOR WHICH YOU DO NOT SERVE AS A PARTICIPATING PROVIDER IS REFERRED TO YOU FOR SPECIALTY CARE BY A PRIMARY CARE DENTIST PARTICIPATING IN ONE OF OUR MANAGED DENTAL PLANS, AND YOU TREAT THAT MEMBER, THE COMPENSATION TERMS OF YOUR PARTICIPATION AGREEMENT MAY BE APPLIED BY AETNA TO ALL COVERED SERVICES YOU PROVIDE TO THAT MEMBER.

IF THE MEDICAL PLAN IS A NON-AETNA MANAGED CARE PLAN, MEMBERS REQUIRING THESE SERVICES MUST BE SENT TO THEIR PRIMARY CARE PHYSICIAN FOR REFERRAL TO A PARTICIPATING ORAL SURGEON, I.E., ANY ORAL SURGERY COVERED BY A NON-AETNA MANAGED MEDICAL PLAN MAY REQUIRE A MEDICAL, NOT DENTAL, REFERRAL.

IF THE MEMBER IS COVERED UNDER A NON-AETNA MEDICAL PARTICIPATING PROVIDER ORGANIZATION (PPO) PLAN THAT COVERS ORAL SURGICAL PROCEDURES, HE/SHE MUST RECEIVE SERVICES FROM A PARTICIPATING DENTIST IN THE MEDICAL PPO NETWORK IN ORDER TO RECEIVE MAXIMUM BENEFITS.

The Primary Care Dentist may directly refer a member to a participating Specialty Dentist for the following conditions or treatment, and the Specialty Dentist may render treatment without approval in advance:

Oral surgery specialty services eligible for direct referral

1. Consultation or problem-focused examinations
2. Single symptomatic and/or pathologically involved partial or full bony impaction
3. Surgical exposure of impacted teeth
4. Alveoloplasty (in conjunction with three or more extractions in the same quadrant or in an edentulous area)
5. Complications midtreatment
   - Uncontrolled bleeding
   - Unable to complete extraction
6. Treatment needs due to cellulitis
7. Frenectomy
8. Exostosis removal
9. Removal of foreign body from bone
10. Sequestrectomy
11. Closure of oral fistula
12. Transplantation of tooth or tooth bud
13. Sialolithotomy
14. Excision of hyperplastic tissue per arch (in conjunction with fabrication of prosthetic device)
15. Biopsy
16. Five or more routine extractions to be performed in one visit (except for third molar teeth)
17. Surgical removal of residual roots

Primary Care Dentist responsibilities include, but are not limited to:

1. Initial and emergency examinations
2. Appropriate radiographs
3. Emergency treatment (including pain control, palliative treatment and infection management)
4. Routine surgical and nonsurgical extraction of erupted teeth and soft tissue impactions (including third molars)
5. Root removal-exposed roots

California Participating Dentists - Refer to Network Bulletin Section
Date: December 2018
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

Specialty review protocols

Prospective review

The following oral surgical procedures are subject to prospective review. The Specialty Dentist should include all diagnostic material and submit for review prior to rendering treatment to the appropriate Aetna claim office (see the Quick Facts chart).

1. Surgical removal of severely dilacerated, divergent roots
2. Surgical removal of an ankylosed tooth
3. Surgical removal of an endodontically treated tooth
4. Two or more impactions
5. Cyst and related lesions
6. Third molar extraction (unless for a single symptomatic/pathologically involved third molar)
7. Any other treatment that does not appear under the Direct Referral list of services/conditions

Retrospective review

1. Any service not prospectively reviewed or not eligible for Direct Referral

Periodontic Protocols

The Primary Care Dentist may directly refer eligible patients exhibiting generalized Advanced Periodontitis and Refractory Periodontitis to a participating Specialty Dentist for a consultation or problem-focused examination.

Referral for Gingivitis, Early Periodontitis and Moderate Periodontitis must be submitted for pre-approval by Aetna.

Normally, the Primary Care Dentist is responsible for all treatment; however, if you believe a specialty consultation or problem-focused examination is warranted, you must complete a Specialty Referral Form and submit it, along with all diagnostic materials to Aetna for approval.

Aetna utilizes the American Academy of Periodontology classification system of periodontal disease.

Gingivitis: Inflammation of the gingiva characterized clinically by changes in color, gingival form, position, surface appearance and presence of bleeding and/or exudate.

Early Periodontitis: Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest, with slight bone loss. There is usually a slight loss of connective tissue attachment and alveolar bone.

Moderate Periodontitis: A more advanced stage of early periodontitis with increased destruction of the periodontal structures and noticeable loss of bone support, possibly accompanied by an increase in tooth mobility. There may be furcation involvement in multirooted teeth.

Advanced Periodontitis: Further progression of periodontitis with major loss of alveolar bone support usually accompanied by increased tooth mobility. Furcation involvement in multirooted teeth is likely.

Refractory Periodontitis: Includes those patients with multiple disease sites which continue to demonstrate attachment loss after appropriate therapy. These sites presumably continue to be infected by periodontal pathogens no matter how thorough or frequent the treatment provided. Also includes those patients with recurrent disease at single or multiple sites.

Primary Care Dentist responsibilities include, but are not limited to, the following for:

Gingivitis, Early Periodontitis and Moderate Periodontitis

1. Initial, recall and emergency examinations
2. Appropriate radiographs
3. Periodontal evaluation and charting
4. Prophylaxis and oral hygiene instructions
5. Scaling and root planing
6. Re-evaluation of periodontal condition after initial scaling and root planing

Advanced Periodontitis and Refractory Periodontitis

1. Initial and emergency examinations
2. Appropriate radiographs (to include periapical X-rays of pathological areas)
3. Initial periodontal probing

The Primary Care Dentist may directly refer eligible patients exhibiting generalized Advanced Periodontitis and Refractory Periodontitis to a participating Specialty Dentist for a consultation or problem-focused examination.

Specialty review protocols
Prospective review

The Specialty Dentist should submit the following services for review. The predetermination should include six-point periodontal charting and radiographs and/or narrative if appropriate.

1. Gingivectomy
2. Mucogingival surgery
3. Tissue grafts
4. Osseous surgery
5. Osseous grafts

Retrospective review

This will be done for any treatment that was not reviewed prospectively.

Pediatric Protocols

The Primary Care Dentist may directly refer to a participating Specialty Dentist for consultation or problem-focused examination of children under age 7 if (a) the Primary Care Dentist has documented at least one unsuccessful attempt to treat the child, and (b) *at least one* of the following conditions is present. The child:

1. Has an existing medical condition or is developmentally disabled (please include a physician's statement of condition — such as cerebral palsy, Down's syndrome, etc.)
2. Presents a behavioral management problem
3. Has rampant caries
4. Requires emergency care that is beyond the scope or ability of the Primary Care Dentist

Once a child is given an approved referral by the PCD to a contracted Pediatric dentist, the child can continue to be treated by the Pediatric dentist until the age of 7 without additional referrals from the PCD.

All other conditions or procedures not indicated must be approved in advance by Aetna. This includes referrals for children age 7 or older with a medical condition, significant behavioral management problem and severe caries that may require referral to a Specialty Dentist. THE PARENT SHOULD BE INSTRUCTED THAT UNTIL THE REFERRAL IS APPROVED, ONLY THE CONSULTATION WILL BE COVERED.

The Primary Care Dentist responsibilities include, but are not limited to:

1. Assessment of the need for pediatric referral
2. Appropriate radiographs (if possible)

Specialty review protocols
Prospective review

1. Any treatment plan on a child under age 7 where the proposed treatment is $600 or more
2. All treatment plans for children age 7 and over

Retrospective review

1. Any treatment not reviewed prospectively

California Participating Dentists - Refer to Network Bulletin Section
Date: December 2018
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

General Anesthesia and Intravenous Sedation

Intravenous sedation or general anesthesia will be reimbursed only when approved in advance by Aetna. Treatment procedures that can be successfully completed with local anesthesia will not be eligible for intravenous sedation or general anesthesia. If a patient requests these services, he/she will be fully responsible for the cost. The patient should be informed in advance when intravenous sedation or general anesthesia is not a covered benefit. Guidelines only apply to cases that have the coverage. Not covered on Fixed Copay plans as well as some other plans.

General anesthesia is considered necessary and covered without question for the following conditions:

1. Local anesthesia is ineffective because of acute infection, anatomic variation (e.g., cleft lip and/or cleft palate), or documented allergy to local anesthesia
2. A child up to 6 years old, with a dental condition of significant complexity
3. Removal of one or more impacted pathologic teeth on the same day (applies to codes D7230, D7240, andD7241)
4. The extraction of five or more teeth on the same day
5. More than one surgical extraction (D7210 and/or D7220) involving more than one quadrant on the same day
6. Full arch alveoloplasty or alveolectomy
7. One or more quadrants of any type of periodontal surgery performed on the same day
8. Surgical root recovery from the maxillary antrum (sinus)
9. Tooth transplantation
10. Surgical exposure of bone impacted or unerupted cuspids (i. e. includes impacted bicuspid or canine teeth)
11. Full arch stomatoplasty/vestibuloplasty
12. Radical excision of lesions in excess of 1.25 cm (1/2 in.)
13. Radical resection or ostectomy with or without bone graft
14. Patients exhibiting physical, intellectual, or medically-compromising conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result. Conditions include but are not limited to cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation).
15. Extremely uncooperative, fearful, unmanageable, anxious, or uncommunicative child or adolescent (age 18 years or younger) with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection loss of teeth or other increased oral or dental morbidity
16. Chronic disability that is attributable to a mental or physical impairment or combination of both; likely to continue indefinitely; and results in substantial functional limitations in one or more of the following: self care; respective and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency (verified by appropriate medical documentation)
17. Patients who have sustained extensive oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised

Orthodontic Protocols

The DMO plans provide for direct access to orthodontic care. The "DMO Orthodontic Direct Access Program" permits members to visit any participating orthodontist without first obtaining a referral from their Primary Care Dentist. In addition, members are not required to see their Primary Care Dentist for initial consultation regarding possible need for orthodontic care. Of course, the Primary Care Dentist may also refer eligible patients for consultation and/or problem-focused examination and treatment planning for orthodontic treatment without prior approval from Aetna.

The Primary Care Dentist is responsible for the following for any patient he/she refers to you:

1. Ensuring the member is eligible for orthodontic coverage
2. Assessing the need for orthodontic referral
3. Taking necessary radiographs (full-mouth series and panoramic survey)

It is recommended that the Specialty Dentist verifies the member's eligibility for patients who use the Orthodontic Direct Access Program. (National Dentist Line 1-800-451-7715)

Specialty review protocols

All orthodontic treatment plans must be submitted for approval in advance.

Orthodontic coverage/benefits determinations

The DMO offers a variety of orthodontic coverage options to plan participants. In addition, some employers may opt not to include orthodontic care as a dental benefit. Since there are a number of coverage options available subject to different plan provisions, limitations and exclusions, **a predetermination of orthodontic treatment is required. It is also important to note the total treatment length when submitting for approval.** This requirement ensures that both the orthodontist and the member are aware of the potential benefit available under the member's plan. Determining the benefits takes into consideration the plan specifics and the orthodontic care orthodontists have been contracted to provide, based on case type and length of treatment. The negotiated contracted case fee is based on a standard treatment length ranging from 18-24 or 18-30 months depending on the plan design. This will be indicated in the approval. Refer to the following examples below for specific information.

Coverage for orthodontic services is offered under either coinsurance plans or fixed copayment plans. Each type is discussed at a high level below:

- **Coinsurance** — The orthodontic benefit is based on a specific percent of the negotiated fee. For example, if a plan provides orthodontic coverage at 50 percent, the member is responsible for 50 percent of the negotiated fee, and the plan reimburses the participating orthodontist 50 percent of the negotiated fee.
- **Fixed Copayment** — The member's out of pocket is "fixed" – this means that the member's copayment cannot exceed a set amount. These amounts represent the total member out-of-pocket maximum for an orthodontic evaluation/examination through the retention phase for orthodontic care.

The following examples represent the standard orthodontic coverage currently offered by Aetna:

Example A — Available under a DMO coinsurance-type coverage

These plans provide benefits for comprehensive orthodontic treatment limited to a lifetime maximum of one full course of active, usual and customary orthodontic treatment, plus post-treatment retention.

Under this type of coverage, there is no orthodontic length-of-treatment maximum or dollar maximum. In addition, specific dentition types are not excluded from coverage. For these plan types, the plan benefits and the member copayment may be prorated when the treatment length is less than 18 months or more than 30 months. (As noted above, one of the elements used to contract for orthodontic care is based on 18-30-month or 18-24-month treatment lengths.) The prorated amount is determined by using the approved case fee and calculating the monthly dollar value using a 24-month treatment length as a standard. The prorated benefits amount is "shared" by the member and the plan based on plan coinsurance level. Details on plan benefits, member out of pocket and any prorated amounts are provided upon predetermination of benefits.

Benefits for treatment beyond 30 months are not predetermined and will be considered at the time the treatment reaches 30 months.

California Participating Dentists - Refer to Network Bulletin Section
Date: December 2018
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

Example B — Available for DMO fixed copayment-type coverage
These plans provide benefits for comprehensive orthodontic treatment of adult and adolescent dentition. (Coverage is not provided for primary or transitional dentition.)

Again, using 24 months as a standard treatment length, the member fixed copayment and the plan benefits are prorated using the same methodology detailed in Example A. Under these plan types, the member copayment cannot exceed the fixed copayment amount. In instances where treatment exceeds 30 months, the plan is responsible for the entire prorated amount. Details on plan benefits, member out of pocket and any prorated amounts are provided upon predetermination of benefits.

For these plan types the member's maximum out of pocket is "fixed." Fixed copay options include $1,500, $2,000, $2,300 and $2,400. Note – If the member elects not to proceed with treatment, the orthodontist may collect up to $30 for the problem-focused examination and up to $150 for diagnostic work-up (e.g., radiographs, study models, cephlometric analysis).

In the event a member switches to another participating orthodontist for retention, the orthodontist can collect a maximum of $275 for retention.

Benefits for treatment beyond 30 months are not predetermined and will be considered at the time the treatment reaches 30 months.

Example C — Available for DMO fixed copayment and coinsurance-type coverage
These plans provide benefits for comprehensive orthodontic treatment limited to a lifetime maximum of 24 months of active, usual and customary orthodontic treatment on permanent dentition, plus an additional 24 months of post-treatment retention.

These types of coverage provide benefits for comprehensive treatment of adult and adolescent dentition. (Treatment of primary or transitional dentition is not covered.) Removable and fixed appliances to correct harmful habits are also considered as orthodontic in nature. This coverage type also limits benefits consideration to 24 months of active treatment and 24 months of retention.

The fixed copay options include $1,500, $2,000, $2,300 and $2,400. Note – If the member elects not to proceed with treatment, the orthodontist may collect up to $30 for the problem-focused examination and up to $150 for diagnostic work-up (e.g., radiographs, study models, cephlometric analysis).

In the event a member switches to another participating orthodontist for retention, the orthodontist can collect a maximum of $275 for up to 24 months of retention.

When the treatment length is less than 18 months, the plan benefits and member copayment are prorated as detailed in the plan examples provided for coinsurance or fixed copayment type of plans. When the active or retention treatment length exceeds 24 months, the member is responsible for the prorated amount. Details on plan benefits, member out of pocket and any prorated amounts are provided upon predetermination of benefits.

Benefits for treatment beyond 30 months are not predetermined and will be considered at the time the treatment reaches 30 months.

Terminations and orthodontic treatment
If a member or plan terminates Aetna coverage during treatment, the orthodontist may charge his/her usual fee for the remaining treatment.

If a member switches into an Aetna indemnity or PPO plan, benefits will be subject to that plan's lifetime orthodontic maximum.

If the Specialty Dentist terminates his/her participation in the Aetna dental network, he/she must continue to treat the member at the contracted fee. Aetna will continue to make payments under the plan. The patient will remain responsible for payment of all plan copayments. The Specialty Dentist may not balance bill the patient for any additional charges. This information is detailed in the Specialty Dentist Agreement.

Orthodontic direct access
Under DMO plans, members are permitted to go directly to any participating orthodontist without obtaining referrals from their Primary Care Dentists.

Emergency Approvals

Emergency care is treatment that must be rendered in order to alleviate pain and/or prevent worsening of a condition that would be caused by delay. It is the Primary Care Dentist's responsibility to take all appropriate steps to alleviate the pain or otherwise provide palliative treatment whenever possible. Once the patient's condition is stabilized to the degree possible, referral to a Specialty Dentist may be appropriate in certain circumstances.

The Specialty Dentist may contact the National Dentist Line (1-800-451-7715) to confirm that the member is eligible for benefits.

Treatment Not Approved in Advance

The Primary Care Dentist is responsible for ensuring that proper emergency and specialty referral guidelines are followed.

Treatment that does not meet the Direct Referral criteria or treatment that has not been approved in advance by Aetna either verbally (for emergency care) or via a predetermination statement will be considered unapproved. If you perform a service that has not been approved, you may not be compensated by the plan, and you cannot collect any fee or copayment from the member.

Should you determine that additional or other treatment is required that has not been approved by Aetna or was not part of a Direct Referral, call the National Dentist Line (1-800-451-7715) prior to performing the service(s).

Completed treatment performed as a result of a Direct Referral or Emergency Approval may be subject to retrospective review which includes clinical review by licensed dentist consultants. This review assists Aetna in determining if a referral was made in accordance with the guidelines and protocols listed for that specialty.

Consultation vs. Problem-Focused Examinations

If you will be treating a patient for a condition, please submit the service as a problem-focused examination. If you are rendering a diagnosis for a condition that will be treated by the patient's Primary Care Dentist, submit the procedure as a consultation.

California Participating Dentists - Refer to Network Bulletin Section
Date: December 2018
Starting January 1, 2019, prospective review is not applicable for the California DMO® plans.

AETNA MANAGED DENTAL SPECIALTY REFERRAL FORM FOR DMO

☐ **DIRECT REFERRAL (Eligible only to participating Specialty Dentists)** ☐ **SPECIALTY APPROVAL**

IF SUBMITTING A UNIVERSAL CLAIM FORM FOR PAYMENT OR SPECIALTY APPROVAL, THIS REFERRAL FORM MUST BE INCLUDED.

COMPLETE MEMBER/PATIENT INFORMATION

PART I EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) PLEASE PRINT			MEMBER IDENTIFICATION NUMBER	GROUP NUMBER OR CONTROL NUMBER	DATE OF BIRTH (MM/DD/YYYY)
HOME ADDRESS			WORK PHONE		HOME PHONE
CITY	STATE	ZIP CODE	OTHER INSURANCE COVERAGE? ☐ YES ☐ NO IF YES, NAME OF PLAN		

Is this member listed as a Late Entrant (LE) on your Monthly Roster? ☐ YES ☐ NO

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT PAYMENT WILL BE MADE DIRECTLY TO ATTENDING DENTIST.

PATIENT SIGNATURE (If minor, parent signature required) _____ DATE _____

PART II COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT

PATIENT'S NAME (LAST, FIRST, MI) If a Dependent	☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YYYY)	DEPENDENT **STATUS** ☐ SPOUSE ☐ CHILD ☐ OTHER	IF CHILD, IS HE/SHE WHOLLY DEPENDENT FOR SUPPORT & MAINTENANCE ☐ YES ☐ NO

REFERRING DENTIST

PART III

REFERRING DR. _____ PHONE # _____ OFFICE CODE # _____

REFERRING TO DR. _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

☐ **IN** Network ☐ **OUT** of Network; if so, indicate reason _____

DMO Plan Code _____

ALL PROCEDURES BELOW, PRECEDED BY AN " * ", MUST BE APPROVED PRIOR TO REFERRAL.

PLEASE INDICATE PRIMARY REASON FOR PATIENT REFERRAL:

ENDODONTICS* - *Include Pre-OP and Post-OP Periapical X-rays

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Molar root canal therapy Tooth # _____
- ☐ Calcified/inaccessible canals (with conclusive radiograph evidence) Tooth # _____
- ☐ Root canal retreatments Tooth # _____
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

PEDIATRICS* - *Direct referral eligible only for consultation/evaluation for children under age 7. Detailed narrative required for children age 7 or over.

- ☐ Medically compromised or developmentally disabled (please include a physician's statement of condition)
- ☐ Presents a documented behavioral management problem (please indicate below any attempts made to manage patient)
- ☐ Has rampant caries, or
- ☐ Requires emergency care that is beyond the scope or ability of the Primary Care Dentist
- ☐ Other * - **Any other service requires approval. Please explain below.**

ORAL SURGERY* - *Include Pre-OP X-ray/Panoramic X-ray *(Bitewings are NOT acceptable) and provide rationale for each tooth requested.*

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Single symptomatic and/or pathologically involved partial or full bony impaction Tooth # _____ Symptoms: _____
- ☐ Five or more routine extractions to be performed in one visit (except for 3rd molars) Teeth #s _____ Symptoms: _____
- ☐ Alveoloplasty (in conjunction with three or more extractions in the same quadrant or in an edentulous area)
- ☐ Surgical removal of residual roots
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

PERIODONTICS* - *Include Periodontal charting, full mouth mounted Intraoral X-rays (Panoramic X-ray is NOT acceptable)

- ☐ Generalized moderate to severe periodontitis - consultation only
- ☐ Indicate date(s) and quadrants Scaling and Root Planing completed _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

ORTHODONTICS - Verify patient is eligible for Orthodontic benefits

- ☐ Consultation or problem focused examination only

Clinical Indications / Rationale / Additional Comments: _____

SIGNATURE OF REFERRING DR. _____ DATE _____

ATTENDING SPECIALIST

PART IV EXAMINATION, TREATMENT PLAN, and/or SERVICES RENDERED

Tooth # or Letter	Surface	Description of Services	Date Service Performed MM	DD	YYYY	Procedure Number (ADA Code)	Fee	Copay Collected

I hereby certify that the procedure(s) indicated by date have been completed and that the copay represents the actual copay collected.

Treating Dentist's Signature _____ TIN/SSN _____ NPI _____

Please see reverse side for additional information.

Note: Approval is ***not required*** if a member requires **emergency care** from a **pediatric dentist** because the needed care is beyond the scope or ability of the Primary Care Dentist.

ADDITIONAL PROCEDURES ELIGIBLE FOR DIRECT REFERRAL - Please indicate selected procedure in the appropriate area on the front of the form.

PLEASE NOTE: A Primary Care Dentist may Directly Refer only to a participating Specialty Dentist. Any procedure not specifically listed as eligible for Direct Referral or referrals to non-participating Specialty Dentists must be approved in advance by the appropriate Aetna Dental Service Center prior to referral. When submitting requests for approval or reimbursement consideration, please ensure supporting diagnostic material is included. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

ENDODONTICS - Include Pre-OP and Post-OP Periapical X-rays

- Severely dilacerated and/or sclerosed roots (with conclusive radiographic evidence)
- Tortuous and/or convoluted roots (with conclusive radiographic evidence)
- Complications encountered during treatment (please explain on other side)
- Hemisection
- Root amputation
- Apexification/recalcification

ORAL SURGERY - Include Pre-OP X-ray/Panoramic X-ray
(Bitewings are not acceptable)

- Complications mid-treatment
- Treatment needs due to cellulitis
- Frenectomy
- Exostosis removal
- Removal of foreign body from bone
- Sequestrectomy
- Closure of oral fistula
- Transplantation of tooth or tooth bud
- Sialolithotomy
- Excision of hyperplastic tissue per arch (in conjunction with fabrication of prosthetic device)
- Biopsy

SPECIALTY DENTIST: Additional approval is required for treatment beyond the approved directly referred procedure(s). Approval must be obtained from the appropriate Aetna Dental Service Center for treatment to be eligible for benefit consideration. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

The Specialty Dentist may report examination, treatment plan approval, or services rendered as follows:

Complete the appropriate section of the Specialty Referral Form, attach supporting diagnostic material and submit to the appropriate Aetna Dental Service Center.

OR

Submit a completed ADA type claim form along with a copy of the Specialty Referral Form indicating prescribed treatment and supporting diagnostic material to the appropriate Aetna Dental Service Center.

DID YOU REMEMBER TO . . . . . .

- ☐ OBTAIN APPROVAL AS REQUIRED?
- ☐ Complete each box applicable on the form?
- ☐ Provide copies of payment or rejection statements from another group?
- ☐ Provide all required diagnostic information?
- ☐ Sign the form and secure patient's signature?
- ☐ Mail completed forms to Aetna Dental, P.O. Box 14094, Lexington, KY 40512-4094

Questions may be directed to 1-800-451-7715.

IV. Professional Standards/Clinical Practice Guidelines

Introduction

Aetna managed dental plan patients make their decision to be treated in your office based on your professional reputation as well as the location and appearance of your office. It is, therefore, important to you and Aetna that decisions regarding treatment to be rendered are always made in the best interest of the patient's dental health.

Building a long-term patient relationship begins with the patient's initial call for an appointment. While it is not expected that patients covered under Aetna's managed dental plans should be given any preference over other patients, they must be accorded the same appointment availability as all other patients. All regular appointments should be scheduled as soon as possible after the patient's initial call for an appointment and emergencies should be handled immediately.

The following sections discuss the professional standards that Aetna expects of all offices participating in its networks. The sections deal respectively with:

- Record Keeping
- Sterilization and Infection Control
- Medical Emergencies
- Dental Emergencies
- Radiology

Record Keeping

Review and analysis of the dental record is essential for the assessment of the nature and appropriateness of the care delivered to patients covered by Aetna managed dental plans. Although the physical structure and appearance of a dental record may vary greatly among offices depending upon a dentist's education, experience or choice, there are certain key elements and processes that must be common and present in any dental record for it to be professionally acceptable.

(It should be noted that data related to malpractice claims against dentists indicates that lack of adequate record keeping is the major reason for adverse decisions against the dentist-defendant.)

Function of the dental record

1. The primary function of any dental record is to accurately and clearly document the diagnosis and course of a patient's dental history, status, needs and treatment. An appropriate dental record will provide the differential diagnosis, treatment planning and eventual care in clear language and in sequential manner so that anyone reading the record, including someone unfamiliar with the particular patient and his/her dental needs, would have a clear understanding of the patient's existing dental condition, related medical factors, treatment plan(s) proposed and accepted, subsequent treatment and outcome results. Any reviewer should be able to understand the treating dentist's thought processes in arriving at the particular diagnosis and treatment sequence.
2. The dental record is a means of communication among the treating dentist, patient, other health care professionals, consultants, subsequent care providers and plan administrators so that all treatment for any particular patient can be reasonably and accurately recreated.
3. The dental record is an official document. It will assist in protecting the interests and responsibilities of both the patient and his/her health care team. Thus, the creation and maintenance of accurate, timely and complete records are essential.
4. The dental record serves as a basis for the analysis and evaluation of the appropriateness of care rendered to a patient in any post-treatment or peer review situation.

Characteristics of the dental record

1. An acceptable dental record should be logical, sequential, clear, concise and accurate and include all the information necessary to make an appropriate diagnosis, explain ongoing and subsequent treatment, and establish follow-up/recall care. It should document all missed or canceled appointments and reasons, emergency treatment, referrals to specialists, interfaces with other health care professionals, as well as any patient concerns and/or complaints.
2. The segments of the dental record should be interdependent and interrelated so as to present an accurate and timely statement of the facts and occurrences which took place during treatment.
3. Any errors made in the dental record should only be corrected by drawing a single, thin line through the error with the record correction noted as nearby as possible. Never block out any previous entry so it becomes unreadable. All entries should be made only with a pen utilizing a color reproducible by simple copying means.
4. A complete medical history is required. It must be periodically updated upon the patient's return visits.

Record content and format

Every dental record must include the following components:

1. General patient information, medical history and periodic updates
2. Prominent display of all medical alerts and allergies, along with the names and phone numbers of pertinent related health care professionals
3. Indication that, where necessary, pertinent related health care professionals have been contacted, along with comments or recommendations from these providers
4. Dental history, including charting of existing restorations
5. Clinical examination, including head, neck, oral cancer screening and TMJ examination
6. Radiographs
7. Diagnosis
8. Treatment plan(s) and, where applicable, alternate treatment plan(s)
9. Dated and signed consent forms
10. Referral information, along with reason for referral
11. Accurate and legible progress notes
12. Anesthesia/analgesia notations
13. Termination, completion or discharge notes
14. Patient comments/dissatisfaction

Medical history

Many preprinted medical history forms exist that include the information that must be obtained prior to delivering dental care and updated periodically. This medical history must contain the following information:

1. A dated and signed medical questionnaire completed by the patient or parent/guardian
2. A signed and dated indication of review of the medical history by the dentist
3. Notation of the patient's general health and appearance
4. Questions should be designed to elicit information on the following:

- Allergies
- Sensitivities
- Recent illnesses
- Recent surgery
- Hepatitis
- Immunodeficiencies
- Prolonged bleeding
- Stroke
- High blood pressure
- Heart disease
- Pregnancy
- Murmurs
- Current medications
- Liver/kidney disease
- Diabetes
- Chronic disease
- Smoking habits
- Drug dependency
- Nervous disorders
- Radiation therapy
- Reaction to anesthetics
- Lung disease/tuberculosis
- Rheumatic fever
- Infectious diseases/AIDS
- Joint replacements
- Implants
- Latex allergies
- Organ transplant
- Bisphosphonates Therapy

5. Name(s), phone number(s) and address(es) of physicians and other pertinent health care professionals.

Dental history

An acceptable dental record will contain:

1. Chief complaint, problem or reason for visit
2. Date of last dental treatment/visit
3. Frequency of previous dental care
4. Frequency, type and availability of previous radiographs
5. Evaluation of patient's level of oral hygiene, including notation on brushing and flossing habits, use of fluorides, etc.
6. TMJD and related MPD history; notation of any discomfort
7. Notation and history of any oral habits
8. Notation of previous occlusal correction
9. History of any previous untoward dental treatment reactions
10. Name and address of most recent previous dentist

Note: Written documentation is required for problems (e.g., discoloration, swelling, ulceration, bone loss, mobility, etc.) or if the tissue/TMJ/periodontal condition is within normal limits (WNL).

Clinical examination

A clinical examination should include the following:

1. Charting of existing restorations
2. Charting of existing prostheses (including age and condition)
3. Charting of caries, defective restorations, food impaction areas, unrestorable teeth, and missing teeth
4. Pulp vitality testing, percussion, transillumination (as needed)
5. Tooth mobility
6. Evaluation of periodontal status. This should include full-mouth charting of pocket depths, bleeding indices, possible etiologic factors, plaque, furcation involvement, oral hygiene habits, possible previous treatment and possible need for specialist referral
7. Use of appropriate and necessary radiographs
8. Diagnostic casts, when indicated
9. Occlusal status (i.e., jaw relationship, growth and development)
10. Soft-tissue examination and oral cancer evaluation
11. Evaluation of patient comments as to their status, needs and desires

Note: Written documentation is required for problems (e.g., discoloration, swelling, ulceration, bone loss, mobility, etc.) or if the tissue/TMJ/periodontal condition is within normal limits (WNL).

Radiographs

Appropriate radiographs of diagnostic quality are a vital component of almost any dental examination. Radiographic exposure should never present any danger to either patients or staff. This requires appropriately functioning equipment, use of "fast" film speeds, proper technique and shielding. (See separate section on Radiology for further guidelines.)

1. All radiographs should be properly exposed, developed, mounted, identified and dated.

2. All radiographs should be of acceptable diagnostic quality:
   a) Films exhibit no fog
   b) No discoloration, stain or foreign body images are present
   c) Film density is acceptable
   d) Films reproduce geographic areas desired
   e) Images should not be elongated or foreshortened
   f) Periapical films should exhibit tooth apices and 1/8 inch beyond
   g) Interproximal surfaces should not overlap
   h) Interproximal bone crests should not have adjacent tooth superimposition

3. A sufficient number of X-rays to diagnose and monitor existing dental and periodontal conditions

NOTE: Where a computer-enhanced substitute for radiographs is utilized, it should meet the same requirements as for radiographs.

Soft-tissue examination

A soft-tissue examination is a vital and necessary component of any complete dental examination. It should include examination and recording of the status of the following:

- Lips
- Tongue
- Floor of mouth
- Frena
- Palate
- Salivary glands
- Oropharynx
- Mucosa

Written diagnosis

The diagnosis definitively states what is dentally "wrong" and "right" with the patient's dental condition, as well as associated nondental issues. It should be prominently displayed on the chart. Whenever possible, it should classify the patient's problems by categories of disease or dysfunction.

Treatment plan/recommendations

The treatment plan is a written statement of the logical sequence of care meant to eliminate or alleviate the patient's dental problems/complaints, diseases or symptoms. It should be appropriately supported by the histories, clinical examination and diagnosis. It should prioritize the sequence of treatment based upon the urgency of logical application of procedures necessary to obtain objectives. Whenever possible, sequence of treatment should list services to be performed related to specific visits to be scheduled. All necessary referrals to other health care professionals should be noted, along with reason, instructions and names of all concerned.

A complete treatment plan should include:

1. Concise delineation of patient problems/needs requiring treatment
2. A prime proposed treatment plan, probable prognosis and rationale
3. Alternate treatment plans indicating covered vs non-covered services
4. Probability of risks involved with various treatment plans
5. A signed consent for treatment plan accepted by patient or parent/guardian
6. Probability of risk involved if treatment is rejected
7. Financial estimates and patient responsibility, including all financial arrangements agreed upon with the patient
8. Proposed prioritized appointment schedule

Careful documentation should be evident whenever a patient refuses necessary care. This should include a statement by the dentist as to the potential consequences of delaying treatment, signed and dated by both the dentist and the patient or parent/guardian.

Retrospective review of patient charts should indicate adherence to treatment plan recommendations and time ranges or an explanation for any variations.

Progress notes

Any appropriate dental record must contain concise, dated progress notes fully describing and documenting services rendered to treat existing dental conditions. These progress notes should be legible and enable any reviewer to accurately reconstruct care delivered to the patient. These notes should be a running narrative and include any changes made from the original diagnosis (with explanation).

Materials used must be fully noted, as well as medications and dosages. Names of analgesia, anesthetics, doses and reactions should be noted for each visit.

Progress notes should also include any unusual or untoward reactions to care received by the patient, as well as any treatment and responses to such reactions. This includes documentation of the necessity for referral to other health care professionals, including the name of the referred doctor and the reason for referral.

The signature of the dentist(s) of any direct care must be evident for each treatment.

Completion notes

Completion notes summarize treatment delivered and expected results. They are particularly important if recommended treatment has been terminated by either the patient or dentist. In the latter instance, specific reasons for failure to complete treatment in a timely fashion must be noted, along with written verification to the patient describing problematic results of premature or incomplete termination of care.

Completion notes should include:

1. Prognosis of treatment completed
2. Listing of any treatment still needing to be completed, along with a tentative schedule for treatment
3. Home care instructions given to patient or parent/guardian
4. Recall instructions, along with methodology and recall timeframe
5. Potential problem areas, instructions for problems and any office follow-up required

Sterilization and Infection Control

All patients and all staff members must be protected from infectious and environmental contaminants. Complete OSHA requirements can be obtained from the American Dental Association. The list below are some of the more pertinent OSHA requirements:

1. Personnel should scrub with bactericidal soap before all oral procedures.
2. Sterile gloves should be worn.
3. Face and eye protection should be worn by the dentist and/or staff when indicated.
4. Prior to sterilization, all instruments should be thoroughly scrubbed and debrided.
5. All instruments and equipment, including burs, mirrors and matrix bands, that can be sterilized should be rendered sterile between use on patients.
6. All instruments and equipment that cannot be sterilized, including operating lights, chair switches, handpieces, cabinet working surfaces and water/air syringes and their tips, should be disinfected, using approved techniques, after each use.
7. ADA-approved sterilization solutions should be utilized.
8. Sterilization equipment should be monitored, using process indicators with each load and spore testing on a weekly basis.
9. Handling of sharps and environmental waste, including the disposal of waste and solutions, must be in compliance with all applicable federal, state and local laws and regulations.

Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization will not be covered. The member will be responsible for the charge.

Medical Emergencies

The office should be well prepared to deal with a medical emergency through implementation of one or more of the following:

1. The dentist and one other staff member should have current training in CPR procedures.
2. (For offices relying upon outside sources for emergency care.) A formal medical emergency plan should be prepared and staff members should understand their individual responsibilities if the plan needs to be implemented. Emergency numbers should be prominently posted.
3. Risk-prone patients should be identified in advance by routinely taking a proper medical history for every patient.
4. All dental offices should have a portable source of oxygen with a positive demand valve, or ambu-bag blood pressure cuff and stethoscope.
5. (For offices who will deliver the emergency care.) If a formal emergency plan is not in place, a full complement of emergency equipment should be readily available including sphygmomanometer, stethoscope, ambubag, oxygen source (mobile), emergency drug kit and oral-pharyngeal airway.

Dental Emergencies

Patient access to emergency dental treatment must be available on a 24-hour/seven-day-per-week basis. Acute conditions must be treated within 24 hours. You must designate another dentist to treat emergencies that may arise when you are not available. Usually this is best accomplished by designating another mutually agreeable dentist participating in the Aetna network. Your Network Manager can assist you in locating nearby participating offices. The Specialty Dentist may be financially responsible for services delivered to his/her plan patients when he/she is not personally available to deliver treatment or has not made arrangements for emergency care.

While the Specialty Dentist must be available and provide treatment within 24 hours, this does not necessarily require that the dentist see the patient in the office outside regular office hours except in extreme emergencies. If it is necessary to open the office to see the patient outside regular office hours, while the treatment rendered will be covered under DMO plans, the office visit is not. Therefore, you may charge the patient your usual fee for an office visit outside regular office hours (ADA Procedure Code D9440) in addition to any other copayment that may be required by the plan. You should advise the patient of this in advance.

Special Note for Texas: After–hours emergency visits are covered in full under Texas DMO plans. Therefore, you may not bill the patient for the office visit. You may only charge the plan copayment for any services provided.

Radiology

Radiology procedures should not pose an undue hazard to patients or staff and should assure that patients have precisely the exposure dose and radiographs recommended by the Department of Health and Human Service's guidelines. This should be ensured by the following:

1. The number of radiographic exposures for each patient should be the minimum number needed to produce the desired diagnostic information.
2. Only films with the National Standards Institute Group's fastest ratings should be used.
3. Shields and collimating devices should be used.
4. Leaded aprons and thyroid collars should be available and used, in accordance with Department of Health and Human Services guidelines.
5. Dosimeters should be worn by all dental personnel and properly analyzed.
6. X-ray equipment should be placed so that when exposures are made the operator can stand at least six feet from the patient outside the path of the useful beam and can be protected by an adequate barrier.
7. Radiation sources should be periodically inspected and certified by qualified personnel.
8. The initial radiograph series should be appropriate to the age and oral status of the patient, in regard to the type and number of films, in accordance with the Department of Health and Human Services guidelines (see chart on following pages).
9. The dentist's decision to take recall radiographs should depend upon the individual's age, general or systemic condition and his/her dental needs and status. Therefore, recall and/or posttreatment radiographs should not be taken on a routine basis, but rather be determined on an individual needs basis.
10. A full radiographic series should not be routinely taken unless there are specific indications for such an evaluation.
11. Radiographs should be an available part of the patient's record for reference in subsequent evaluations and treatment.
12. Upon request of patient or dentist, duplicate films shall be forwarded with patient referral or transferred to another practitioner to prevent or minimize the need for radiation exposure at no additional cost to the member.
13. All radiographs should be properly mounted, dated and labeled.
14. A written waiver, with the patient's or guardian's signature, should be placed in the record if radiographs are refused.

The "Radiographic Guidelines" on the following pages should be referenced for general guidelines as to when to take radiographs.

Refer to the Claim Documentation Guidelines in Appendix 1 to determine when to send radiographs to Aetna.

Guidelines for prescribing dental radiographs

The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

Type of Encounter	Patient Age and Dental Developmental Stage				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New patient* being evaluated for dental diseases and dental development	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars	Usually not indicated	
Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.				

***Clinical situations for which radiographs may be indicated include but are not limited to:**

A. Positive Historical Findings
1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms
1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

****Factors increasing risk for caries may include but are not limited to:**
1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects
11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemo/radiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care

From: American Dental Association, U.S. Food & Drug Administration. The Selection of Patients For Dental Radiograph Examinations. Available on www.ada.org

V. Quality Management

An important Aetna objective is the promotion of appropriate, affordable and timely dental care by participating dentists to all plan members. As a result, Aetna has implemented a nationwide Dental Quality Management Program (QM Program). This QM Program is supported by various systems that tabulate, sort and analyze data collected on prospective and existing dental offices.

Certain key components of the QM Program are summarized below. Because the success of the QM Program depends upon the full cooperation of participating dentists, network dentists are contractually required to participate in and comply with all requirements of Aetna's quality management programs, policies and procedures, whether or not they are specifically included in the Dental Office Guide. We work closely with participating dentists on tools that help measure dental care delivery effectiveness and encourage you to contact us with any questions.

Credentialing

Aetna's credentialing process has two major elements.

1. Initial verification — Initial verification is performed on a prospective level prior to accepting a dentist into the network. Primary source verification is performed to verify or identify the following:
   - Current dental licensure and expiration date
   - DEA certification eligibility/licensure
   - Appropriate certifications
   - Highest educational level
   - Current professional liability insurance
   - Malpractice and disciplinary history
   - Medicaid/Medicare sanctions
   - Negative past professional histories

   A Specialty Dentist who renders general anesthesia and/or intravenous sedation must have a current and valid state certification or permit, if available.

   An attestation to the written application is included in the initial verification process and covers items such as:
   - Revocation of hospital privileges, participation in various programs
   - Lack of drug use
   - Felony convictions
   - Physical and emotional capability to perform dental procedures
2. Ongoing verification — All existing offices will be recredentialed every three years (or more frequently if required by state law). Primary source verification is completed to ensure current licensure and to obtain an update on past professional history.

Aetna is responsible for ensuring that all dentists participating in our managed dental plans are credentialed and recredentialed. To that end, it is the **Specialty Dentist's responsibility to notify his/her regional network support office when the office adds or terminates dentist associates. The Specialty Dentist is also responsible for notifying Aetna of any adverse action with respect to any of the credentialing and recredentialing elements noted above. Failure to do so may result in the termination of your participation agreement.**

Participation Criteria

The Specialty Dentist Participation Criteria lists a variety of requirements that the participating Specialty Dentist must meet. These requirements include standards regarding your office's physical attributes, practice coverage, patient access, office procedures, patient load, office records and insurance, and professional competence and qualifications. These criteria are used in our credentialing and recredentialing process and are attached to our current Specialty Dentist Agreements. A copy of the criteria is included in the Appendix I section of this Guide.

Termination of Participating Dentist

A participating dentist may be terminated from the network for any misrepresentation(s) made on his/her application or failure to disclose any required information. Other causes for termination include, but are not limited to, fraud; failure to comply with the terms of the Specialty Dentist Agreement or those outlined in the Specialty Dental Office Guide or any other supplementary material provided in writing by Aetna; failure to follow referral guidelines for Specialty Services; failure to meet Participation Criteria; etc.

Utilization Analysis

Aetna employs various tools to analyze care provided to members of its managed dental plans. The analysis includes treatment patterns emerging from a specific office as well as comparing treatment patterns among peer network offices. A critical source for utilization analysis is the reporting of the treatment provided by the Specialty Dentist. This information is received directly from your office by means of submission of claim forms. Treatment data from these forms is collected and sorted and facilitates the development of treatment pattern models and comparative benchmarks for commonly performed dental services. Reports are generated that provide a "snapshot" of the type of care delivered and the level of patient utilization. This aids in determining the impact of Aetna managed dental plans in a specific office.

Alternative methods of reporting treatment provided to plan members must be approved by Aetna.

Members are periodically contacted to verify the service performed, determine if there was discussion regarding alternate treatment options, determine if the member signed an Informed Consent form for any elective/optional treatment, and verify the copayment that was billed or collected. In addition to serving as an oversight mechanism, it offers us an opportunity to determine if training of your office staff is indicated.

Access to Care

An essential part of QM is the promotion of timely and appropriate dental care. Appropriate access to care can vary by the type of dental care needed. The following appointment availability standards are monitored via the QM Program:

I. **Emergency Care — patient must have access 24 hours/7 days a week**
The Specialty Dentist must provide or arrange for 24-hour-per-day, seven-day-per-week emergency care coverage. Emergency care is defined as those dental services needed to relieve pain or prevent worsening of a condition when that would be caused by delay. Coverage for emergency care is subject to state law.

II. **Urgent Care — must be provided immediately or within 24 hours**
The Specialty Dentist must be available immediately or within 24 hours for urgent care (conditions involving swelling, bleeding, fever or infection).

III. **Routine Care — within 5 weeks (3 weeks in California; 10 days in Connecticut)**
Most routine care should be appointed within five (5) weeks of request, provided the patient can schedule the next available appointment.

IV. **Hygiene appointments — within 8 weeks (4 weeks in California; 6 weeks in Arizona)** ***if applicable to the specialty.***
Hygiene appointments must be scheduled within eight (8) weeks of the request, provided the patient can schedule the next available appointment.
(It is recognized that requests for special times, such as after work hours or on weekends, may take longer to schedule for routine care and hygiene appointments.)
Access to care is monitored by the regional provider relations staff. Periodically, a written inquiry or phone call may be generated by an Aetna service representative to obtain information concerning your next available appointment. This information is also recorded at the time of your on-site office review. Member complaints regarding appointment availability are documented and investigated.

Note: Participating dentists are also required to comply with applicable state-specific requirements regarding appointment availability.
This includes, but is not limited to, the following:
California - In-office wait time of 30 minutes or less.

Member Satisfaction Surveys

Member satisfaction surveys assist in rating patient perception of the network. The feedback is based upon experiences of members who have had dental treatment rendered in participating dentists' offices. The survey addresses key patient issues such as level of satisfaction with the program, access to care, referral for specialty services, utilization, perceptions of care received and interaction with your office staff. The surveys may be random or targeted to specific covered patients, certain plan sponsors or specific offices or administered in a variety of combinations.

Analysis of the Member and Dentist Documentation Systems

Another important element of the QM Program is the timely response to all member and Primary Care and Specialty Dentist inquiries and the resolution of all complaints. Aetna is committed to ensuring that Customer Service Professionals are trained to research and respond to concerns expressed by managed dental plan members and dentists.

Documentation systems are used to record and track resolution activities on all inquiries and complaints. These systems collect, coordinate, sort and store incoming and outgoing communications associated with these inquiries and complaints. These databases link local and national representatives with all areas supporting Aetna managed dental plan operations such as Provider Relations, Billing, Eligibility and Claims. Complaints are routed to the appropriate area for resolution.

These systems allow Aetna to respond to the needs of members, dentists and plan sponsors quickly and efficiently, regardless of the reason for the call. Reports are routinely produced to monitor the number of calls and the type of calls and to evaluate the handling and resolution of those calls.

Grievance and Appeal Process

Aetna has policies and procedures in place to address member and dentist complaints. The scope of this program includes timeframes and processes for the acknowledgment, evaluation, monitoring and resolution of complaints. **(It should be noted that the handling of complaints may be subject to federal and state legislative requirements.)**

NOTE: In order for the Grievance and Appeal process to function effectively, it is imperative that the Specialty Dentist cooperate fully by submitting all requested information (records, X-rays, etc.) in a timely manner. Lack of complete documentation can impact on the ability to meet state mandated deadlines and can also adversely affect the final decision. **Non-compliance with policies and procedures may result in termination of network participation.**

All complaints are documented and are routed to the area responsible for resolution. Complaints will be resolved and communicated in a timely manner depending on the urgency of the situation and requirements of specific state laws.

Aetna may not take any action against dentists based solely on the fact that the dentist may have filed a grievance or appeal on behalf of a patient or on his/her own behalf.

Appendix I

CLAIM DOCUMENTATION GUIDELINES

CDT- 2007 CODE*	DOCUMENTATION GUIDELINES
Restorative	
D2390 D2542-D2544 D2642-D2644 D2662-D2664 D2710-D2799 D2960-D2962	Current dated pre-operative radiographs ■ Prior placement date and rationale for replacement, if applicable
D2971	Current dated pre-operative radiographs ■ Narrative ▲
Periodontal	Based on the American National Standard/American Dental Association Specification No. 1047, Standard Content of an Electronic Periodontal Attachment
D4210 & D4211	Current dated pre-operative periodontal charting ●
D4240 & D4241	Current dated pre-operative periodontal charting ● Current dated pre-operative radiographs ■
D4249	Current dated pre-operative radiographs ■
D4260 & D4261	Current dated pre-operative periodontal charting ● Current dated pre-operative radiographs ■
D4263, D4264, D4265, D4266, D4267	Current dated pre-operative periodontal charting ● Identify each site Current dated pre-operative radiographs ■ Note: A single code for multiple sites is not valid.
D4268	Recent dated post surgical periodontal charting ● Narrative with tooth/teeth numbers and rationale for surgical revision ▲ Note: Date of surgical revision should be no more than twenty-four months and generally no less than six months from the date of the initial surgery.
D4270, D4271 D4273, D4275, & D4276 *	For each tooth/site proposed to receive a soft tissue graft, A chart or narrative containing the following Mucogingival Data • Tooth # _____ • MM Recession_____ • MM Attached Gingiva _____
D4274	Current dated pre-operative periodontal charting ● Current dated pre-operative radiographs ■
D4320 & D4321	Current dated pre-operative radiographs ■
D4381	Current dated pre-operative periodontal charting ● Narrative ▲

AETNA RESERVES THE RIGHT TO CHANGE OR UPDATE THIS INFORMATION WITHOUT NOTICE. CDT-2007

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CDT- 2007 CODE*	DOCUMENTATION GUIDELINES (continued)
Implant Services	
D6010-D6050	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, if applicable) Numbers of all missing teeth Tooth number of proposed implants
D6053-D6079 D6094 & D6194	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, if applicable) Numbers of all missing teeth Tooth number (s) of proposed treatment sites (s) • The radiographs should be post-operative to the implant placement, but pre-operative to the crown and /or bridge placement.
D6090-D6100	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Narrative ▲ • The radiographs should be post-operative to the implant placement, but pre-operative to the crown and /or bridge placement.
Prosthodontics, fixed	
D6205-D6252 D6545 D6548 D6600-D6634 D6710-D6794 D6985	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, and rationale), and rationale for replacement if applicable Numbers/letters of all missing teeth
Oral And Maxillofacial Surgery	
D7210-D7241	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Narrative ▲ – To include rationale for extraction and prior treatment history
D7310 & D7311	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■
D7410- D7412	Pathology report.
D7950-D7953	Current dated full mouth pre-operative radiographs and/or panoramic radiograph ■ Narrative describing the planned prosthetic reconstruction ▲
Miscellaneous	
D9220-D9248	Current dated pre-operative radiographs ■ Narrative ▲ Anesthesia Records
D9952	Current dated pre-operative radiographs ■ Narrative ▲
By Report" procedures	
D2999 D3999 D4999 D5899 D5999 D6199 D6999 D7999 D8999 D9999	Narrative describing specific clinical conditions addressed by the procedure, rationale demonstrating need, pertinent history and treatment plan ▲ Radiographs, if applicable, to assist in describing clinical condition ■
General Comments	
■	**QUALITY OF RADIOGRAPHS**: All radiographs or prints of digital radiographs should be of diagnostic quality, dated, mounted, and labeled right and left. Submitted radiographs should be duplicates and less than 36 months old and labeled with the patient's name and the provider's name and address.
●	**PERIODONTAL CHARTING**: Must be comprehensive full mouth, legible, dated, documented with six measuring points recorded in mm. per tooth, labeled right and left, mandibular and maxillary, with classified furcation defects and tooth mobility recorded as 1st, 2nd or 3rd degree.
▲	**WRITTEN NARRATIVES**: Must be clear, legible and provide rationale for the proposed treatment. Example: describes specific clinical conditions addressed by the procedure.
	These guidelines represent frequently submitted procedures which require attachments and are not all inclusive. There may be other dental procedures not listed which require additional documentation. Submit only a completed claim for routine dental procedures such as cleanings and minor restorations, unless otherwise requested.

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Specialty Dentist Participation Criteria

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Specialty Dentist participating in Plans and shall be enforced at the sole discretion of Company[1].
2. Each applicant for participation as a Specialty Dentist must satisfactorily document evidence meeting the criteria listed herein for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.
3. Each participating Specialty Dentist must continue to meet the following criteria for the duration of participation in the Company Plans.
4. Unless specifically permitted otherwise by Company in its sole discretion, if Specialty Dentist is part of a group practice, all dentists in the group must meet Company's Participation Criteria and must agree to participate in all Company Plans in which Specialty Dentist participates. If all dentists in the group do not meet Company's criteria, the group cannot participate.
5. Each Specialty Dentist must execute a Provider Agreement (with a footer dated 5/97 or later) or an alternative acceptable to Company, under which Specialty Dentist agrees to provide services to Members of all health products, plans or programs issued, administered, or serviced by Company or one of its affiliates and specified in the Agreement.
6. Each applicant must fully complete the participation application form, and each applicant and participating Specialty Dentist shall periodically supply to Company all requested information, including, but not limited to, the confidential information forms.

B. Office Standards

Each Specialty Dentist's office must:

1. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
2. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
3. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
4. Be clean, presentable, and have a professional appearance.
5. Provide clean, properly equipped patient toilet and hand washing facilities.
6. Have a waiting room able to accommodate at least four (4) patients.
7. Have treatment rooms which are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
8. Have a no-smoking policy.
9. Have at least one (1) staff person (in addition to Specialty Dentist) on duty during normal office hours.
10. Provide evidence that Specialty Dentist has a copy of current licenses for all dental hygienists and other non-dentist dental professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).
11. Keep on file and make available to Company any state required practice protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in office.
12. Complete a Location Form identifying the address(es) and physical location(s) of office(s).
13. Have appropriate, safe x-ray equipment. Radiation protection devices, including, without limitation, lead aprons, must be available at all times and used according to professionally recognized guidelines (e.g., Food and Drug Administration). All equipment in Specialty Dentist's office must comply with and maintain such certifications as may be required by federal, state and local laws and regulations (including, but not limited to, laws and regulations regarding maintenance and calibration of equipment).
14. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; and maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and

1 Company refers to Aetna Health Management, LLC. and/or its affiliates.

regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association ("ADA") and the component state and local societies.

15. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
16. Use an appointment book (or an electronic equivalent acceptable to Company) for scheduling of dental appointments. Appointments should be made in a manner which will prevent undue patient waiting time and in compliance with the access criteria in D. below.
17. Have documented emergency procedures, including procedures addressing treatment and transportation plans to provide for the safety of Members.

C. Coverage

1. When applicable to the relevant specialty, as determined by Company in its sole discretion Specialty Dentist shall ensure that twenty-four (24) hour-a-day coverage for Members is arranged with another Company Participating Specialty Dentist, except as otherwise provided in Section C.3 below.
2. The covering dentist's office must be located within sixty (60) minutes of the Specialty Dentist's office.
3. A Specialty Dentist must submit for prior approval by Company any coverage arrangements made with a nonparticipating Specialty Dentist. Approval of coverage by a nonparticipating Specialty Dentist is subject to Company's sole discretion, and such approval must be in writing. If Specialty Dentist receives approval from Company for coverage by a nonparticipating Specialty Dentist, Specialty Dentist shall require such nonparticipating Specialty Dentist to comply with applicable terms of the Agreement. Specialty Dentist shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating Specialty Dentist shall be compensated, provided, however, that Specialty Dentist shall ensure that (except with respect to Reduced Fee Services) the covering dentist will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

D. Access

1. Each Specialty Dentist's office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least three (3) days per week.
2. Each Specialty Dentist or his or her covering Specialty Dentist must respond to a Member within thirty (30) minutes after notification of an emergency/urgent call.
3. Each Specialty Dentist must provide access to Members within the following time frames (except as more speedily required by applicable law):
   - Emergency care: must have access 24 hours per day, seven days per week. Access may include consultation with, treatment and/or appropriate referral (may include ER) by the Specialty Dentist or covering dentist.
   - Urgent care: immediate or less than 24 hours for conditions involving swelling, bleeding, fever or infection.
   - Routine care: within 5 weeks (3 weeks in CA) (10 days in CT)
4. Each Specialty Dentist office must have adequate plans for managing an increase in patient load.
5. Unless deemed inapplicable to the relevant specialty by Company, in its sole discretion, each Specialty Dentist office must have a reliable system, twenty-four (24) hours-a-day, seven (7) days-a- week, for reaching a Specialty Dentist in an emergency. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Patient Load

1. Each Specialty Dentist must designate by age, according to Company guidelines, those Members for whom Specialty Dentist will provide care. If Specialty Dentist participates in Company's dental preferred provider organization (PPO or PDN) plan(s), Specialty Dentist may not close his/her practice to members of those plans.
2. Any use of a dental hygienist or other non-dentist dental professional by a Specialty Dentist must comply with Company's then current policies and all applicable legal requirements regarding practice of such dental professionals.

F. Office Records

1. A Specialty Dentist must demonstrate, at the time of application and thereafter as requested by Company, that his/her dental records are legible, reproducible and otherwise meet Company's standards for confidentiality, and dental/medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members' dental records shall include reports from referred and/or referring providers, records of emergency care received, a complete medical history of the Member which is updated periodically and includes, without limitation, any allergies, medications, cardiovascular problems, high blood pressure and/or diabetes of Member, and such other information as Company may require from time to time.
2. Each Member encounter must be documented in writing and signed or initialed by the Specialist Dentist or as required by state law.

G. Professional Liability Insurance

1. During the entire term of this Agreement, Specialty Dentist shall maintain insurance at minimum levels required from time to time by Company, but in no event less than: (a) professional liability insurance at a minimum level of two hundred thousand dollars ($200,000) per claim and six hundred thousand dollars ($600,000) in the annual aggregate, except in cases where this level of insurance exceeds that required by applicable state law, in which instance Specialty Dentist shall maintain the maximum level of professional liability insurance required by law; and (b) comprehensive general liability insurance at a minimum level of $1 million dollars ($1,000,000) per claim and $3 million dollars ($3,000,000) in the annual aggregate. Specialty Dentists who are oral surgeons or who render general anesthesia/intravenous sedation services shall maintain professional liability insurance at a minimum level of $1 million dollars ($1,000,000) per claim and $3 million dollars ($3,000,000) in the annual aggregate. Specialty Dentist's insurance shall cover the acts and omissions of Specialty Dentist, as well as Specialty Dentist's agents and employees. Memorandum copies of such policies shall be delivered to Company upon request. Specialty Dentist must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

H. Philosophy

1. A Specialty Dentist must be supportive of the philosophy and concept of managed care and Company. A Specialty Dentist shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.
2. Each Specialty Dentist shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.
3. Specialty Dentist's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Specialty Dentist to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Specialty Dentist's legal or ethical obligations.
4. Specialty Dentist is encouraged to discuss Company's reimbursement methodology with Specialty Dentist's patients who are Members, subject only to Specialty Dentist's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the reimbursement methodology under which Specialty Dentist is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. PROFESSIONAL CRITERIA

A. Licensure

1. A Specialty Dentist must have a valid, unencumbered license to practice dentistry in his/her state of practice, or in the case of a Specialty Dentist with an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.
2. A Specialty Dentist must be eligible for or possess an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification, unless otherwise approved in writing by Company.
3. A Specialty Dentist who renders general anesthesia and/or intravenous sedation services must have a current and valid state certification or permit, if available in the applicable state.

B. Education

1. A Specialty Dentist must be a graduate of a school of dentistry which is accredited by the Commission on Dental Accreditation (of the ADA) or be a graduate of a non-accredited school of dentistry and have completed a pre-licensure advanced education program at an ADA accredited school of dentistry.
2. A Specialty Dentist is required to have successfully completed a clinical postgraduate training program in a dental subspecialty (orthodontics, periodontics, etc.) which is accredited by the Commission on Dental Accreditation of the American Dental Subspecialty Board recognized by the American Dental Association (ADA), for which the dentist requests to be recognized.

C. Continuing Education

1. A Specialty Dentist shall meet the continuing education requirements required by state law. An applicant for participation in Company must demonstrate that he/she has met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

III. PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA

A. General

1. Specialty Dentist must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of dentistry.
2. Specialty Dentist must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

B. Professional Liability Claims History

1. Specialty Dentist must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

C. History of Involuntary Termination or Restriction

1. Specialty Dentist must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, or reduction or restriction of duties or privileges, or of a contract to provide health care services, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

D. Notification of Adverse Actions or Limitations

1. Specialty Dentist shall provide immediate notice to Company of any adverse action relating to said dentist's: (i) hospital staff privileges (if applicable); (ii) DEA or state narcotics numbers; (iii) participation in the Medicare, Medicaid, or other governmental programs; or (iv) state licensure, certification, accreditation or other authorization required by law or the Agreement, including censure. Each applicant and Specialty Dentist shall inform the Company in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusions; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subjection to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may

be grounds for action, including without limitation denial, termination or other sanctions imposed pursuant to Company's credentialing/quality improvement programs.

2. Specialty Dentist shall provide immediate notice to Company of any condition or circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Specialty Dentist.
3. Specialty Dentist shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.
4. Specialty Dentist shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Specialty Dentist to report.

E. References

1. Each applicant for participation must supply references as specified in the application and as requested by the applicable peer review committee.
2. The applicable peer review committee shall have the right to act on any reference or information received from a Specialty Dentist's colleagues or other professionals. Specialty Dentist waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable peer review committee.

These criteria may be modified at the sole discretion of Company.

Member Rights and Responsibilities

Discrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, sex, age, religion, color, disability, national origin, marital status, sexual orientation or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV-positive status).

Confidentiality policy

Aetna's participation agreements require that all dentists maintain patient information in a current, detailed, organized and comprehensive manner and in accordance with customary dental practice, applicable state and federal laws and accreditation standards. Accordingly, participating dentists must have in place appropriate policies and procedures to implement these confidentiality requirements.

In addition to complying with customary medical practice, applicable state and federal laws, and accreditation standards, these policies and procedures should include, but not be limited to, protection of patient confidentiality under the following circumstances:

- The release of information at the request of the Member and in response to a legal request for information. The use of a release form, where applicable, is suggested
- The storage of medical records, including restricted access and maintenance of such records, in secured files
- Transmitting medical records electronically
- Educating employees regarding confidentiality of medical records and patient information

Informed consent

Aetna expects all participating dentists to understand and comply with applicable legal requirements, as well as to adhere to the polices of the dental community in which they practice, regarding informed consent from their patients. In general, it is the participating dentist's duty to give patients adequate information and be reasonably sure the patient has understood it before proceeding to treat the patient. Informed consent documents should be written and signed.

Dental members have the right to:

- Get up-to-date information about the dentists who participate in the plan.
- Obtain necessary care from participating dentists, including participating Specialty Dentists (with referrals if required by the plan) or from any licensed dentist if your plan covers out-of-network services.
- Be told by their dentists how to make appointments and get dental care during and after office hours.
- Be told how to get in touch with their dentist or a back-up dentist 24 hours a day, every day.

- Call 911 in a situation that might be life threatening.
- Receive a copy of their dental records (including radiographs and other diagnostic materials) for transfer to a new office.
- Be treated with respect for their privacy and dignity.
- Have their dental records kept private, except as otherwise required by law or with your approval.
- Have their dentist help them make decisions about their dental care.
- Refuse any proposed dental treatment.
- Discuss with their dentist their condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that their dentist cannot be penalized for filing a complaint or appeal.
- Know how their plan decides what services are covered.
- Know how the plan pays their dentists.
- Get up-to-date information about the services covered by their plan; for instance, what is, and is not, covered and any applicable limitations or exclusions.
- Get information about copayments and fees, if any, they must pay.
- Be told how to file a complaint or appeal with the plan.
- Receive a prompt reply when they ask the plan questions or request information.
- Have their dentist's help in decisions about the need for services and in the complaint and appeal process.
- Suggest changes in the plan's policies and services.
- Receive a copy of the plan's Member Rights and Responsibilities Statement.

Dental members have the responsibility to:

- Follow the directions and advice they and their dentists have agreed upon.
- Tell their dentist promptly when they have unexpected problems or symptoms.
- Tell their dentist if they do not understand the treatment they receive and to ask if they do not understand how to care for their condition.
- Understand that participating dentists and any other dental care professionals who care for them are not employees of Aetna and that Aetna does not control them.
- Promptly follow Aetna's complaint and appeal procedures if they believe they need to submit a complaint or appeal.
- Give correct and complete information to dentists and any other health care professionals who care for them.
- Treat dentists and all health care professionals, their staffs, and the staff of the plan with respect.
- Tell Aetna about other medical/dental coverage they or their family members may have.
- Not be involved in dishonest activity directed to the plan or any health or dental care professional.
- Read and understand their plan benefits. Know what services are covered and what services are not covered.

Members may have additional rights and responsibilities depending upon the state law applicable to their plan.

Specialty Dentist Responsibilities

Patient advocacy

You must serve as an advocate on behalf of your patients. Familiarize yourself with the Member Rights and Responsibilities (see previous section). Help members understand their rights and assure that they take an active role in maintaining their dental health. Let them know they should ask for clarification if they do not understand directions on how to care for their dental problems.

Emergencies

Instruct Members in how to handle dental emergencies. Members should attempt to call you, explain their symptoms and provide you with any other information required to help determine appropriate action.

Informed consent

You must provide Members with all information relevant to their conditions and care alternatives, including potential risks and benefits, even if a care option is not covered. This information helps Members take active roles in making decisions about their dental health. You are also encouraged to discuss Aetna's payment methodology with Members.

Independent contractor

Our member materials clearly indicate that we do not employ or control participating dentists. Make sure that Members understand that your relationship with us is that of an independent contractor.

Advice on coverage

It is the plan's responsibility to make coverage determinations. Members have the right to obtain up-to-date information about their plan; they can obtain this information by directly contacting Aetna. If you are unsure whether a particular service or procedure is covered under a Member's plan, call our National Dentist Line (1-800-451-7715) or have the Member call the Member Services line. However, information related to the Member's out-of-pocket expenses should be provided by you, based on your compensation schedule.

Participation criteria

The Specialty Dentist Participation Criteria lists a variety of requirements that the participating Specialty Dentist must meet. These criteria are used in our credentialing and recredentialing process and are attached to our current Specialty Dentist Agreements.

Billing practices

Company's denial or adjustment of payment based on Company's performance of utilization management (if applicable) is not a denial of Covered Services under the terms of a Member's Plan and, therefore, Members may not be billed for services denied/adjusted as a result.

Aetna is committed to prevent health care fraud and improper billing. Participating dentists must adhere to appropriate billing standards and avoid all forms of fraudulent billing.

Any network dentist who engages in fraudulent billing, exhibits a pattern of inappropriate or improper billing practices, or fails to provide documentation regarding services rendered is subject to immediate termination from our networks.

Patient Copayments by Plan Code for DMO® Plans

When Patients receive treatment for certain dental procedures, they may be required to pay a copayment directly to the Primary Care or Specialty Dentist who provided the dental care. The amount of the patient copayment is either a fixed dollar amount per procedure or a percentage of the dentist's fee, as submitted to and approved by Aetna. The copayment percentage varies by plan code and the age and frequency limits that apply.

Service Description	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**	**Q**	**R#**	**S#**	**SC#**	**T#**	**U#**	**V#**	**W#**
Diagnostic/Preventive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Basic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NC	NC	0	0	0	0
Major (see below)	10%	20%	25%	30%	40%	50%	*	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Space Maintainers ♦	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	0	NC	NC	NC	Fixed	0	NC	0
General Anesthesia/ IV Sedation	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	50%	NC	NC	Fixed	0	40%	20%

Major Services	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**	**Q**	**R#**	**S#**	**SC#**	**T#**	**U#**	**V#**	**W#**
Metal/Inlay	10%	20%	25%	30%	40%	50%	10%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Individual Crowns	10%	20%	25%	30%	40%	50%	10%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Fixed Bridgework	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Full or Partial Dentures	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Habit Appliances	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Crown/Bridge Denture Repairs	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Add Teeth to Denture	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%
Denture Reline/Rebase	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	40%	50%	50%	25%	NC	NC	NC	Fixed	0	NC	20%

Major Services	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**	**Q**	**R#**	**S#**	**SC#**	**T#**	**U#**	**V#**	**W#**
Molar Root Canal	0	0	0	0	0	0	0	10%	20%	25%	30%	40%	50%	0	50%	50%	25%	50%	NC	NC	Fixed	0	40%	20%
Surgical Removal (partial or complete) Bony Impaction	0	0	0	0	0	0	0	10%	20%	25%	30%	40%	50%	0	0	50%	25%	50%	NC	NC	Fixed	0	40%	20%
Periodontal Osseous Surgery	0	0	0	0	0	0	0	10%	20%	25%	30%	40%	50%	0	50%	50%	25%	NC	NC	NC	Fixed	0	40%	20%

*Plan G has 2 levels for Major Services. Refer to Major Services Chart.
♦ Space Maintainers are covered as Preventive under new Standard plans
NC = Not Covered
Fixed = Fixed Dollar Copayment
# = Nonstandard List of Services
Basic/major services may have varying copayment percentages. Call The National Dentist Line (1-800-451-7715) for a list of services.

SEE NEXT PAGE FOR ADDITIONAL PLAN CODES

Patient Copayments by Plan Code for DMO® Plans

When Patients receive treatment for certain dental procedures, they may be required to pay a copayment directly to the Primary Care or Specialty Dentist who provided the dental care. The amount of the patient copayment is either a fixed dollar amount per procedure or a percentage of the dentist's fee, as submitted to and approved by Aetna. The copayment percentage varies by plan code and the age and frequency limits that apply.

Service Description	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**10**	**12**	**21**	**22**	**23**	**24**	**25**	**26**
Diagnostic/Preventive	0	0	0	0	0	0	0	0	0	0	0	0	10%	20%	0	0
Basic (see below)	20%	20%	50%	20%	75%	50%	#	10%	20%	0	10%	20%	10%	20%	0	0
Major	40%	50%	50%	40%	75%	75%	#	40%	40%	50%	10%	20%	10%	20%	25%	40%
Space Maintainers ♦	40%	50%	50%	40%	75%	75%	0	0	0	50%	10%	20%	10%	20%	25%	40%
General Anesthesia/ IV Sedation	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	20%	20%
Basic Services	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**10**	**12**	**21**	**22**	**23**	**24**	**25**	**26**
Basic Restorative	20%	20%	50%	20%	75%	50%	#	10%	20%	0	10%	20%	10%	20%	0	0
Endodontics (except those services listed below)	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%	20%	10%	20%	0	0
Periodontics (except those services listed below)	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%	20%	10%	20%	0	0
Oral Surgery (except those services listed below)	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%	20%	10%	20%	0	0
Major Services	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**10**	**12**	**21**	**22**	**23**	**24**	**25**	**26**
Molar Root Canal	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	0	0
Surgical Removal (partial or complete) Bony Impaction	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	0	0
Periodontal Osseous Surgery	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	0	0

♦ Space Maintainers are covered as Preventive under new Standard plan
= Nonstandard List of Services
Basic/major services may have varying copayment percentages. Call The National Dentist Line (1-800-451-7715) for a list of services.

SEE PREVIOUS PAGE FOR ADDITIONAL PLAN CODES

Fixed Dollar Copayments by Plan Code for DMO® Plans

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
DIAGNOSTIC			
D0120	Periodic Oral Exam	$0	$0
D0150	Comprehensive Oral Exam	$0	$0
D0170	Reevaluation – Limited, Problem Focused	$0	$0
D0210	Complete (Full Mouth) Series/Including Bitewings	$0	$0
D0220	Periapical – First Film	$0	$0
D0230	Periapical – Each Additional Film	$0	$0
D0240	Occlusal Film	$0	$0
D0250	Periapical – First Film	$0	$0
D0260	Periapical – Each Additional Film	$0	$0
D0270	Bitewing – Single Film	$0	$0
D0272	Bitewing – Two Films	$0	$0
D0274	Bitewing – Four Films	$0	$0
D0277	Vertical Bitewings – 7 To 8 Films	$0	$0
D0330	Panoramic Film	$0	$0
D0460	Pulp Vitality Tests	$0	$0
D0472	Accession Of Tissue, Gross Exam By Rpt	$0	$0
D0473	Accession Of Tissue, Gross And Micro Exam	$0	$0
D0474	Accession Of Tissue, Gross And Micro Exam	$0	$0
PREVENTIVE			
D1110	Prophylaxis – Adult	$0	$0
D1120	Prophylaxis – Child	$0	$0
D1201	Topical Application Of Fluoride, Inc Prophy – Child	$10	$10
D1203	Topical Application Of Fluoride – Child	$0	$0
D1204	Topical Application Of Fluoride – Adult	$0	$0
D1205	Topical Application Of Fluoride And Prophy – Adult	$12	$12
D1330	Oral Hygiene Instructions	$0	$0
D1351	Sealant – Per Tooth	$10	$10
D1510	Space Maintainer – Fixed – Unilateral	$100	$100
D1515	Space Maintainer – Fixed – Bilateral	$100	$100
D1520	Space Maintainer – Removable – Unilateral	$100	$100
D1525	Space Maintainer – Removable – Bilateral	$100	$100
D1550	Recementation Of Space Maintainer	$15	$15
D1555	Removal of Fixed Space Maintainer (by dentist who did not place the appliance)	$15	$15
RESTORATIVE			
D2140	Amalgam – 1 Surface	$22	$22
D2150	Amalgam – 2 Surface	$32	$32
D2160	Amalgam – 3 Surface	$43	$43
D2161	Amalgam – 4 Or More Surface	$53	$53
D2330	Resin – 1 Surface – Anterior	$40	$40
D2331	Resin – 2 Surface – Anterior	$55	$55
D2332	Resin – 3 Surface – Anterior	$60	$60
D2335	Resin – 4 Or More Surface – Anterior	$70	$70
D2390	Resin – Based Composite Crown, Anterior	$80	$80
D2391	Resin One – Surface – Posterior	$22	$22

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Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
D2392	Resin – Two Surfaces – Posterior	$32	$32
D2393	Resin – Three Surfaces – Posterior	$43	$43
D2394	Resin – Four Or More Surfaces – Posterior	$53	$53
D2910	Recement Inlay, Onlay Or Partial	$18	$18
D2915	Recement Cast Or Prefab Post And Core	$9	$9
D2920	Recement Crown	$18	$18
D2930	Stainless Steel Crown – Primary	$65	$65
D2931	Stainless Steel Crown – Permanent	$80	$80
D2932	Prefabricated Resin Crown	$32	$32
D2933	Stainless Steel Crown W/Resin Window	$33	$33
D2934	Prefab Stainless Crown – Primary Tooth	$53	$53
D2940	Sedative Filling	$15	$15
D2951	Pin Retention – Per Tooth In Addition To Restoration	$15	$15
CROWNS/BRIDGES			
D2510	Inlay – Metallic – 1 Surface	$463	$463
D2520	Inlay – Metallic – 2 Surface	$463	$463
D2530	Inlay – Metallic – 3 Or More Surface	$463	$463
D2542	Onlay – Metallic – 2 Surface	$463	$463
D2543	Onlay – Metallic – 3 Surface	$463	$463
D2544	Onlay – Metallic – 4 Or More Surface	$463	$463
D2610	Inlay – Porc/Ceramic – 1 Surface	$463	$463
D2620	Inlay – Porc/Ceramic – 2 Surface	$463	$463
D2630	Inlay – Porc/Ceramic – 3 Or More Surface	$463	$463
D2642	Onlay – Porc/Ceramic – 2 Surface	$463	$463
D2643	Onlay – Porc/Ceramic – 3 Surface	$463	$463
D2644	Onlay – Porc/Ceramic – In Add To Inlay	$463	$463
D2650	Inlay – Comp/Resin – 1 Surface	$463	$463
D2651	Inlay – Comp/Resin – 2 Surface	$463	$463
D2652	Inlay – Comp/Resin – 3 Surface	$463	$463
D2662	Onlay – Comp/Resin – 2 Surface	$463	$463
D2663	Onlay – Comp/Resin – 3 Surface	$463	$463
D2664	Onlay – Comp/Resin – 4 Or More Surface	$463	$463
D2710	Crown – Resin – Based Composite, Indirect	$488	$488
D2712	Crown – 3/4 Resin – Based Comp, Indirect	$445	$445
D2720	Crown – Resin With High Noble Metal	$488	$488
D2721	Crown – Resin With Predominately Base Metal	$488	$488
D2722	Crown – Resin With Noble Metal	$488	$488
D2740	Crown – Porcelain/Ceramic Subtrate	$488	$488
D2750	Crown – Porcelain Fused High Noble Metal	$488	$488
D2751	Crown – Porcelain Fused Predominately Base Metal	$488	$488
D2752	Crown – Porcelain Fused To Noble Metal	$488	$488
D2780	Crown – 3/4 Cast High Noble Metal	$475	$475
D2781	Crown – 3/4 Cast Predominately Base Metal	$475	$475
D2782	Crown – 3/4 Cast Noble Metal	$475	$475
D2783	Crown – 3/4 Cast Porcelain/Ceramic	$475	$475
D2790	Crown – Full Cast High Noble Metal	$488	$488

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Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
D2791	Crown – Full Cast Predominately High Metal	$488	$488
D2792	Crown – Full Cast Noble Metal	$488	$488
D2794	Crown – Titanium	$488	$488
D2950	Core Buildup, Including Any Pins	$103	$103
D2952	Cast Post And Core In Add'T To Crown	$160	$160
D2953	Cast Post – Ea Additional – Same Tooth	$160	$160
D2954	Prefab Post And Core In Add'T To Crown	$138	$138
D2957	Prefabricated Post – Ea Add – Same Tooth	$138	$138
D2971	Addl Procedures – New Crown Under Partial	$49	$49
D6053	Implant Abut Sup Removable Full Denture	$500	$500
D6054	Implant Abut Sup Removable Partl Denture	$513	$513
D6058	Abutment Supported Porc/Ceramic Crown	$488	$488
D6059	Abutment Sup Porc Fused Metal Crown High	$488	$488
D6060	Abutment Sup Porc Fused Metal Crown Base	$488	$488
D6061	Abutment Sup Porc Fused Metal Crown Noble	$488	$488
D6062	Abutment Sup Cast Metal Crown High Noble	$488	$488
D6063	Abutment Sup Cast Metal Crown Base Noble	$488	$488
D6064	Abutment Sup Cast Metal Crown Noble Metal	$488	$488
D6065	Implant Supported Porc/Ceramic Crown	$488	$488
D6066	Implant Sup Porc Fused Metal Crown High	$488	$488
D6067	Implant Supported Metal Crown High	$488	$488
D6068	Abutment Supported Retainer For Porc/Cer	$488	$488
D6069	Abutment Sup Ret For Porc Fused Metal High	$488	$488
D6070	Abutment Sup Ret For Porc Fused Metal Base	$488	$488
D6071	Abutment Sup Ret For Porc Fused Metal Noble	$488	$488
D6072	Abutment Sup Ret For Cast Metal High	$488	$488
D6073	Abutment Sup Ret For Cast Metal Base	$488	$488
D6074	Abutment Sup Ret For Cast Metal Noble	$488	$488
D6075	Implant Supported Retainer For Ceramic	$488	$488
D6076	Implant Sup Ret For Porc Fused Metal High	$488	$488
D6077	Implant Sup Ret For Cast Metal High	$488	$488
D6078	Implant/Abutment Sup Fixed Denture Com	$500	$500
D6079	Implant/Abutment Sup Fixed Denture Part	$475	$475
D6094	Abutment Supported Crown – (Titanium)	$488	$488
D6194	Abutment Sup Retainer Crown For Fpd	$488	$488
D6205	Pontic – Indirect Resin Based Composite	$488	$488
D6210	Pontic – Cast High Noble Metal	$488	$488
D6211	Pontic – Cast Predominantly Base Metal	$488	$488
D6212	Pontic – Cast Noble Metal	$488	$488
D6214	Pontic – Titanium	$488	$488
D6240	Pontic – Porcelain Fused To High Noble	$488	$488
D6241	Pontic – Porcelain Fused To Base Metal	$488	$488
D6242	Pontic – Porcelain Fused To Noble Metal	$488	$488
D6245	Pontic – Porcelain/Ceramic	$488	$488
D6250	Pontic – Resin With High Noble Metal	$488	$488
D6251	Pontic – Resin W Predominantly Base Metal	$488	$488

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Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
D6252	Pontic – Resin With Noble Metal	$488	$488
D6545	Retainer Cast Metal for Resin Bonded Fixed Prosthesis	$378	$378
D6548	Retainer Proc/Ceramic Resin Bonded Fixed Prosthesis	$463	$463
D6600	Inlay – Porcelain Ceramic, 2 Surfaces	$463	$463
D6601	Inlay – Porcelain Ceramic, 3 Or More Surfaces	$463	$463
D6602	Inlay – Cast High Noble Metal, 2 Surfaces	$478	$478
D6603	Inlay – Cast High Noble Metal, 3 Or More Surfaces	$478	$478
D6604	Inlay – Cast Pred Base Metal 2 Surfaces	$463	$463
D6605	Inlay – Cast Pred Base Metal 3 Or More Surfaces	$463	$463
D6606	Inlay – Cast Noble Metal, 2 Surfaces	$473	$473
D6607	Inlay – Cast Noble Metal, 3 Or More Surfaces	$473	$473
D6608	Onlay – Porcelain Ceramic, 2 Surfaces	$463	$463
D6609	Onlay – Porcelain Ceramic, 3 Or More Surfaces	$463	$463
D6610	Onlay – Cast High Noble Metal, 2 Surfaces	$478	$478
D6611	Onlay – Cast High Noble Metal 3 Or More Surfaces	$478	$478
D6612	Onlay – Cast Pred Base Metal, 2 Surfaces	$463	$463
D6613	Onlay – Cast Pred Base Metal 3 Or More Surfaces	$463	$463
D6614	Onlay – Cast Noble Metal, 2 Surfaces	$473	$473
D6615	Onlay – Cast Noble Metal 3 Or More Surfaces	$473	$473
D6624	Inlay – Titanium	$478	$478
D6634	Onlay – Titanium	$478	$478
D6710	Crown – Indirect Resin Based Composite	$488	$488
D6720	Crown – Resin With High Noble Metal	$488	$488
D6721	Crown – Resin With Predom Base Metal	$488	$488
D6722	Crown – Resin With Noble Metal	$488	$488
D6740	Crown Porcelain/Ceramic	$488	$488
D6750	Crown – Porcelain Fused To High Noble Meta	$488	$488
D6751	Crown – Porcelain Fused Predom Base Metal	$488	$488
D6752	Crown – Porcelain Fused Noble Metal	$488	$488
D6780	Crown – 3/4 Cast High Noble Metal	$475	$475
D6781	Crown 3/4 Cast Predominately Based Metal	$488	$488
D6782	Crown 3/4 Cast Noble Metal	$488	$488
D6783	Crown 3/4 Porcelain/Ceramic	$488	$488
D6790	Crown – Full Cast High Noble Metal	$488	$488
D6791	Crown – Full Cast Predominantly Base Metal	$488	$488
D6792	Crown – Full Cast Noble Metal	$488	$488
D6794	Crown – Titanium	$488	$488
D6930	Recement Fixed Partial Denture	$20	$20
D6970	Post And Core In Addt To Partial Denture	$160	$160
D6971	Cast Post As Part Fixed Part Denture Retainer	$160	$160
D6972	Prefab Post & Core In Addition To Partial Denture	$138	$138
D6973	Core Build Up For Retainer, Includes Pin	$103	$103
D6976	Each Additional Cast Post Same Tooth	$160	$160
D6977	Each Additional Prefab Post Same Tooth	$138	$138
D6985	Pediatric Partial Denture, Fixed	$110	$110

*Copay noted applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist negotiated fee.

Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
ENDODONTICS			
D3110	Pulp Cap – Direct	$8	$8
D3120	Pulp Cap – Indirect	$8	$8
D3220	Pulpotomy (Therapeutic)	$50	$50
D3221	Gross Pulpal Debridement Primary And Perm	$10	$10
D3230	Pulpal Therapy – Anterior Primary Tooth	$50	$50
D3240	Pulpal Therapy – Posterior Primary Tooth	$50	$50
D3310	Rct – Anterior Excluding Final Restoration	$150	$150
D3320	Rct – Bicuspid Excluding Final Restoration	$195	$195*
D3330	Rct – Molar Excluding Final Restoration	$435	$435*
D3331	Treatment Of Rt Canal Obstruct – Non Surgical Acces	$150	$150*
D3332	Incomplete Endo Therapy Inop Or Fracture	$98	$98*
D3333	Internal Root Repair Of Perforation Defe	$130	$130*
D3348	Re – Rct – Molar	$485	$485*
D3346	Retreatment – Rct – Anterior	$250	$250*
D3347	Retreatment – Rct – Bicuspid	$295	$295*
D3410	Apicoectomy/Periradicular – Anterior	$156	$156*
D3421	Apicoectomy/Periradicular – Bicuspid	$156	$156*
D3425	Apicoectomy/Periradicular – Molar 1 Root	$190	$190*
D3426	Apicoectomy/Periradicular – Add'L Roots	$130	$130*
D3430	Retrograde Filling – Per Root	$75	$75*
D3450	Root Amputation – Per Root	$100	$100*
PERIODONTICS			
D4210	Gingivectomy/Gingivoplasty, 4 + Tth	$160	$160*
D4211	Gingivectomy/Gingivoplasty, 1 To 3 Tth	$43	$43*
D4240	Gingival Flap W/Rt Pl, 4 Or More Tth	$200	$200*
D4241	Gingival Flap – Includes Rt Pl, 1 – 3 Tth	$120	$120*
D4245	Apically Positioned Flap	$200	$200
D4260	Osseous Surgery – 4 + Tth/Quad	$445	$445*
D4261	Osseous Surgery – 1 – 3 Tth/Quad	$427	$427*
D4270	Pedicle Soft Tissue Graftprocedure	$260	$260*
D4271	Pedicle Soft Tissue Graft Procedure	$275	$275*
D4273	Subepithelia Connective Tissue Graft – Tth	$155	$155*
D4275	Soft Tissue Allograft	$480	$480*
D4276	Subepithelia Connective Tissue Graft – Tth	$256	$256*
D4268	Surgical Revision Procedure Per Tooth	$136	$136
D4341	Perio Scaling And Root Planing, 4 + Tth	$65	$65
D4342	Perio Scaling And Root Planing, 1 – 3 Tth	$39	$39
D4910	Periodontal Maintenance – Procedures	$60	$60
D4920	Unscheduled Dressing Change	$10	$10*
PROSTHETICS – REMOVABLE			
D5110	Complete Denture – Maxillary	$500	$500
D5120	Complete Denture – Mandibular	$500	$500
D5130	Immediate Denture – Maxillary	$588	$588
D5140	Immediate Denture – Mandibular	$588	$588
D5211	Maxillary Partial Denture – Resin Base	$513	$513

*Copay noted applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist negotiated fee.

Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
D5212	Mandibular Partial Denture – Resin Base	$513	$513
D5213	Maxillary Partial Denture – Cast Base	$625	$625
D5214	Mandibular Partial Denture Cast Base	$625	$625
D5225	Maxillary Partial Denture – Flexible Base	$613	$613
D5226	Mandibular Partial Denture – Flexible Base	$613	$613
D5281	Removable Unilateral Partial Denture	$513	$513
D5410	Adjustments Maxillary Complete Denture	$30	$30
D5411	Adjustments Mandibular Complete Denture	$30	$30
D5421	Adjustments Partial Denture – Maxillary	$30	$30
D5422	Adjustments Partial Denture – Mandibular	$30	$30
D5860	Overdenture – Complete, By Report	$500	$500
D5861	Overdenture – Partial, By Report	$563	$563
REPAIRS TO PROSTHETICS			
D5510	Repair Broken Complete Denture Base	$45	$45
D5520	Replace Missing Or Broken Teeth, Comp Denture	$53	$53
D5610	Repair Resin Denture Base	$63	$63
D5620	Repair Cast Framework	$68	$68
D5630	Repair Or Replace Broken Clasp	$68	$68
D5640	Replace Broken Teeth – Per Tooth	$63	$63
D5650	Add Tooth To Existing Partial Denture	$63	$63
D5660	Add Clasp To Existing Partial Denture	$68	$68
D5670	Replace All Teeth – Upper Partial	$173	$173
D5671	Replace All Teeth – Lower Partial	$173	$173
D5710	Rebase Complete Maxillary Denture	$173	$173
D5711	Rebase Complete Mandibular Denture	$173	$173
D5720	Rebase Partial Maxillary Denture	$173	$173
D5721	Rebase Partial Mandibular Denture	$173	$173
D5730	Reline Complete Maxillary Denture, Chairside	$100	$100
D5731	Reline Complete Mandibular Denture Chair	$100	$100
D5740	Reline Complete Maxillary Denture Chair	$100	$100
D5741	Reline Complete Mandibular Partial Denture Chairside	$100	$100
D5750	Reline Complete Maxillary Denture Laboratory	$145	$145
D5751	Reline Complete Mandibular Denture Laboratory	$145	$145
D5760	Reline Maxillary Partial Denture Laboratory	$145	$145
D5761	Reline Mandibular Partial Denture Laboratory	$145	$145
D5820	Interim Partial Denture – Upper (Maxillary)	$195	$195
D5821	Interim Partial Denture – Lower (Mandibular)	$195	$195
D5850	Tissue Conditioning, Upper	$63	$63
D5851	Tissue Conditioning, Lower	$63	$63
ORAL SURGERY			
D7111	Extraxct, Coronal Remnants – Deciduous Tooth	$12	$12
D7140	Extraction – Erupted Tooth Or Exposed Root	$30	$30
D7210	Surgical Removal Of Erupted Tooth	$60	$60
D7220	Removal Of Impacted Tooth – Soft Tissue	$80	$80
D7230	Removal Of Impacted Tooth – Part Bony	$175	$175*
D7240	Removal Of Impacted Tooth – Full Bony	$225	$225*

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Fixed Dollar Copayments by Plan Code for DMO® Plans (continued)

		Patient Pays:	
ADA Code**	**Description**	**41**	**42**
D7241	Removal Of Impacted Tooth – Complication	$238	$238*
D7250	Surgical Removal Of Residual Tooth Roots	$55	$55
D7282	Mobilization Of Erupted Or Malpositioned Tooth	$90	$90*
D7285	Biopsy Of Oral Tissue – Hard	$100	$100*
D7286	Biopsy Of Oral Tissue – Soft	$100	$100*
D7287	Cytology Sample Collection	$50	$50*
D7310	Alveoloplasty In Conjuct With Extraction	$55	$55*
D7311	Alveoloplasty In Conj W/Ext, 1 – 3 Tooth	$28	$28*
D7320	Alveoloplasty Not In Conjuc W Extraction	$75	$75*
D7321	Alveoloplasty Not In Conjuc W/Ext, 1 – 3 Tooth	$38	$38*
D7510	Incision And Drainage Of Abscess Intraoral	$50	$50*
D7511	Incision And Drainage Of Abscess – Extraoral Complex	$55	$55*
D7960	Frenulectomy	$128	$128*
D7963	Frenuloplasty	$134	$134*
OTHER (ADJUNCTIVE SERVICES)			
D9220	General Anesthesia – First 30 Minutes	$165	NC[6]
D9221	General Anesthesia – Each Additional 15 Minutes	$70	NC[6]
D9241	Intravenous Sedation/Analgesia – First 30 Minutes	$165	$165
D9242	Intravenous Sedation/Analgesia – Each Additional 15 Minutes	$70	$70
D9310	Consultation	$0	$0
D9940	Occlusial Guards	$183	$183
D9942	Repair And/Or Relining Occlusal Guard	$23	$23
D9951	Occlusial Adjustment – Limited	$25	$25
D9952	Occlusial Adjustment – Complete	$90	$90*
EMERGENCY SERVICES			
D0140	Limited Oral Eval – Problem Focused	$0	$0
D0160	Detailed And Extensive Oral Eval – By Report	$0	$0
D0180	Comprehensive Periodontal Evaluation	$0	$0
D9110	Palliative Tx Of Dental Pain, Minor	$10	$10
ORTHODONTICS			
Comprehensive Orthodontic Treatment –			
The total patient copayment is for the entire treatment plan, from ortho examination through ortho retention.			
One of the following total patient copayments will apply, based on the option selected by the plan sponsor:			
Adolescent or Adult Dentition – $2400 / $2300 / $2000 / $1500			
To determine which copayment applies to your patient, please contact the National Dentist Line (1-800-451-7715)			
Individual Ortho Services –			
In the event the comprehensive treatment is not performed by your office, the following copayments apply to individual services:			
Comprehensive Orthodontic Treatment			
	Ortho Screening Exam	$30	$30
	Diagnostic Records	$150	$150
	Ortho Retention	$275	$275

*Copay noted applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist negotiated fee.

[6] Copay applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist's negotiated fee.

Fixed Dollar Copayments by Plan Code for DMO Plan

CODE**	PROCEDURE	51	52	53	54	55/55A	56	57	58
Office Visit Copay (See roster)		0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10
DIAGNOSTIC									
D0120-D0180	Oral Evaluations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0210	X- Ray, Intraoral - Complete Series (including bitewings)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0220	X-Ray, Intraoral - Periapical First Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0230	X-Ray, Intraoral - Periapical Each Additional Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0240	X-Ray, Intraoral - Occlusal	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0250	X-Ray, Extraoral - First Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0260	X-Ray, Extraoral - Each Additional Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0270	X-Ray, Bitewing - Single Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0272	X-Ray, Bitewings - Two Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0273	X-Ray, Bitewings - Three Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0274	X-Ray, Bitewings - Four Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0277	Vertical Bitewings - 7 to 8 Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0330	X-Ray, Panoramic	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0460	Pulp Vitality Test	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0470	Diagnostic Casts	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0472-D0474	Accession of Tissue	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
PREVENTIVE									
D1110	Prophylaxis - Adult	$12	$12	$8	No Charge	No Charge	No Charge	No Charge	No Charge
D1120	Prophylaxis - Child	$10	$10	$7	No Charge	No Charge	No Charge	No Charge	No Charge
D1203-D1204	Topical Application of Fluoride	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1206	Topical Fluoride Varnish	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1330	Oral Hygiene Instruction	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1351	Sealant - per Tooth	$10	$10	$8	No Charge	No Charge	No Charge	$10	$5
D1510-D1515	Space Maintainer - Fixed	$100	$85	$65	$60	No Charge	No Charge	$65	$60
D1520-D1525	Space Maintainer - Removable	$100	$95	$80	$70	No Charge	No Charge	$80	$70
D1550	Recementation of Space Maintainer	$15	$15	$15	$12	$12	$12	$15	$12
D1555	Removal of Fixed Space Maintainer (by dentist who did not place the appliance)	$15	$15	$15	$12	$12	$12	$15	$12
RESTORATIVE									
D2140	Amalgam - 1 Surface, Primary or Permanent	$22	$20	$16	$10	No Charge	No Charge	No Charge	No Charge
D2150	Amalgam - 2 Surfaces, Primary or Permanent	$32	$30	$24	$12	No Charge	No Charge	No Charge	No Charge
D2160	Amalgam - 3 Surfaces, Primary or Permanent	$43	$36	$32	$16	No Charge	No Charge	No Charge	No Charge

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS:							
		51	52	53	54	55/55A	56	57	58
D2161	Amalgam - 4 or More Surfaces, Primary or Permanent	$53	$50	$40	$18	No Charge	No Charge	No Charge	No Charge
D2330	Resin-Based Composite - 1 Surface, Anterior	$40	$40	$25	$15	No Charge	No Charge	No Charge	No Charge
D2331	Resin-Based Composite - 2 Surfaces, Anterior	$55	$50	$35	$21	No Charge	No Charge	No Charge	No Charge
D2332	Resin-Based Composite - 3 Surfaces, Anterior	$60	$55	$35	$25	No Charge	No Charge	No Charge	No Charge
D2335	Resin-Based Composite - 4 or More Surfaces or Involving Incisal Angle, Anterior	$70	$66	$46	$35	No Charge	No Charge	No Charge	No Charge
D2390	Resin-Based Composite Crown, Anterior	$80	$70	$60	$50	$40	No Charge	$60	$50
D2940	Sedative Filling	$15	$15	$8	$3	No Charge	No Charge	$8	$3
D2951	Pin Retention - per Tooth, in Addition to Restoration	$15	$15	$6	$6	$6	No Charge	$6	$6
CROWNS/BRIDGES									
D2510-D2530	Inlay - Metallic*	$275	$255	$220	$180	$160	$150	$220	$180
D2542-D2544	Onlay - Metallic*	$275	$255	$220	$180	$160	$150	$220	$180
D2740	Crown- Porcelain/Ceramic Substrate	$325	$300	$260	$210	$185	$150	$260	$210
D2750-D2752	Crown - Porcelain Fused to Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D2790-D2794	Crown - Full Cast Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$18	$15	$15	$10	$5	No Charge	$15	$10
D2915	Recement Cast or Prefabricated Post and Core	$9	$8	$8	$5	$3	No Charge	$8	$5
D2920	Recement Crown	$18	$15	$15	$10	$5	No Charge	$15	$10
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$65	$55	$45	$35	No Charge	No Charge	$45	$35
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$80	$70	$60	$50	$40	No Charge	$60	$50
D2950	Core Buildup, including any Pins	$55	$50	$45	$40	$30	$35	$45	$40
D2952	Cast Post and Core in addition to Crown*	$95	$79	$80	$70	$50	$45	$80	$70
D2954	Prefabricated Post and Core in addition to Crown	$90	$90	$71	$63	$60	$40	$71	$63
D6210-D6214	Pontic - Cast Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D6240-D6242	Pontic - Porcelain Fused to Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D6750-D6752	Crown - Porcelain Fused to Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D6790-D6792	Crown - Full Cast Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D6794	Crown Full Cast Metal*	$325	$300	$260	$210	$185	$150	$260	$210
D6930	Recement Fixed Partial Denture	$20	$20	$20	$15	$15	$15	$20	$15
Additional Charge Per Unit for Full Mouth Rehabilitation†		$125	$125	$125	$125	$125	$125	$125	$125

*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.

†Full mouth rehabilitation is defined as 6 or more units of covered crown and/or bridge in the same treatment plan.

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS:							
		51	52	53	54	55/55A	56	57	58
ENDODONTICS									
D3110-D3120	Pulp Cap - Direct or Indirect	$8	$8	$6	$4	No Charge	No Charge	No Charge	No Charge
D3220	Therapeutic Pulpotomy	$50	$40	$35	$14	No Charge	No Charge	$35	$14
D3310	Root Canal Therapy- Anterior	$150	$140	$120	$70	$50	No Charge	$120	$70
D3320	Root Canal Therapy- Bicuspid	$195	$165	$140	$85	$70	No Charge	$140	$85
D3330	Root Canal Therapy - Molar	$295	$290	$260	$240	$150	$125	$280	$240
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$250	$240	$220	$170	$150	$100	$220	$170
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$295	$265	$240	$185	$170	$100	$240	$185
D3348	Retreatment of Previous Root Canal Therapy - Molar	$395	$390	$360	$340	$250	$225	$380	$340
D3410	Apicoectomy/Periradicular Surgery - Anterior	$156	$140	$130	$85	$60	No Charge	$130	$85
D3421	Apicoectomy/Periradicular Surgery- Bicuspid (1st Root)	$156	$140	$130	$85	$60	No Charge	$130	$85
D3425	Apicoectomy/Periradicular Surgery, Molar (1st Root)	$190	$170	$150	$90	$80	No Charge	$150	$90
D3426	Apicoectomy/Periradicular Surgery (each additional root)	$130	$110	$90	$55	$40	No Charge	$90	$55
D3430	Retrograde Filling - per Root	$75	$70	$65	$40	$20	No Charge	$65	$40
D3450	Root Amputation - per Root	$100	$90	$80	$70	$60	$60	$80	$70
PERIODONTICS									
D4210	Gingivectomy or Gingivoplasty - 4 or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$160	$140	$120	$100	$75	$65	$120	$100
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$43	$43	$40	$38	$20	$20	$40	$38
D4240	Gingival Flap Procedure, Including Root Planing 4 or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$200	$160	$140	$110	$90	$70	$140	$110
D4241	Gingival Flap Procedure, Including Root Planing - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$120	$96	$84	$66	$54	$42	$84	$66
D4249	Clinical Crown Lengthening - Hard Tissue	$204	$210	$195	$180	$150	$84	$195	$180
D4260	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$340	$350	$325	$300	$250	$140	$325	$300
D4261	Osseous Surgery (Including Flap Entry and Closure) - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$204	$210	$195	$180	$150	$84	$195	$180
D4270	Pedicle Soft Tissue Graft Procedure	$260	$270	$250	$230	$190	$110	$250	$230
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$275	$285	$265	$245	$205	$115	$265	$245
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	$155	$160	$150	$138	$115	$65	$150	$138
D4275	Soft Tissue Allograft	$310	$320	$300	$275	$230	$130	$300	$275
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth	$256	$264	$248	$227	$190	$107	$248	$227
D4341	Periodontal Scaling & Root Planing - 4 or More Teeth Per Quadrant	$65	$50	$50	$45	$40	$25	$60	$55
D4342	Periodontal Scaling and Root Planing - 1 to 3 Teeth Per Quadrant	$39	$30	$30	$27	$24	$15	$36	$33
D4910	Periodontal Maintenance	$60	$60	$40	$30	$20	$15	$40	$30

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS:							
		51	52	53	54	55/55A	56	57	58
PROSTHODONTICS-REMOVABLE* **									
D5110-D5120	Complete Denture - Maxillary or Mandibular	$350	$325	$300	$275	$250	$185	$320	$275
D5130-D5140	Immediate Denture - Maxillary or Mandibular	$400	$340	$330	$315	$300	$200	$330	$315
D5211-D5212	Maxillary or Mandibular Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)	$375	$320	$300	$275	$250	$185	$300	$275
D5213-D5214	Maxillary or Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)	$475	$450	$400	$350	$300	$200	$400	$350
D5225	Maxillary Partial Denture - Flexible Base	$450	$384	$360	$330	$300	$222	$360	$330
D5226	Mandibular Partial Denture - Flexible Base	$450	$384	$360	$330	$300	$222	$360	$330
D5410-D5411	Adjust Complete Denture - Maxillary or Mandibular	$15	$15	$10	$10	$10	$10	$10	$10
D5421-D5422	Adjust Partial Denture - Maxillary or Mandibular	$15	$15	$10	$10	$10	$10	$10	$10
*** Includes relines, adjustments and rebases within the first 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	$35	$30	$30	$25	$25	$25	$30	$25
D5520	Replace Missing or Broken Tooth - Complete Denture (each tooth)	$25	$20	$25	$20	$35	$25	$25	$20
D5610	Repair Resin Denture Base	$45	$30	$35	$35	$35	$30	$35	$35
D5620	Repair Cast Framework	$45	$30	$35	$35	$35	$30	$35	$35
D5630	Repair or Replace Broken Clasp	$45	$30	$35	$35	$35	$30	$35	$35
D5640	Replace Broken Teeth - Per Tooth	$45	$40	$35	$35	$35	$25	$35	$35
D5650	Add Tooth to Existing Partial	$45	$40	$35	$35	$35	$30	$35	$35
D5660	Add Clasp to Existing Partial	$50	$45	$45	$40	$40	$30	$45	$40
D5670-D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)	$95	$86	$86	$86	$86	$86	$86	$86
D5710-D5711	Rebase Complete Maxillary or Mandibular Denture	$95	$86	$86	$86	$86	$86	$86	$86
D5720-D5721	Rebase Maxillary or Mandibular Partial Denture	$95	$86	$86	$86	$86	$86	$86	$86
D5730-D5731	Reline Complete Maxillary or Mandibular Denture (Chairside)	$65	$55	$50	$45	$40	No Charge	$50	$45
D5740-D5741	Reline Maxillary or Mandibular Partial Denture (Chairside)	$65	$55	$50	$45	$40	No Charge	$50	$45
D5750-D5751	Reline Complete Maxillary or Mandibular Denture (Laboratory)	$110	$100	$95	$85	$75	$40	$95	$85
D5760-D5761	Reline Maxillary or Mandibular Denture (Laboratory)	$110	$100	$95	$85	$75	$40	$95	$85
D5820-D5821	Interim Partial Denture (Maxillary or Mandibular)	$110	$100	$95	$60	$60	$60	$95	$60
D5850-D5851	Tissue Conditioning, Maxillary or Mandibular	$35	$30	$25	$20	$20	$20	$25	$20
ORAL SURGERY									
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$12	$10	$6	$4	No Charge	No Charge	No Charge	No Charge
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$30	$25	$15	$11	No Charge	No Charge	No Charge	No Charge
D7210	Surgical Removal of Erupted Tooth	$60	$48	$36	$28	No Charge	No Charge	$36	$28
D7220	Removal of Impacted Tooth - Soft Tissue	$80	$70	$60	$46	No Charge	No Charge	$60	$46
D7230	Removal of Impacted Tooth - Partially Bony	$100	$85	$72	$58	$45	$45	$72	$58
D7240-D7241	Removal of Impacted Tooth - Completely Bony	$150	$135	$110	$100	$60	$60	$110	$100
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$55	$45	$35	$25	$15	$15	$35	$25

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS:							
		51	52	53	54	55/55A	56	57	58
D7280	Surgical Access of an Unerupted Tooth	$77	$68	$60	$26	$26	$26	$60	$26
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$90	$80	$70	$30	$30	$30	$70	$30
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$18	$16	$14	$6	$6	$6	$14	$6
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$100	$90	$80	$30	$20	$20	$80	$30
D7286	Biopsy of Oral Tissue - Soft	$100	$90	$80	$30	$20	$20	$80	$30
D7310	Alveoplasty in Conjunction with Extractions - Per Quadrant	$55	$45	$35	$25	$18	$18	$35	$25
D7311	Alveoplasty in Conjunction with Extractions - 1 to 3 Teeth or Tooth Spaces, Per Quadrant	$28	$23	$18	$13	$9	$9	$18	$13
D7320	Alveoplasty Not in Conjunction with Extractions - Per Quadrant	$75	$70	$60	$40	$25	$25	$60	$40
D7321	Alveoplasty Not in Conjunction with Extractions - 1 to 3 Teeth or Tooth Spaces, Per Quadrant	$38	$35	$30	$20	$13	$13	$30	$20
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$50	$40	$30	$20	$10	$10	$30	$20
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Facial Spaces)	$55	$44	$33	$22	$11	$11	$33	$22
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$128	$110	$90	$34	$24	$24	$90	$34
D7963	Frenuloplasty	$134	$116	$95	$36	$25	$25	$95	$36
OTHER (ADJUNCTIVE) SERVICES									
D9220	General Anesthesia – First 30 Minutes	$165	$165	$165	$165	$165	$165	$165	$165
D9221	General Anesthesia – Each Additional 15 Minutes	$70	$70	$70	$70	$70	$70	$70	$70
D9241	Intravenous Sedation/Analgesia – First 30 Minutes	$165	$165	$165	$165	$165	$165	$165	$165
D9242	Intravenous Sedation/Analgesia – Each Additional 15 Minutes	$70	$70	$70	$70	$70	$70	$70	$70
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D9940	Occlusal Guard, By Report	$90	$70	$70	$70	$70	$70	$70	$70
D9942	Repair and/or Reline of Occlussal Guard	$23	$15	$18	$18	$18	$15	$18	$18
D9951	Occlusal Adjustment- Limited	$25	$10	$10	$10	$10	$10	$10	$10
D9952	Occlusal Adjustment - Complete	$90	$60	$60	$60	$60	$60	$60	$60
EMERGENCY SERVICES									
D0140-D0160 & D0180	Oral Evaluation - Problem Focused	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D9110	Emergency Palliative Treatment	$10	$10	$10	$10	$10	$10	$10	$10
ORTHODONTICS									
Comprehensive Orthodontic Treatment -									
The total patient copayment is for the entire treatment plan, from ortho examination through ortho retention.									
One of the following total patient copayments will apply, based on the option selected by the plan sponsor:									
Adolescent or Adult Dentition - $2400 / $2300 / $2000 / $1500									
To determine which copayment applies to your patient, please contact the National Dentist Line (1-800-451-7715)									
Individual Ortho Services -									
In the event the comprehensive treatment is not performed by your office, the following copayments apply to individual services:									
	Ortho Screening Exam	$30	$30	$30	$30	$30	$30	$30	$30
	Diagnostic Records	$150	$150	$150	$150	$150	$150	$150	$150
	Ortho Retention	$275	$275	$275	$275	$275	$275	$275	$275

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS: 63	64	65	66	67	68
Office Visit Copay (See roster)		0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10	0, $5 or $10
DIAGNOSTIC							
D0120-D0180	Oral Evaluations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0210	X-Ray, Intraoral - Complete Series (including bitewings)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0220	X-Ray, Intraoral - Periapical First Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0230	X-Ray, Intraoral - Periapical Each Additional Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0240	X-Ray, Intraoral - Occlusal	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0250	X-ray, Extraoral - First Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0260	X-ray, Extraoral - Each Additional Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0270	X-Ray, Bitewing - Single Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0272	X-Ray, Bitewings - Two Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0273	X-Ray, Bitewings - Three Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0274	X-Ray, Bitewings - Four Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0277	Vertical Bitewings - 7 to 8 Films	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0330	X-Ray, Panoramic	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0460	Pulp Vitality Test	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0470	Diagnostic Casts	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D0472-D0474	Accession of Tissue	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
PREVENTIVE							
D1110	Prophylaxis - Adult	$8	No Charge	No Charge	No Charge	No Charge	No Charge
D1120	Prophylaxis - Child	$7	No Charge	No Charge	No Charge	No Charge	No Charge
D1203-D1204	Topical Application of Fluoride	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1206	Topical Fluoride Varnish	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1330	Oral Hygiene Instruction	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1351	Sealant - per Tooth	$8	No Charge	No Charge	No Charge	$10	$5
D1510-D1515	Space Maintainer - Fixed	$80	$75	No Charge	No Charge	$80	$75
D1520-D1525	Space Maintainer - Removable	$80	$70	No Charge	No Charge	$80	$70
D1550	Recementation of Space Maintainer	$15	$12	$12	$12	$15	$12
D1555	Removal of Fixed Space Maintainer (by dentist who did not place the appliance)	$15	$12	$12	$12	$15	$12
RESTORATIVE							
D2140	Amalgam - 1 Surface, Primary or Permanent	$16	$10	No Charge	No Charge	No Charge	No Charge
D2150	Amalgam - 2 Surfaces, Primary or Permanent	$24	$12	No Charge	No Charge	No Charge	No Charge
D2160	Amalgam - 3 Surfaces, Primary or Permanent	$32	$16	No Charge	No Charge	No Charge	No Charge
D2161	Amalgam - 4 or More Surfaces, Primary or Permanent	$40	$18	No Charge	No Charge	No Charge	No Charge
D2330	Resin-Based Composite - 1 Surface, Anterior	$25	$15	No Charge	No Charge	No Charge	No Charge
D2331	Resin-Based Composite - 2 Surfaces, Anterior	$35	$21	No Charge	No Charge	No Charge	No Charge
D2332	Resin-Based Composite - 3 Surfaces, Anterior	$35	$25	No Charge	No Charge	No Charge	No Charge
D2335	Resin-Based Composite - 4 or More Surfaces or Involving Incisal Angle, Anterior	$60	$45	$40	$35	$60	$45
D2390	Resin-Based Composite Crown, Anterior	$60	$50	$40	No Charge	$60	$50
D2391	Resin-Based Composite - 1 Surface, Posterior	$45	$35	$35	$35	$35	$35
D2392	Resin-Based Composite - 2 Surfaces, Posterior	$60	$50	$45	$45	$45	$45
D2393	Resin-Based Composite - 3 Surfaces, Posterior	$85	$60	$55	$55	$55	$55
D2394	Resin-Based Composite - 4 or More Surfaces, Posterior	$90	$90	$75	$75	$75	$75
D2940	Sedative Filling	$8	$3	No Charge	No Charge	$8	$3
D2951	Pin Retention - per Tooth, in Addition to Restoration	$10	$10	$10	No Charge	$10	$10

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS: 63	64	65	66	67	68
CROWNS/BRIDGES							
D2510-D2530	Inlay- Metallic*	$225	$195	$190	$180	$225	$195
D2542-D2544	Onlay - Metallic*	$240	$210	$200	$190	$240	$210
D2740	Crown - Porcelain/Ceramic Substrate	$315	$255	$225	$180	$315	$255
D2750-D2752	Crown - Porcelain Fused to Metal*	$315	$255	$225	$180	$315	$255
D2790-D2794	Crown - Full Cast Metal*	$315	$255	$225	$180	$315	$255
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$15	$10	$5	No Charge	$15	$10
D2915	Recement Cast or Prefabricated Post and Core	$8	$5	$3	No Charge	$8	$5
D2920	Recement Crown	$15	$10	$5	No Charge	$15	$10
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$50	$40	No Charge	No Charge	$50	$40
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$60	$50	$40	No Charge	$60	$50
D2950	Core Buildup, including any Pins	$90	$80	$60	$70	$80	$80
D2952	Cast Post and Core, in addition to Crown*	$128	$112	$80	$72	$100	$112
D2954	Prefabricated Post and Core in addition to Crown	$83	$74	$70	$63	$90	$74
D6210-D6214	Pontic - Cast Metal*	$315	$255	$225	$180	$315	$255
D6240-D6242	Pontic- Porcelain Fused to Metal*	$315	$255	$225	$180	$315	$255
D6750-D6752	Crown - Porcelain Fused to Metal*	$315	$255	$225	$180	$315	$255
D6790-D6792	Crown - Full Cast Metal*	$315	$255	$225	$180	$315	$225
D6794	Crown - Full Cast Metal*	$315	$255	$225	$180	$315	$225
D6930	Recement Fixed Partial Denture	$20	$15	$15	$15	$20	$15
	Additional Charge Per Unit for Full Mouth Rehabilitation†	$125	$125	$125	$125	$125	$125
*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 (*).							
†Full mouth rehabilitation is defined as 6 or more units of covered crown and/or bridge in the same treatment plan.							
ENDODONTICS							
D3110-3120	Pulp Cap - Direct or Indirect	$6	$4	No Charge	No Charge	No Charge	No Charge
D3220	Therapeutic Pulpotomy	$55	$22	No Charge	No Charge	$55	$22
D3310	Root Canal Therapy - Anterior	$120	$70	$50	No Charge	$120	$70
D3320	Root Canal Therapy - Bicuspid	$180	$109	$70	No Charge	$180	$109
D3330	Root Canal Therapy - Molar	$303	$280	$175	$146	$300	$280
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$220	$170	$150	$100	$220	$170
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$280	$209	$170	$100	$280	$209
D3348	Retreatment of Previous Root Canal Therapy - Molar	$403	$380	$275	$246	$400	$380
D3410	Apicoectomy/Periradicular Surgery, Anterior	$141	$92	$65	No Charge	$170	$92
D3421	Apicoectomy/Periradicular Surgery, Bicuspid	$141	$92	$65	No Charge	$170	$92
D3425	Apicoectomy/Periradicular Surgery, Molar (1st Root)	$150	$90	$80	No Charge	$170	$90
D3426	Apicoectomy/Periradicular Surgery (each additional root)	$90	$55	$40	No Charge	$100	$55
D3430	Retrograde Filling - per Root	$65	$40	$20	No Charge	$65	$40
D3450	Root Amputation - per Root	$80	$70	$60	$60	$80	$70

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS: 63	64	65	66	67	68
PERIODONTICS							
D4210	Gingivectomy or Gingivoplasty - 4 or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$160	$133	$100	$87	$125	$133
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$60	$57	$30	$30	$55	$57
D4240	Gingival Flap Procedure, Including Root Planing 4 or More - Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$171	$134	$110	$86	$155	$134
D4241	Gingival Flap Procedure, Including Root Planing - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$103	$80	$66	$52	$93	$80
D4249	Clinical Crown Lengthening - Hard Tissue	$195	$180	$150	$84	$225	$180
D4260	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$325	$300	$250	$140	$375	$300
D4261	Osseous Surgery (Including Flap Entry and Closure) - 1 to 3 Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$195	$180	$150	$84	$225	$180
D4270	Pedicle Soft Tissue Graft Procedure	$250	$230	$190	$110	$285	$230
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$265	$245	$205	$115	$305	$245
D4273	Subepithelial Connective Tissue Graft Procedures, per Tooth	$150	$138	$115	$65	$173	$138
D4275	Soft Tissue Allograft	$300	$275	$230	$130	$345	$275
D4276	Combined Connective Tissue and Double Pedicle Graft	$248	$227	$190	$107	$285	$227
D4341	Periodontal Scaling and Root Planing - 4 or More Teeth, Per Quadrant	$56	$51	$50	$35	$60	$62
D4342	Periodontal Scaling and Root Planing - 1 to 3 Teeth Per Quadrant	$34	$31	$30	$21	$36	$37
D4910	Periodontal Maintenance	$60	$45	$30	$23	$40	$45

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS: 63	64	65	66	67	68
PROSTHODONTICS-REMOVABLE* **							
D5110-D5120	Complete Denture - Maxillary or Mandibular	$300	$275	$275	$200	$320	$275
D5130-D5140	Immediate Denture - Maxillary or Mandibular	$330	$315	$325	$225	$330	$315
D5211-D5212	Maxillary or Mandibular Partial Denture Resin Base (Including any Conventional Clasps, Rests and Teeth)	$300	$275	$275	$200	$320	$275
D5213-D5214	Maxillary or Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)	$400	$350	$325	$225	$400	$350
D5225	Maxillary Partial Denture - Flexible Base	$360	$330	$330	$240	$360	$330
D5226	Mandibular Partial Denture - Flexible Base	$360	$330	$330	$240	$360	$330
D5410-D5411	Adjust Complete Denture - Maxillary or Mandibular	$10	$10	$10	$10	$10	$10
D5421-D5422	Adjust Partial Denture- Maxillary or Mandibular	$10	$10	$10	$10	$10	$10
***Includes relines, adjustments and rebases within the first 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	$36	$30	$30	$30	$40	$30
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	$25	$20	$35	$25	$40	$20
D5610	Repair Resin Denture Base	$35	$35	$35	$30	$40	$35
D5620	Repair Cast Framework	$35	$35	$35	$30	$40	$35
D5630	Repair or Replace Broken Clasp	$35	$35	$35	$30	$40	$35
D5640	Replace Broken Teeth - Per Tooth	$35	$35	$35	$25	$45	$35
D5650	Add Tooth to Existing Partial	$35	$35	$35	$30	$40	$35
D5660	Add Clasp to Existing Partial	$45	$40	$40	$30	$45	$40
D5670-D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)	$100	$100	$100	$100	$100	$100
D5710-D5711	Rebase Complete Maxillary or Mandibular Denture	$100	$100	$100	$100	$100	$100
D5720-D5721	Rebase Maxillary or Mandibular Partial Denture	$100	$100	$100	$100	$100	$100
D5730-D5731	Reline Complete Maxillary or Mandibular Denture (Chairside)	$50	$45	$40	No Charge	$60	$45
D5740-D5741	Reline Maxillary or Mandibular Partial Denture (Chairside)	$50	$45	$40	No Charge	$60	$45
D5750-D5751	Reline Complete Maxillary or Mandibular Denture (Laboratory)	$114	$102	$90	$48	$100	$102
D5760-D5761	Reline Maxillary or Mandibular Partial Denture (Laboratory)	$114	$102	$90	$48	$100	$102
D5820-D5821	Interim Partial Denture (Maxillary or Mandibular)	$143	$90	$90	$90	$120	$90
D5850-D5851	Tissue Conditioning, Maxillary or Mandibular	$50	$40	$40	$40	$55	$40
ORAL SURGERY							
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$6	$4	No Charge	No Charge	No Charge	No Charge
D7140	Extraction, Erupted Tooth or Exposed Root Elevation and/or Forceps Removal)	$15	$11	No Charge	No Charge	No Charge	No Charge
D7210	Surgical Extraction of an Erupted Tooth	$36	$28	No Charge	No Charge	$50	$28
D7220	Removal of Impacted Tooth - Soft Tissue	$60	$46	No Charge	No Charge	$60	$46
D7230	Removal of Impacted Tooth - Partially Bony	$72	$58	$45	$45	$80	$58
D7240-D7241	Removal of Impacted Tooth - Completely Bony	$128	$117	$70	$70	$120	$117

Fixed Dollar Copayments by Plan Code for DMO Plans (continued)

CODE**	PROCEDURE	PATIENT PAYS:					
		63	64	65	66	67	68
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$35	$25	$15	$15	$55	$25
D7280	Surgical Access of an Unerupted Tooth	$60	$26	$26	$26	$60	$26
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$70	$30	$30	$30	$70	$30
D7283	Placement of Device to Aid Eruption of Impacted Tooth	$14	$6	$6	$6	$14	$6
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$200	$75	$50	$50	$80	$75
D7286	Biopsy of Oral Tissue - Soft	$200	$75	$50	$50	$80	$75
D7310	Alveoplasty in Conjunction with Extractions - Per Quadrant	$35	$25	$18	$18	$60	$25
D7311	Alveoplasty in Conjunction with Extractions 1 to 3 Teeth or Tooth Spaces, Per Quadrant	$18	$13	$9	$9	$30	$13
D7320	Alveoplasty Not in Conjunction with Extractions - Per Quadrant	$60	$40	$25	$25	$75	$40
D7321	Alveoplasty Not in Conjunction with Extractions 1 to 3 Teeth or Tooth Spaces, per Quadrant	$30	$20	$13	$13	$38	$20
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$30	$20	$10	$10	$30	$20
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Facial Spaces)	$33	$22	$11	$11	$33	$22
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$90	$34	$24	$24	$90	$34
D7963	Frenuloplasty	$95	$36	$25	$25	$95	$36
OTHER (ADJUNCTIVE) SERVICES							
D9220	General Anesthesia – First 30 Minutes	$165	$165	$165	$165	$165	$165
D9221	General Anesthesia – Each Additional 15 Minutes	$70	$70	$70	$70	$70	$70
D9241	Intravenous Sedation/Analgesia – First 30 Minutes	$165	$165	$165	$165	$165	$165
D9242	Intravenous Sedation/Analgesia – Each Additional 15 Minutes	$70	$70	$70	$70	$70	$70
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D9940	Occlussal Guard, By Report	$130	$100	$100	$100	$130	$100
D9942	Repair and/or Reline of Occlusal Guard						
D9951	Occlussal Adjustment - Limited	$30	$20	$20	$20	$30	$20
D9952	Occlussal Adjustment - Complete	$100	$80	$80	$80	$100	$80
EMERGENCY SERVICES							
D0140-D0160 & D0180	Oral Evaluation - Problem Focused	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D9110	Emergency Palliative Treatment	$10	$10	$10	$10	$10	$10
ORTHODONTICS							
Comprehensive Orthodontic Treatment - The total patient copayment is for the entire treatment plan, from ortho examination through ortho retention. One of the following total patient copayments will apply, based on the option selected by the plan sponsor: Adolescent or Adult Dentition - $2400 / $2300 / $2000 / $1500 **To determine which copayment applies to your patient, please contact the National Dentist Line (1-800-451-7715)**							
Individual Ortho Services - In the event the comprehensive treatment is not performed by your office, the following copayments apply to individual services:							
	Ortho Screening Exam	$30	$30	$30	$30	$30	$30
	Diagnostic Records	$150	$150	$150	$150	$150	$150
	Ortho Retention	$275	$275	$275	$275	$275	$275

Notes

Notes

Notes

Network Bulletins

- 2024-10 CDT® 2025 updates to the Dental Office Guide for DMO Specialist Dentists
- 2023-12 CDT® D4341/D4342 Claim Submission Guidelines
- 2023-10 CDT® 2024 updates to the Dental Office Guide for DMO Specialist Dentists
- 2023-10 DMO Changes – Effective 01/01/2024
- 2023-07 Claims administration policy change – Effective 11/01/2023 (D4355)
- 2023-04 Claims administration policy change – Effective 08/01/2023 (D2975)
- 2022-12 Claim administration policy change (D4910) – Effective 04/01/2023
- 2022-11 CDT® 2023 updates to the Dental Office Guide for DMO Specialist Dentists
- 2021-12 CDT 2022 updates to the Dental Office Guide for DMO Specialist Dentists
- 2021-09 Claim administration policy change (D9910)
- 2020-10 CDT 2021 updates to the Dental Office Guide for DMO Specialist Dentists
- 2019-10 CDT 2020 updates to the Dental Office Guide for DMO Specialist Dentists
- 2020-05 Claim administration policy changes (D0431 & D4355)
- 2018-12 Pre-Determination of Benefits for All Aetna California DMO® Providers
- 2018-09 CDT 2019 updates to the Dental Office Guide for DMO Specialist Dentists
- 2018-06 Claim administration policy changes – effective September 18, 2018
- 2017-09 CDT 2018 updates to the Dental Office Guide for DMO Specialist Dentists
- 2017-04 Claim administration policy changes – effective July 17, 2017
- 2017-01 Changes to the provider appeal process
- 2016-12 DMO Pediatric Protocols – Change in Age Limit
- 2016-09 CDT 2017 updates to the Dental Office Guide for DMO Specialist Dentists
- 2015-09 CDT 2016 updates to the Dental Office Guide for DMO Specialist Dentists
- 2015-05 New Southern California DMO® Copay plans – CAM, CMI, CAL, CLI Series
- 2015-03 Aetna Dental – DMO® is now DNO (Dental Network Only) in Virginia
- 2014-10 CDT 2015 Updates to the Dental Office Guide for DMO Specialist Dentists
- 2013-12 Dental ID card suppression
- 2013-10 New CDT 2014 Codes – Applies to Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental
- 2013-09 CDT 2014 Updates to the Dental Office Guide for DMO Specialist Dentists
- 2010-06 D4355 Full Mouth Debridement
- 2009-10 2009 Corrections for the Dental Office Guide for Specialty Dentists
- 2008-09 Revised Copay Charts and Other Updates to the Specialty Dental Office Guide

Network Bulletin

Date: October 2024

From: Anna Huck, Director, Network Management, Dental

Subject: CDT® 2025 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2025[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2025**. We've listed them below.

Fee information for the new CDT 2025 codes

Your rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2025 Code[1]	Nomenclature	Contracted Fees for CDT 2025 codes are based on the following:
D2000 – D2999	**III. Restorative**	
D2956	Removal of an Indirect Restoration on a Natural Tooth	30% of negotiated fee for D9120
D6000-D6199	**VIII. Implant Services**	
D6180	Implant Maintenance Procedures When a Full Arch Fixed Hybrid Prosthesis is Not Removed, including Cleansing of Prosthesis and Abutments	Not Covered
D6193	Replacement of an Implant Screw	100% of negotiated fee for D6096 Only covered if implants are covered.
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7252	Partial Extraction for Immediate Implant Placement	100% of negotiated fee for D3920 Only covered if implants are covered.
D7259	Nerve Dissection	Not Covered

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CDT 2025 Code[1]	Nomenclature	Contracted Fees for CDT 2025 codes are based on the following:
D9000-D9999	**XII. Adjunctive General Services**	
D9913	Administration of Neuromodulators	Not Covered
D9914	Administration of Dermal Fillers	Not Covered
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered

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Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - U

ADA Code[1]	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D2956	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6180	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C 40%	N/C 50%	N/C	N/C	N/C	N/C
D6193	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D7252	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C 40%	N/C 50%	N/C	N/C	N/C	N/C
D7259	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9913	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
1 – 22

ADA Code[1]	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
D2956	40%	50%	50%	50%	40%	0	10%	10%	20%
D6180	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6193	40%	50%	50%	50%	40%	50%	40%	10%	20%
D7252	20%	20%	20%	50%	10%	0	10%	10%	20%
D7259	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9913	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D2956	N/C	N/C	N/C	N/C
D6180	N/C	N/C	N/C	N/C
D6193	N/C	N/C	N/C	N/C
D7252	$60	N/C	N/C	$80
D7259	N/C	N/C	N/C	N/C
D9913	$0	N/C	N/C	$5
D9914	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
41 – 59i

ADA Code[1]	41	41S	51	52	53 53i	54	55 55A	56	56H	56X	57 57i	58	59i
D2956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6180	N/C	N/C	N/C	N/C	N/C $22	N/C	N/C	N/C	N/C	N/C	N/C $14	N/C	$14
D6193	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7252	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7259	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9913	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

[1]Current Dental Terminology.

FIXED COPAY PLAN CODES
63 – 68i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i
D2956	N/C	N/C	N/C	N/C	N/C	N/C
D6180	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22
D6193	N/C	N/C	N/C	N/C	N/C	N/C
D7252	N/C	N/C	N/C	N/C	N/C	N/C
D7259	N/C	N/C	N/C	N/C	N/C	N/C
D9913	N/C	N/C	N/C	N/C	N/C	N/C
D9914	N/C	N/C	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
73 – 78i
CAM/CMI, CAL/CLI, SFL/SFi

ADA Code[1]	73 73i	73S	74 74i	75F	75 75i	76 76i	77 77i	78 78i	CAM CMI	CAL CLI	SFL SFi
D2956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6180	N/C $22	$22	N/C $22	$22	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22
D6193	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7252	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7259	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9913	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.
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Network Bulletin

Date: December 2023

From: Anna Huck, Director, Network Management, Dental

Subject: CDT® D4341/D4342 Claim Submission Guidelines

Applies to: All Aetna Dental plans

This bulletin is part of your *Dental Office Guide*.

According to the American Academy of Periodontology treatment guidelines, periodontal health should be achieved in the least invasive manner, often via scaling and root planing.

Periodontal scaling and root planing (CDT code D4341/4342) is distinctly different from a dental prophylaxis (CDT code D1110) and scaling in the presence of generalized moderate or severe gingival inflammation (CDT code D4346). Key to scaling and root planing is the instrumentation and removal of deposits from the root surfaces of the tooth for patients with indicators of chronic periodontitis as described in the ADA's guide, "Claims Submission: Scaling and Root Planing."

Scaling and root planing typically takes a substantial amount of time per quadrant and routinely requires local anesthetic. The length and nature of the procedure and use of local anesthetic normally necessitates multiple appointments, with one or two quadrants being performed per appointment. For a submission of D4341, the quadrant must include at least 4 teeth with periodontitis, and a submission of D4342 is appropriate for a partial quadrant that includes 1-3 teeth with periodontitis. Periodontal maintenance visits (D4910) by definition also include site-specific scaling and root planing for any number of teeth.

Documentation to support a diagnosis of chronic periodontitis and the delivery of scaling and root planing must consist of the following:

1) Periodontal charting that records pocket depths at 6 points per tooth, bleeding on probing, gingival recession, frenum involvement, and furcation defects. With periodontitis, pocket depths are usually at least 4mm, but **we do not base benefit determinations solely on pocket depth**.
2) Full mouth radiographs or digital images that **clearly show bone loss**
3) Chart notes that show whether or not local anesthetic was administered, and details regarding the treatment performed
4) Documentation of length of appointment
   The diagnostic materials must demonstrate the following:
   - Clinical loss of periodontal attachment
   - Radiographic evidence of crestal bone loss, without which root planing cannot be performed
   - Radiographic evidence of root surface calculus

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

Claims Submission: Scaling and Root Planing (SRP)

D4341 – PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT
D4342 – PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT

According to the American Academy of Periodontology, a patient is a periodontitis case in the context of clinical care if:

-- Interdental CAL is detectable at ≥2 non-adjacent teeth, OR

-- Buccal or oral CAL ≥3 mm with pocketing >3 mm is detectable at ≥2 teeth

And the observed CAL cannot be ascribed to non-periodontal causes such as: 1) gingival recession of traumatic origin; 2) dental caries extending in the cervical area of the tooth; 3) the presence of CAL on the distal aspect of a second molar and associated with malposition or extraction of a third molar, 4) an endodontic lesion draining through the marginal periodontium; and 5) the occurrence of a vertical root fracture.[1]

According to the ADA Evidence-Based Clinical Recommendations for patients with chronic periodontitis i.e. with the clinical indicators noted above, clinicians should consider scaling and root planing (SRP) as the initial definitive treatment.

SRP Claims

- D4341 and D4342 are not "by report" codes.
- However, in order to adjudicate the patient's benefit based on plan policies, carriers require additional information to process the claims. Dentists, especially those in-network are contractually obligated to respond to such requests. Supporting documentation that may facilitate faster claim processing include:
    - Narrative indicating periodontal disease
    - Documentation of the amount of millimeter attachment loss/ bone loss. Documentation options include:
        - Diagnostic quality radiographs showing bone loss (see inset for more information). Include images for all affected teeth that need SRP
        - Complete periodontal chart Indicating loss of attachment/bone loss, bleeding on probing, and pocket depths. Proper periodontal charting typically includes documentation on at least 6 sites around each affected tooth/ implant.
- If four (4) quadrants of SRP were completed in one visit/appointment, be sure to indicate why and submit a narrative outlining the reason (Examples of circumstances that may require treatment in multiple quadrants on the same date include but are not limited to: patient's needing IV sedation for treatment, patients with special needs, patients with transportation barriers, patients need pre-treatment antibiotics etc.).

DIAGNOSTIC QUALITY RADIOGRAPHS

Dental plans have stated that a common reason for SRP claim denials or requests for additional information are due to receiving radiographs that are not of diagnostic quality. Staff should perform a quality review before an SRP claim is submitted to a dental plan and verify that:

- ✓ Preferably bite-wings (vertical or horizontal as long as the image captures the bone height in relation to the root and any furcation involvement) or sometimes the full mouth series are submitted. **NOT** panoramic X-rays.
- ✓ Radiographs are properly mounted and labeled (e.g., left and/or right, and with the patient's name)
- ✓ Diagnostic quality depicting appropriate structures
- ✓ Submitted radiographs should be duplicates and taken immediately prior to the diagnostic treatment planning appointment.
- ✓ See Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[1] https://aap.onlinelibrary.wiley.com/doi/10.1002/JPER.18-0006

- Some plans may not benefit 4 quadrants in one visit, regardless of documentation submitted. Refer to the plan's processing policies for more details.
- Some plans may additionally request a copy of your schedule indicating allocation of chair-time necessary to complete 4 quadrants on the same day.
- Some plans may request documentation that in fact local anesthesia was used during the procedure.

Offices that submit the proper documentation will have better chances of getting these claims correctly adjudicated on the first submission.

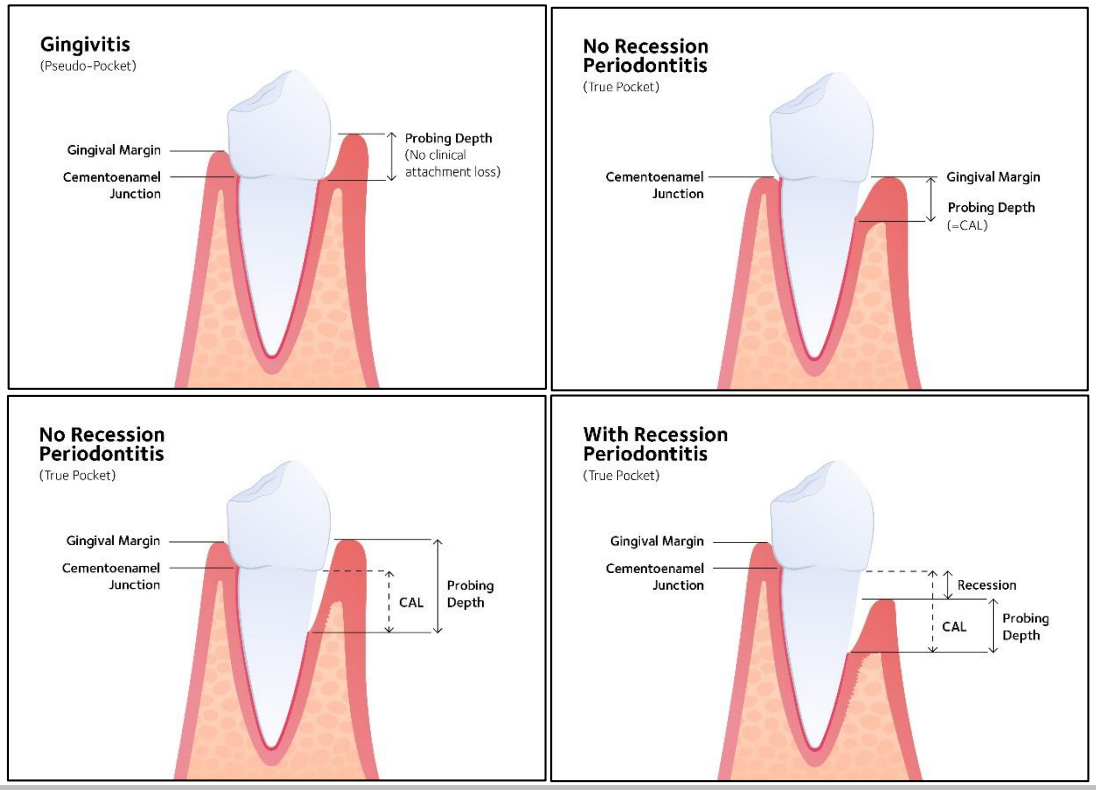
Dentists need to be involved in the claim submission quality review process as the treating dentist has an important responsibility to assure the accuracy of submitted claims. This includes completion of all accompanying clinical documentation necessary for proper claim adjudication.

Front office staff should address any concerns with the completed claim form and accompanying documentation with the treating dentist *before* submission of the claim. This includes radiographs, claim forms, periodontal charting and narrative descriptions.

Recording Attachment Loss

Probing depth or pocket depth is measured from the gingival margin, and the measurement is affected by gingival recession or inflammation. Clinical attachment loss (CAL) is measured from a fixed reference point (typically the cementoenamel junction) and is a more stable indicator of periodontal health.

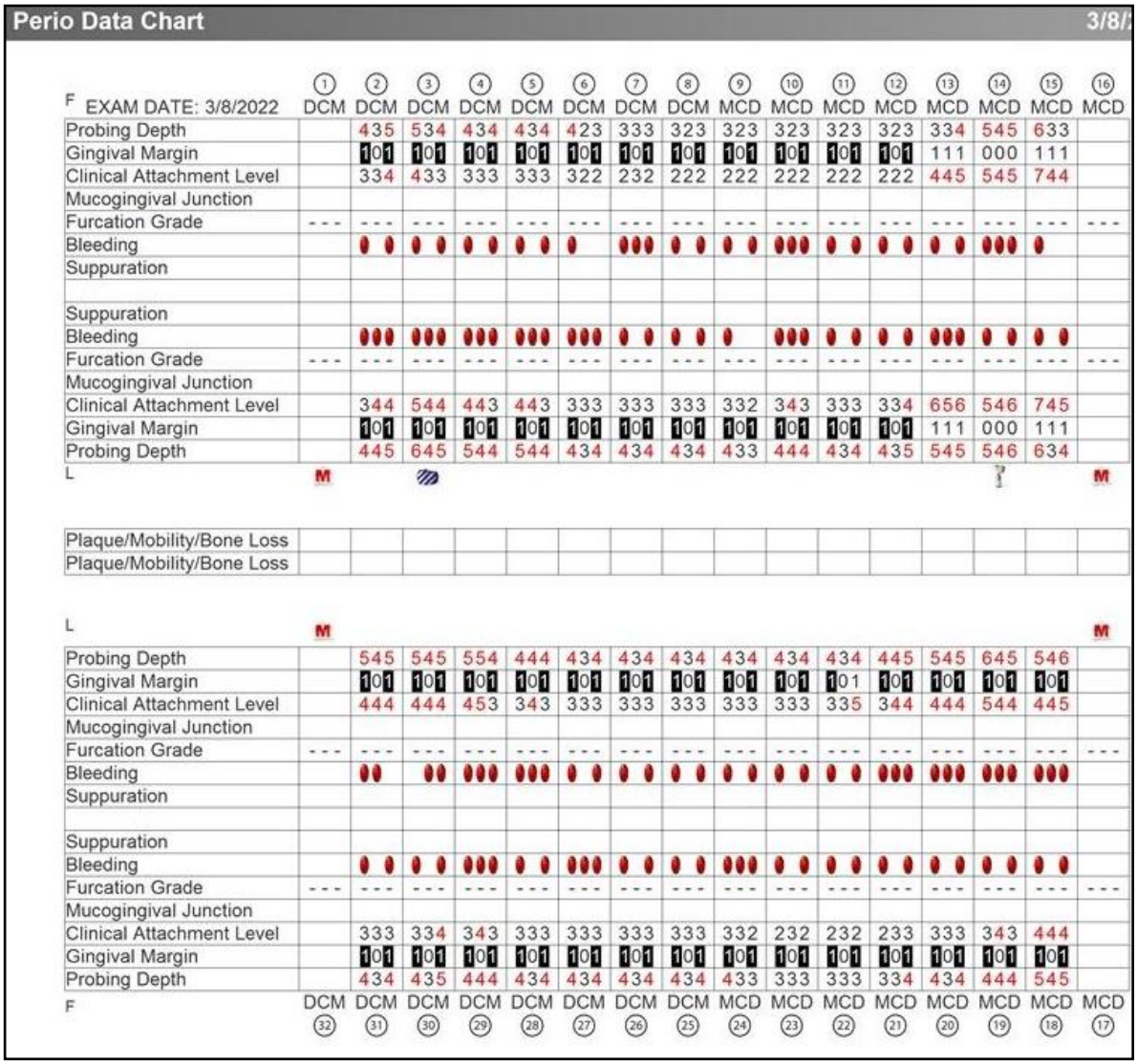
In cases without any recession, Loss of attachment (mm) = Probing Depth (mm) – mm from gingival margin to CEJ.
In cases with recession, Loss of attachment (mm) = Probing Depth (mm) + Recession (mm from CEJ to gingival margin).



Pseudo-pocketing caused by hyperplastic gingival tissue or inflamed gingival tissue can result in abnormal probing depth without concomitant bone loss/ loss of attachment. Treatment of this condition should be reported as a prophylaxis (D1110 or D1120) or scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346). More info can be found in the ADA Guide to Reporting D4346.

Sample Periodontal Chart

Dental offices that use a practice management software typically have a periodontal module that can generate a periodontal chart that can be communicated to the dental plan. A sample chart appears below. Note the different periodontal parameters included on a **complete periodontal chart**.



Perio Data Chart 3/8/

F EXAM DATE: 3/8/2022	① DCM	② DCM	③ DCM	④ DCM	⑤ DCM	⑥ DCM	⑦ DCM	⑧ DCM	⑨ MCD	⑩ MCD	⑪ MCD	⑫ MCD	⑬ MCD	⑭ MCD	⑮ MCD	⑯ MCD
Probing Depth		435	534	434	434	423	333	323	323	323	323	323	334	545	633	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Clinical Attachment Level		334	433	333	333	322	232	222	222	222	222	222	445	545	744	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		• •	• •	• •	• •	•	•••	• •	• •	•••	• •	• •	• •	•••	•	
Suppuration																
Suppuration																
Bleeding		•••	•••	•••	•••	•••	• •	• •	•	•••	• •	• •	•••	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		344	544	443	443	333	333	333	332	343	333	334	656	546	745	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Probing Depth		445	645	544	544	434	434	434	433	444	434	435	545	546	634	
L	M															M

Plaque/Mobility/Bone Loss	
Plaque/Mobility/Bone Loss	

L	M															M
Probing Depth		545	545	554	444	434	434	434	434	434	434	445	545	645	546	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Clinical Attachment Level		444	444	453	343	333	333	333	333	333	335	344	444	544	445	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		••	••	•••	•••	• •	• •	• •	• •	• •	• •	•••	•••	•••	•••	
Suppuration																
Suppuration																
Bleeding		• •	• •	•••	• •	•••	• •	• •	•••	• •	• •	• •	• •	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		333	334	343	333	333	333	333	332	232	232	233	333	343	444	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Probing Depth		434	435	444	434	434	434	434	433	333	333	334	434	444	545	
F	DCM ㉜	DCM ㉛	DCM ㉚	DCM ㉙	DCM ㉘	DCM ㉗	DCM ㉖	DCM ㉕	MCD ㉔	MCD ㉓	MCD ㉒	MCD ㉑	MCD ⑳	MCD ⑲	MCD ⑱	MCD ⑰

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Why do my SRP claims get denied?

Periodontal scaling and root planing (SRP) procedures (D4341 and D4342) tend to have a higher frequency for denial and/or requests for additional information from dental plans in comparison to many other procedures. Dentists may not always understand why claims for SRP are denied when the patient has abnormal pocket depths. A claim may be paid on one patient while at other times a plan may deny the same procedure on another patient who had a similar clinical presentation.

- Different dental plans have different coverage and processing policies for SRP claims. Examples include:

  "Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss."

  "Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits".

- Plans will typically not pay separately for SRP on the same date of service as a surgical periodontal procedure on the same teeth.
- Plans may have different coverage policies for SRP around natural teeth versus implants.
- Plans may implement frequency limitations for retreatment within a designated time frame, for example, twenty-four months from the original treatment date.
- Plans may not provide coverage for more than 2 quadrants of SRP on the same date of service unless there are extenuating circumstances and the documentation supports the need. These plans may request the amount of time it took to scale and root plane and a narrative (which includes details on use of anesthesia) in order to determine coverage and benefits.

It is essential for dentists and their teams to fully read and understand each payer's processing policies.

Payers note that if there is no radiographic evidence of bone loss, root surface calculus or adequate clinical attachment loss demonstrated by the submitted periodontal charting, the claim will typically be denied. If only certain teeth in a quadrant meet these criteria, a partial quadrant, only D4342 may be benefitted. Payers report that a common issue is that radiographs submitted with claim(s) are not properly mounted, labeled, or are not of diagnostic quality. Payers have stated that at times the charting is not legible or is incomplete.

When the claim is denied due to frequency limits, annual benefit or other plan limitations and depending on how the explanation of benefits (EOB) statement is worded, some patients may think that the dentist has provided unnecessary work. This may create unnecessary friction in the dentist-patient relationship. To help prevent this, **dental plans should make it clear to both patients and dentists that claims denials due to processing policies does not mean that the treatment was unnecessary; the denial is based on solely on plan limitations.** Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical needs of the specific patients.

It is the ADA's position that all communications to beneficiaries from third-party payers that attempt to explain the reason(s) for a benefit reduction or denial of a dental benefits plan include the following statement, "*Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted*."

It is always appropriate to appeal the benefit decision if the dentist thinks the claim has not been properly adjudicated. A proper appeal involves sending the plan a written request to reconsider the claim with any additional information.

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Guiding Values for the Treating Dentist

The American Dental Association (ADA) makes a commitment to society that member dentists will adhere to ethical standards of conduct, which have the benefit of the patient as their primary concern as noted in the Preamble of the ADA Principles of Ethics and Code of Professional Conduct (ADA Code). All member dentists voluntarily agree to abide by the ADA Code.

Specific to determining the treatment plan and procedure coding, in Section 5 of the ADA Code, the principle Veracity ("truthfulness") is one which all dentists should remain mindful of. This section specifically states that, “the dentist has a duty to communicate truthfully.”

> *This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.*

For specific information about how Section 5 of ADA Code of Professional Conduct pertains to dentist’s responsibility to assure all claims submitted on their behalf are done so correctly, please refer the ADA Guide *Assuring Accuracy of Claims as a Treating Dentist*.

The Future of Artificial Intelligence (AI) and Its Role in SRP Claims Review

Dental payers complete utilization reviews on all or a portion of the claims they receive, but most notably on SRP claims. Payers use the types of required documentation covered in this guide to review submitted SRP claims, and these reviews have traditionally been carried out by the payers’ dental consultants.

Many payers are now looking towards new technology that can automate the claims review process.

The application of AI as a first pass in the screening of the large amount of documentation being requested and sent in related to SRP claims is something that is becoming more commonplace across the dental payer landscape. When used appropriately, the hope is that AI can step in and deliver immediate benefits that reduce frustration between dentists and dental carriers by ensuring claim completeness, more consistency in payers ’reviews, and an overall increase in efficiency for all parties. The ADA will continue to closely monitor the application of AI to make certain that claims are not unfairly adjudicated during its use.

Additional information on valuable educational ready-to-use resources on innovative dental insurance solutions for dentists can be found at ADA.org/dentalinsurance.

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Appendix 1: Example of Processing Policies

Payer #1:

D4341 Periodontal scaling & root planing-four or more teeth per quadrant

a. Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss.
b. Do not count teeth bounded spaces for D4210, D4341. Count only diseased teeth.
c. When there is a contractual time limitation on the frequency of benefits for scaling and root planing, and subsequent requests for scaling and root planing benefits are submitted within that contractual time limitation, benefits are DENIED. In the absence of a contractual time limitation for scaling and root planing, fees for D4341 are not billable to the patient by a participating dentist within 24 months when done by the same dentist/dental office. If treatment is done by a different dentist within 24 months, benefits are DENIED.
d. Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4341. This time limitation, like all other contractual time limitations, should be defined in the group/individual contract. Fees for the prophylaxis procedure by the same dentist/dental office are not billable to the patient by a participating dentist.
e. Benefit no more than two quadrants of scaling and root planing on the same date of service. More than two quadrants on the same date of service are not billable to the patient by the same participating dentist/dental office/DENIED-nonparticipating dentist.
f. For patients under the age of 30, clinical treatment notes, the most current (less than two years old) complete series of radiographic images, complete periodontal charting (no more 12 months old) and a copy of the appointment schedule showing the length of the appointment time are required. No payment is made for periodontal maintenance (D4910), scaling in presence of generalized moderate or severe gingival inflammation (D4346) or prophylaxis (D1110) when performed on the same day as scaling and root planning (D4341). The fee is not billable to the patient by a participating dentist.

D4342 Periodontal scaling & root planing-one to three teeth per quadrant: Scaling and root planing in the same quadrant is benefited once every 24 months unless specified by group contract. Reporting separately for periodontal root planing is not billable to the patient by a participating dentist on the same date as procedures D4240-D4241, D4249, D4260-4261, D4270-D4285.

Do not count tooth bounded spaces for D4341, D4342. In order to qualify for benefits probing depths must be 4mm or greater on 4 or more teeth. If only 1-3 teeth qualify, use partial quadrant code (D4342). If no teeth in the quadrant qualify, the Dental Consultant will DENY.

Payer #2:

When supporting documentation is requested for periodontal services, please refer to the submission guidelines as outlined in this section.

- A quadrant is defined as four or more contiguous teeth per quadrant.
- A partial quadrant is defined as one to three teeth per quadrant. For billing purposes, a sextant is not a recognized designation by the American Dental Association.
- Alveolar crestal bone loss must be evident radiographically for scaling and root planning to be covered.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, carrier will pay for the more extensive treatment as payment for the total service.

Benefits for all periodontal services are limited to two quadrants per date of service. If you want to request an exception to this due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time.

Payer #3:

Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits.

Payer #4:

Scaling and Root Planing
Scaling and Root Planing is indicated for the treatment of localized or generalized active Periodontal Disease characterized by:
Periodontal probing depths of 4-6+ mm with radiographic evidence of horizontal or vertical bone loss
Refractory or recurrent Periodontal Disease
Periodontal abscess

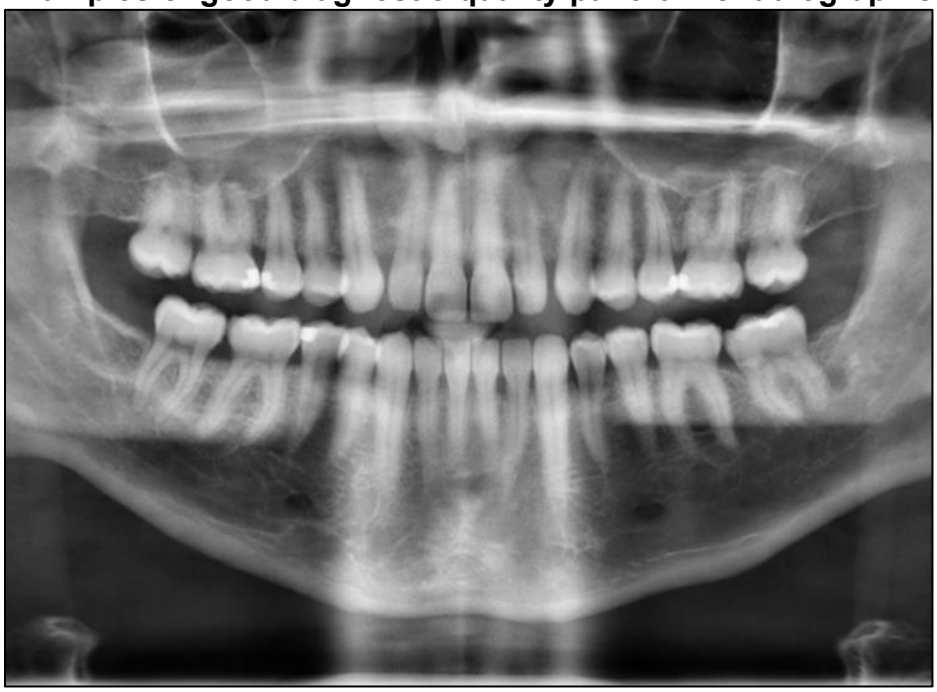
Scaling and Root Planing is not indicated for the following:
For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss
Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue)

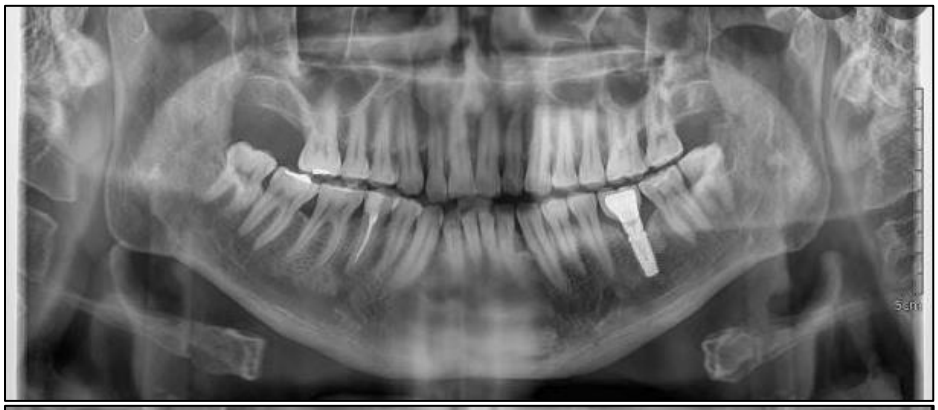
Coverage Limitations
Scaling and Root Planing is limited to 1 time per quadrant per consecutive 24 months

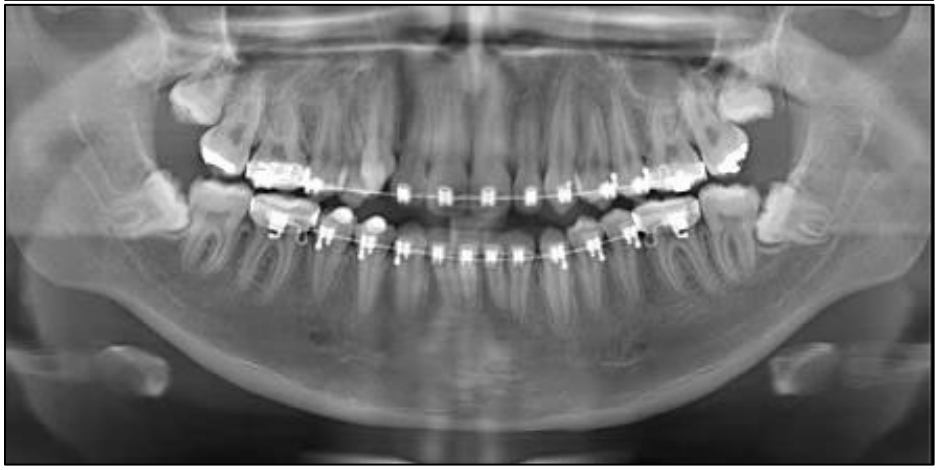
Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[Note: some of the enclosed examples are images that are zoomed-in and enlarged.]

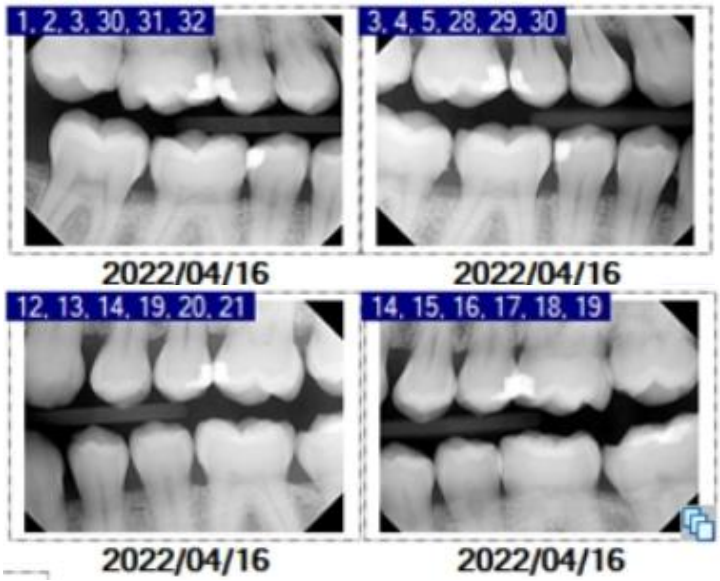
Examples of good diagnostic-quality panoramic radiographic images



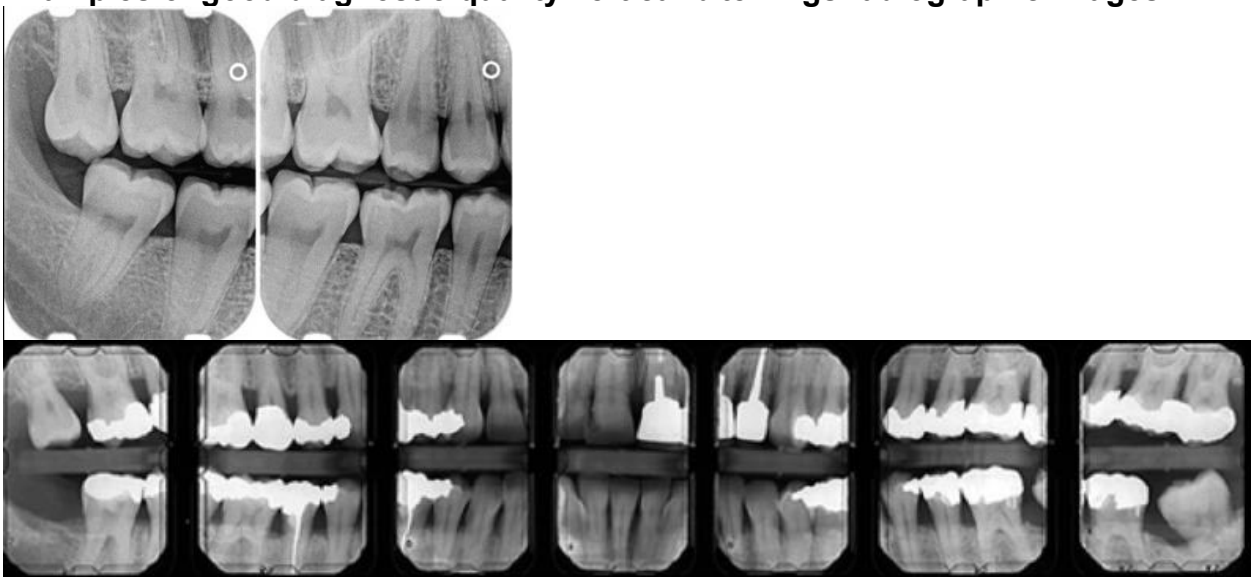




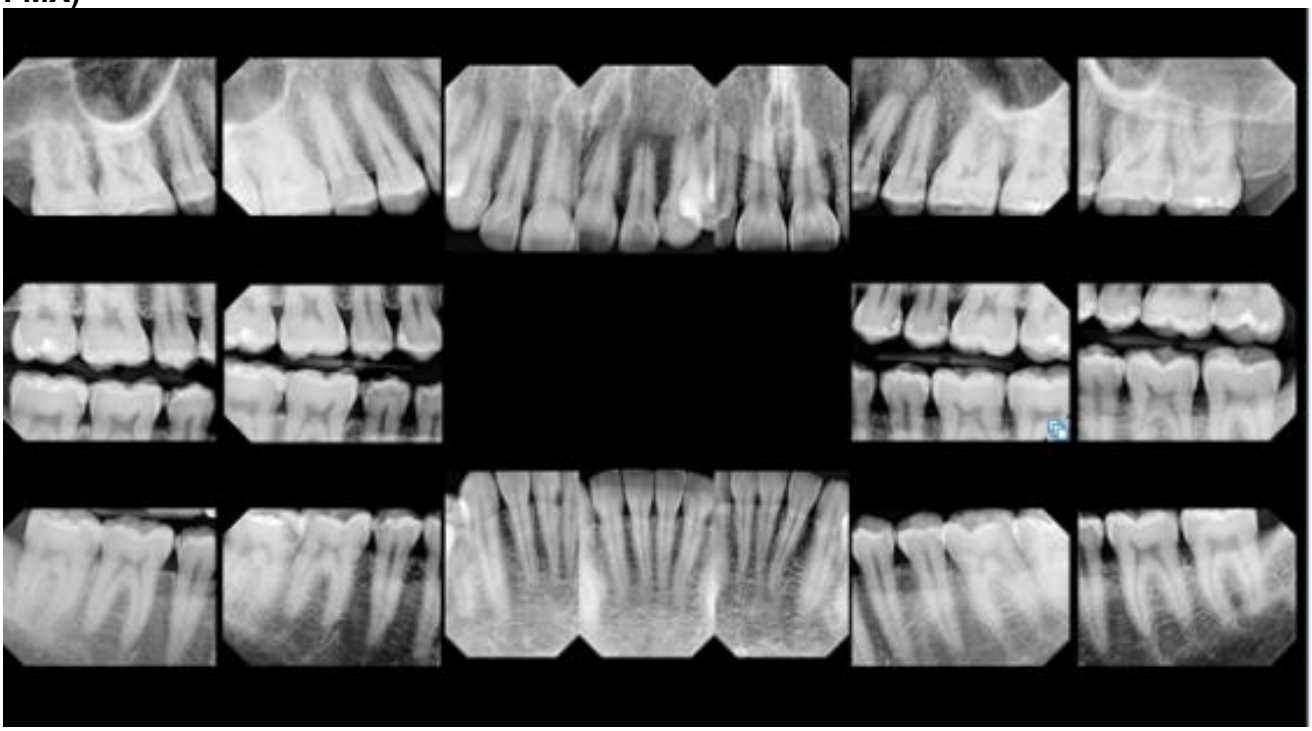
Examples of good diagnostic-quality bitewing radiographic images

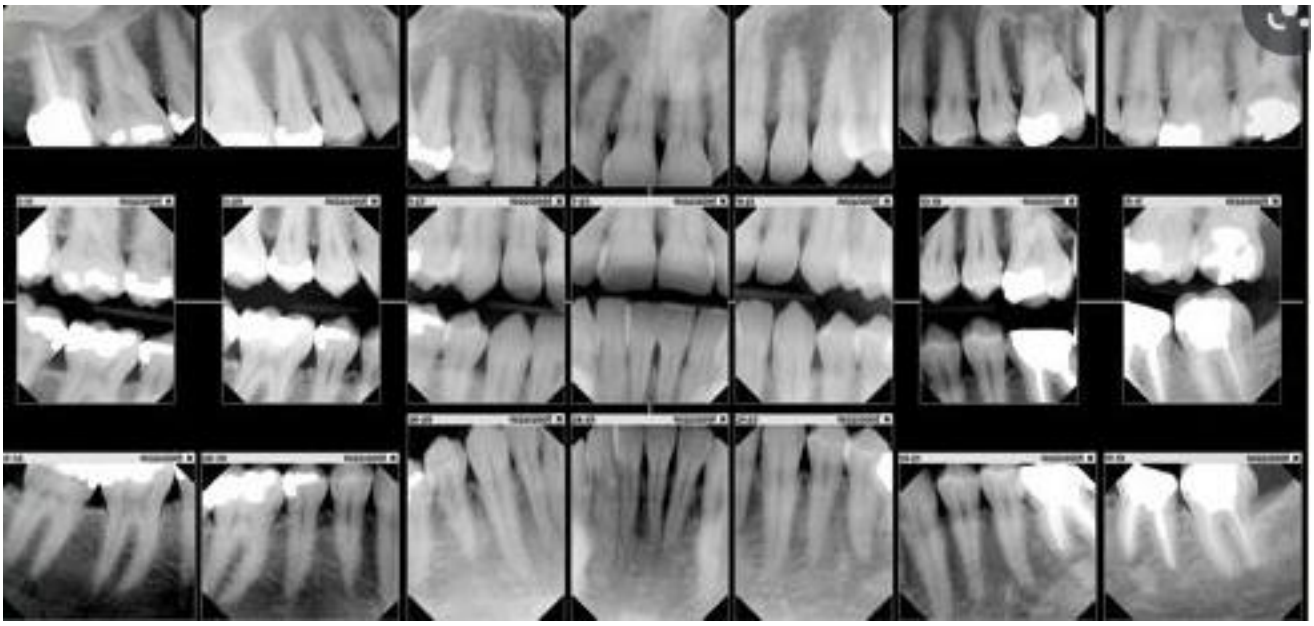


Examples of good diagnostic-quality vertical bitewings radiographic images

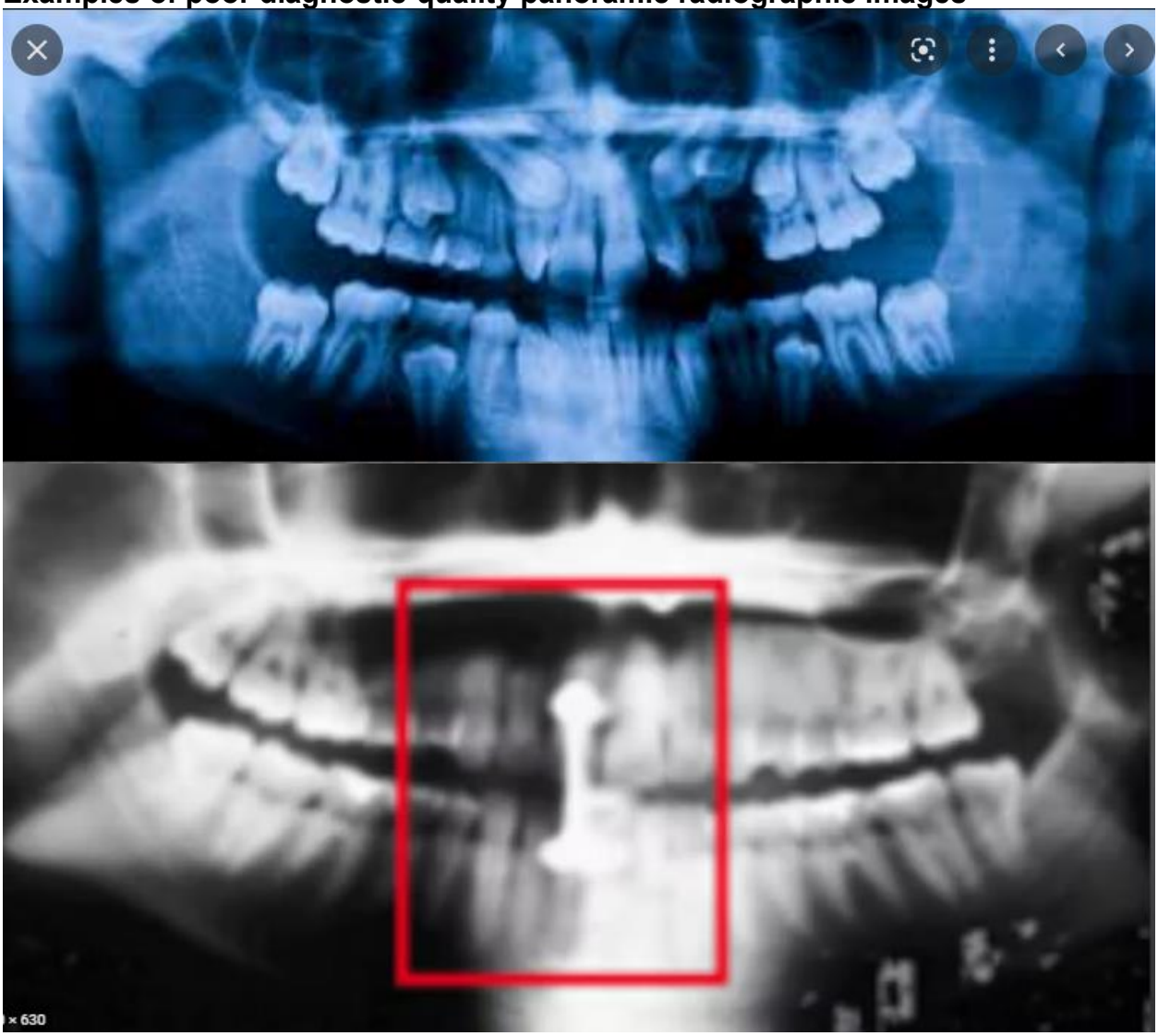


Examples of good diagnostic-quality intraoral – complete series of radiographic images (i.e., FMX)

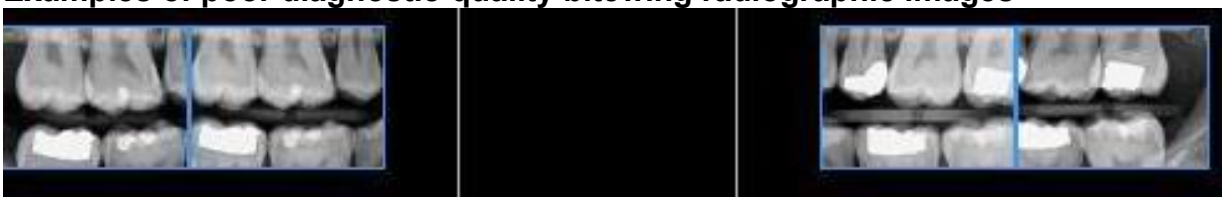


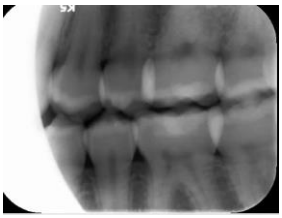


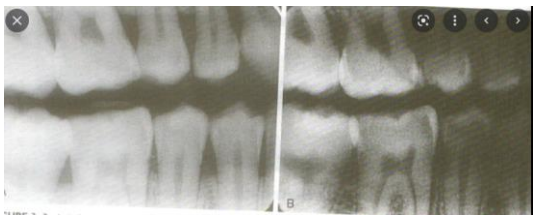
Examples of poor diagnostic-quality panoramic radiographic images



Examples of poor diagnostic-quality bitewing radiographic images







Network Bulletin

Date: October 2023

From: Anna Huck, Director, Network Management, Dental

Subject: CDT® 2024 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2024[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2024**. We've listed them below.

Fee information for the new CDT 2024 codes

Your rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2024 Code[1]	Nomenclature	Contracted Fees for CDT 2024 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered.
D1000 - D1999	**II. Preventive**	
D1301	immunization counseling	Not Covered
D2000 – D2999	**III. Restorative**	
D2976	band stabilization – per tooth	Not Covered
D2989	excavation of a tooth resulting in the determination of non-restorability	50% of negotiated fee for D2140
D2991	application of hydroxyapatite regeneration medicament – per tooth	150% of negotiated fee for D1354

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CDT 2024 Code[1]	Nomenclature	Contracted Fees for CDT 2024 codes are based on the following:
D6000-D6199	**VIII. Implant Services**	
D6089	accessing and retorquing loose implant screw - per screw	40% of negotiated fee for D6096
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7284	excisional biopsy of minor salivary glands	150% of negotiated fee for D7286
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	Not Covered
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	Not Covered
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Not Covered
D9955	oral appliance therapy (OAT) titration visit	Not Covered
D9956	administration of home sleep apnea test	Not Covered
D9957	screening for sleep related breathing disorders	Not Covered

Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - M

ADA Code[1]	A	B	C	D	E	F	G	H	I	J Ji	K	L -LM Li	M Mi
D0396	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	0	0	0	0	0	0	0	0	0	0	0	0	0
D2991	0	0	0	0	0	0	0	0	0	0	0	0	0
D6089	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D7284	0	0	0	0	0	0	0	0	0	0	0	0	0
D7939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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COINSURANCE PLAN CODES
Q - U

ADA Code[1]	Q	R	U Ui	UAB	UNJ
D0396	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C
D2989	0	0	0	0	0
D2991	0	0	0	0	0
D6089	25%	N/C	0	0	0
D7284	0	0	0	0	0
D7939	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C

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COINSURANCE PLAN CODES
1 – 14i

ADA Code[1]	1 1i	2 2i	2BA	3	4	5	6	7	8 8i	10 10i	12	14i
D0396	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	20%	20%	20%	50%	20%	75%	50%	0	10%	20%	0	10%
D2991	0	0	0	0	0	0	0	0	0	0	0	0
D6089	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D7284	0	0	0	0	0	0	0	0	0	0	0	0
D7939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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COINSURANCE PLAN CODES
21 – 26

ADA Code[1]	21	22	23	24	25	26
D0396	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C
D2989	10%	20%	10%	20%	0	0
D2991	0	0	10%	20%	0	0
D6089	10%	20%	10%	20%	25%	40%
D7284	0	0	10%	20%	0	0
D7939	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C

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FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D0396	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C
D2989	$0	N/C	$8	$8
D2991	$0	$0	$0	$0
D6089	N/C	N/C	N/C	N/C
D7284	$38	N/C	N/C	$60
D7939	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C

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FIXED COPAY PLAN CODES
41 – 59i

ADA Code[1]	41	41S	42	51	52	53 53i	54	55 55A	56	56H	56X	57 57i	58	59i
D0396	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	$11	$0	$11	$11	$10	$8	$5	$0	$0	$0	$0	$0	$0	$0
D2991	$15	$15	$15	$15	$15	$12	$0	$0	$0	$0	$0	$15	$8	$0
D6089	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7284	$150	$150	$150	$150	$135	$120	$45	$30	$30	$30	$30	$120	$45	$30
D7939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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FIXED COPAY PLAN CODES
63 – 68i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i
D0396	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C
D2989	$8	$5	$0	$0	$0	$0
D2991	$12	$0	$0	$0	$15	$8
D6089	N/C	N/C	N/C	N/C	N/C	N/C
D7284	$300	$113	$75	$75	$120	$113
D7939	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C

[1]Current Dental Terminology.

FIXED COPAY PLAN CODES
73 – 78i, CAM/CMI, CAL/CLI, SFL/SFi

ADA Code[1]	73 73i	73S	74 74i	75F	75 75i	76 76i	77 77i	78 78i	CAM CMI	CAL CLI	SFL SFi
D0396	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1301	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	$10	$0	$6	$0	$0	$0	$0	$0	$0	$0	$0
D2991	$0	$0	$0	$0	$0	$0	$0	$0	$8	$15	$0
D6089	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7284	$293	$293	$125	$83	$83	$83	$132	$125	$53	$75	$83
D7939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9938	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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Network Bulletin

Date: October 2023
From: Anna Huck, Lead Director, Network Management
Subject: 1) Discontinue upgrade for posterior resin/composite
2) Discontinue of Initial placement rule

1) Effective January 1, 2024**, posterior resin/composite restorations will no longer be subject to an upgrade. DMO® patients will only be responsible for the copayment based on the service performed. This applies to percentage-based co-insurance plans and fixed copay plans.

Coinsurance plans are defined as A-Z and 1-26
Fixed copay plans are defined as 34-78 and CAM/CMI, CAL/CLI, SLF/SFi

For percentage-based co-insurance plans, Aetna will pay a supplemental benefit to your office for posterior resin/composite restorations as shown below:

CDT® Procedure Code	Reimbursement amount (paid to you by Aetna)
D2391	$35
D2392	$40
D2393	$50
D2394	$75

To receive the supplemental payment, you must submit an encounter.

2) Effective January 1, 2024**, Aetna has removed the initial placement rule – tooth missing but not replaced for removable complete or partial dentures, fixed bridges, and other prosthetic services for all DMO plans.

WA effective February 1, 2024

We're here to help

If you have questions, call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental® plans.

Network Bulletin

Date: July 2023

From: Anna Huck, Lead Director, Network Management

Subject: Claims administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following change that will take effect for all Aetna Dental plans on November 1, 2023.

D4355 – Full Mouth Debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit

- D4355 is no longer a separately eligible procedure when performed on same date of service as D0150, D0160, D0180, D1110, D1120, D4341, D4342 and D4366
- Members cannot be billed

We're here to help
If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

MD-2173-21

Network Bulletin

Date: April 2023

From: Anna Huck, Lead Director, Network Management

Subject: Claims administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following change that will take effect for all Aetna Dental plans on August 1, 2023.

D2975 – Coping. A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.

Aetna considers D2975 inclusive to the primary restorative or prosthetic service. Members cannot be billed.

We're here to help
If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

MD-2173-21

Network Bulletin

Date: December 2022

From: Anna Huck, Lead Director, Network Management

Subject: Claim administration policy change

Applies to: DMO® Plans

Effective 4/1/2023, D4341 and D4342 have been added to the DMO list of services that will be allowed for future D4910.

CDT* Code	Procedure
D4210	D4210 - Gingivectomy or Gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (Dental in Nature)
D4211	D4211 - Gingivectomy or Gingivoplasty - one to three teeth contiguous teeth or tooth bounded spaces per quadrant (Dental in Nature)
D4240	D4240 - Gingival Flap Procedure, including Root Planing - four or more contiguous teeth or tooth bounded spaces per quadrant (Dental in Nature)
D4241	D4241 - Gingival Flap Procedure, including Root Planing - one to three contiguous teeth or tooth bounded spaces per quadrant (Dental in Nature)
D4260	D4260 - Osseous Surgery (Including flap entry and closure) - four or more contiguous teeth or tooth bounded teeth spaces per quadrant (Dental in Nature)
D4261	D4261 - Osseous Surgery (Including Flap Entry and Closure) - one to three teeth or tooth bounded spaces per quadrant (Dental in Nature)
D4341	D4341 - Periodontal Scaling and Root Planing, four or more teeth per quadrant
D4342	D4342 - Periodontal Scaling and Root Planing - one to three teeth per quadrant

We're here to help

If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

Network Bulletin

Date: November 2022

From: Anna Huck, Director, Network Management, Dental

Subject: CDT® 2023 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CD 2023[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2023**. We've listed them below.

Fee information for the new CDT 2023 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	100% of negotiated fee for D0210
D0373	intraoral tomosynthesis – bitewing radiographic image	100% of negotiated fee for D0270
D0374	intraoral tomosynthesis – periapical radiographic image	100% of negotiated fee for D0220
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	100% of negotiated fee for D0709
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	100% of negotiated fee for D0708
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	100% of negotiated fee for D0707
D0801	3D dental surface scan – direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D0802	3D dental surface scan – indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D0803	3D facial surface scan – direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D0804	3D facial surface scan – indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D1000 - D1999	**II. Preventive**	
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	Not Covered
D1709	Moderna Covid-19 vaccine administration – third dose	Not Covered
D1710	Moderna Covid-19 vaccine administration – third dose	Not Covered
D1711	Moderna Covid-19 vaccine administration – booster dose	Not Covered
D1712	Janssen Covid-19 vaccine administration - booster dose	Not Covered
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	Not Covered
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	Not Covered
D1781	vaccine administration – human papillomavirus – Dose 1	Not Covered
D1782	vaccine administration – human papillomavirus – Dose 2	Not Covered
D1783	vaccine administration – human papillomavirus – Dose 3	Not Covered
D4000-D4999	**V. Periodontics**	
D4286	removal of non-resorbable barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site
D6000-D6199	**VIII. Implant Services**	
D6105	removal of implant body not requiring bone removal or flap elevation	Not Covered
D6106	guided tissue regeneration – resorbable barrier, per implant	Not Covered
D6107	guided tissue regeneration – non-resorbable barrier, per implant	Not Covered
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	100% of negotiated fee for D2391
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7509	marsupialization of odontogenic cyst	100% of negotiated fee for D7450

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	Not Covered
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9953	reline custom sleep apnea appliance (indirect)	Not Covered

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Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - M

ADA Code[1]	A	B	C	D	E	F	G	H	I	J Ji	K	L -LM Li	M Mi
D0372	0	0	0	0	0	0	0	0	0	0	0	0	0
D0373	0	0	0	0	0	0	0	0	0	0	0	0	0
D0374	0	0	0	0	0	0	0	0	0	0	0	0	0
D0387	0	0	0	0	0	0	0	0	0	0	0	0	0
D0388	0	0	0	0	0	0	0	0	0	0	0	0	0
D0389	0	0	0	0	0	0	0	0	0	0	0	0	0
D0801	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4286	0	0	0	0	0	0	0	0	0	0	0	0	0
D6105	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6197	0	0	0	0	0	0	0	0	0	0	0	0	0
D7509	0	0	0	0	0	0	0	0	0	0	0	0	0
D7956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
Q - U

ADA Code[1]	Q	R	U Ui	UAB	UNJ
D0372	0	0	0	0	0
D0373	0	0	0	0	0
D0374	0	0	0	0	0
D0387	0	0	0	0	0
D0388	0	0	0	0	0
D0389	0	0	0	0	0
D0801	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C
D4286	0	0	0	0	0
D6105	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C
D6197	0	0	0	0	0
D7509	0	0	0	0	0
D7956	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
1 – 14i

ADA Code[1]	1 1i	2 2i	2BA	3	4	5	6	7	8 8i	10 10i	12	14i
D0372	0	0	0	0	0	0	0	0	0	0	0	0
D0373	0	0	0	0	0	0	0	0	0	0	0	0
D0374	0	0	0	0	0	0	0	0	0	0	0	0
D0387	0	0	0	0	0	0	0	0	0	0	0	0
D0388	0	0	0	0	0	0	0	0	0	0	0	0
D0389	0	0	0	0	0	0	0	0	0	0	0	0
D0801	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4286	0	0	0	0	0	0	0	0	0	0	0	0
D6105	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6197	20%	20%	20%	50%	20%	75%	50%	0	10%	20%	0	10%
D7509	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D7956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
21 – 26

ADA Code[1]	21	22	23	24	25	26
D0372	0	0	10%	20%	0	0
D0373	0	0	10%	20%	0	0
D0374	0	0	10%	20%	0	0
D0387	0	0	10%	20%	0	0
D0388	0	0	10%	20%	0	0
D0389	0	0	10%	20%	0	0
D0801	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C
D4286	0	0	0	0	0	0
D6105	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C
D6197	0	0	10%	20%	0	0
D7509	0	0	10%	20%	0	0
D7956	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D0372	$0	$0	$0	$0
D0373	$0	$0	$0	$0
D0374	$0	$0	$0	$0
D0387	$0	$0	$0	$0
D0388	$0	$0	$0	$0
D0389	$0	$0	$0	$0
D1708	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C
D4286	N/C	N/C	N/C	N/C
D6105	$10	N/C	N/C	$18
D6106	$90	N/C	N/C	$120
D6107	$90	N/C	N/C	$135
D6197	$15	N/C	$25	$25
D7509	$60	N/C	N/C	$90
D7956	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C
D9953	$40	N/C	N/C	$60

FIXED COPAY PLAN CODES
41 – 59i

ADA Code[1]	41	41S	42	51	52	53 53i	54	55 55A	56	56H	56X	57 57i	58	59i
D0372	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0373	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0374	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0387	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0388	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0801	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4286	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6105	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6197	$22	$22	$22	$22	$20	$16	$10	$0	$0	$0	$0	$0	$0	$0
D7509	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
63 – 68i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i
D0372	$0	$0	$0	$0	$0	$0
D0373	$0	$0	$0	$0	$0	$0
D0374	$0	$0	$0	$0	$0	$0
D0387	$0	$0	$0	$0	$0	$0
D0388	$0	$0	$0	$0	$0	$0
D0389	$0	$0	$0	$0	$0	$0
D0801	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C
D4286	$0	$0	$0	$0	$0	$0
D6105	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C
D6197	$45	$35	$35	$35	$35	$35
D7509	N/C	N/C	N/C	N/C	N/C	N/C
D7956	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
73 – 78i, CAM/CMI, CAL/CLI, SFL/SFi

ADA Code[1]	73 73i	73S	74 74i	75F	75 75i	76 76i	77 77i	78 78i	CAM CMI	CAL CLI	SFL SFi
D0372	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0373	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0374	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0387	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0388	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0801	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1708	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1709	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1710	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1711	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1712	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1713	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1714	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1782	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1783	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4286	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6105	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6197	$63	$63	$49	$46	$49	$49	$49	$49	$20	$35	$30
D7509	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9953	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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Network Bulletin

Date: December 2021

From: Anna Huck, Director, Dental Network Operations

Subject: CDT 2022 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2022[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2022**. We've listed them below.

Fee information for the new CDT 2022 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2022 Code[1]	Nomenclature	Contracted Fees for CDT 2022 codes are based on the following:
D3000-D3999	**IV. Endodontics**	
D3911	Intraorifice Barrier	Inclusive to root canals
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered
D4000-D4999	**V. Periodontics**	
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered
D5000-D5999	**VI. Prosthodontics (Removable)**	
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	100% of negotiated fee for D5225
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	100% of negotiated fee for D5226

CDT 2022 Code[1]	Nomenclature	Contracted Fees for CDT 2022 codes are based on the following:
D5725	Rebase Hybrid Prosthesis	100% of negotiated fee for D5720
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect	100% of negotiated fee midpoint for D5750/D5760
D6000-D6199	**VIII. Implant Services**	
D6198	Remove Interim Implant Component	Inclusive to permanent restoration
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D7300	Removal of Temporary Anchorage Device, Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D9000-D9999	**XII. Adjunctive General Services**	
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered

Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - M

ADA Code[1]	A	B	C	D	E	F	G	H	I	J Ji	K	L -LM Li	M Mi
D3911	0	0	0	0	0	0	0	0	0	0	0	0	0
D3921	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5227	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D5228	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D5725	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D5765	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6198	0	0	0	0	0	0	0	0	0	0	0	0	0
D7298	0	0	0	0	0	0	0	0	0	0	0	0	0
D7299	0	0	0	0	0	0	0	0	0	0	0	0	0
D7300	0	0	0	0	0	0	0	0	0	0	0	0	0
D9912	0	0	0	0	0	0	0	0	0	0	0	0	0
D9947	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
Q - U

ADA Code[1]	Q	R	U Ui	UAB	UNJ
D3911	0	0	0	0	0
D3921	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C
D5227	25%	N/C	0	0	0
D5228	25%	N/C	0	0	0
D5725	25%	N/C	0	0	0
D5765	25%	N/C	0	0	0
D6198	0	0	0	0	0
D7298	0	0	0	0	0
D7299	0	0	0	0	0
D7300	0	0	0	0	0
D9912	0	0	0	0	0
D9947	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
1 – 14i

ADA Code[1]	1 1i	2 2i	2BA	3	4	5	6	7	8 8i	10 10i	12	14i
D3911	0	0	0	0	0	0	0	0	0	0	0	0
D3921	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5227	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D5228	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D5725	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D5765	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6198	0	0	0	0	0	0	0	0	0	0	0	0
D7298	0	0	0	0	0	0	0	0	0	0	0	0
D7299	0	0	0	0	0	0	0	0	0	0	0	0
D7300	0	0	0	0	0	0	0	0	0	0	0	0
D9912	0	0	0	0	0	0	0	0	0	0	0	0
D9947	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

COINSURANCE PLAN CODES
21 – 26

ADA Code[1]	21	22	23	24	25	26
D3911	0	0	0	0	0	0
D3921	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C
D5227	10%	20%	10%	20%	25%	40%
D5228	10%	20%	10%	20%	25%	40%
D5725	10%	20%	10%	20%	25%	40%
D5765	10%	20%	10%	20%	25%	40%
D6198	0	0	0	0	0	0
D7298	0	0	0	0	0	0
D7299	0	0	0	0	0	0
D7300	0	0	0	0	0	0
D9912	0	0	0	0	0	0
D9947	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D3911	$0	$0	$0	$0
D3921	N/C	N/C	N/C	N/C
D4322	$0	N/C	N/C	$25
D4323	$0	N/C	N/C	$25
D5227	$300	N/C	N/C	$445
D5228	$300	N/C	N/C	$445
D5725	$85	N/C	N/C	$130
D5765	$40	N/C	N/C	$60
D9912	$0	$0	$0	$0
D9947	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
41 – 59i

ADA Code[1]	41	41S	42	51	52	53 53i	54	55 55A	56	56H	56X	57 57i	58	59i
D3911	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3921	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5227	$613	$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165
D5228	$613	$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165
D5725	$173	$173	$173	$95	$86	$86	$86	$86	$86	$45	$86	$86	$86	$86
D5765	$145	$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D6198	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7298	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7299	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7300	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9912	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9947	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
63 – 68i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i
D3911	$0	$0	$0	$0	$0	$0
D3921	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C
D5227	$360	$330	$330	$240	$384	$330
D5228	$360	$330	$330	$240	$384	$330
D5725	$100	$100	$100	$100	$100	$100
D5765	$114	$102	$90	$48	$100	$102
D6198	$0	$0	$0	$0	$0	$0
D7298	$0	$0	$0	$0	$0	$0
D7299	$0	$0	$0	$0	$0	$0
D7300	$0	$0	$0	$0	$0	$0
D9912	$0	$0	$0	$0	$0	$0
D9947	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
73 – 78i, CAM/CMI, CAL/CLI, SFL/SFi

ADA Code[1]	73 73i	73S	74 74i	75F	75 75i	76 76i	77 77i	78 78i	CAM CMi	CAL CLi	SFL SFi
D3911	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3921	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4322	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5227	$396	$396	$363	$363	$363	$264	$422	$363	$150	$175	$394
D5228	$396	$396	$363	$363	$363	$264	$422	$363	$150	$175	$394
D5725	$110	$110	$110	$110	$110	$110	$110	$110	$50	$95	$160
D5765	$125	$125	$112	$35	$99	$53	$110	$112	$40	$50	$90
D6198	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7298	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7299	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7300	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9912	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9947	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9499	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

Network Bulletin

Date: September 2021

From: Anna Huck, Director, Network Management

Subject: Claim administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following changes that will take effect for all Aetna Dental® plans on **January 1, 2022**:

D9910 – Application of desensitizing medicament - Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.

Based on above descriptor, we consider D9910 inclusive with the restoration being performed on the same day of service. Members cannot be billed for this service.

We're here to help

If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

Network Bulletin

Date: October 2020

From: Michelle Neuman, Senior Director, Dental Network Operations

Subject: CDT 2021 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2021[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2021**. We've listed them below.

Fee information for the new CDT 2021 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2021 Code[1]	Nomenclature	Contracted Fees for CDT 2021 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered
D0701	Panoramic radiographic image – image capture only	40% of negotiated fee for D0330
D0702	2-D cephalometric radiographic image – image capture only	40% of negotiated fee for D0340
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	40% of negotiated fee for D0350
D0704	3-D photographic image – image capture only	40% of negotiated fee for D0351
D0705	Extra-oral posterior dental radiographic image – image capture only	10% of negotiated fee for D0251

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.
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MD-2034-20

CDT 2021 Code[1]	Nomenclature	Contracted Fees for CDT 2021 codes are based on the following:
D0706	Intraoral – occlusal radiographic image – image capture only	10% of negotiated fee for D0240
D0707	Intraoral – periapical radiographic image – image capture only	5% of negotiated fee for D0220
D0708	Intraoral – bitewing radiographic image – image capture only	10% of negotiated fee for D0708
D0709	Intraoral – complete series of radiographic images – image capture only	40% of negotiated fee for D0210
D1000 - D1999	**II. Preventive**	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Not Covered
D1355	Caries preventive medicament application – per tooth	80% of negotiated fee for D1354
D2000-D2999	**III. Restorative**	
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.
D3000-D3999	**IV. Endodontics**	
D3471	Surgical repair of root resorption - anterior	60% of negotiated fee for D3427
D3472	Surgical repair of root resorption – premolar	80% of negotiated fee for D3427
D3473	Surgical repair of root resorption – molar	100% of negotiated fee for D3427
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	60% of negotiated fee for D4245
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	80% of negotiated fee for D4245
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	100% of negotiated fee for D4245
D5000-D5999	**VI. Prosthodontics (Removable)**	
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered
D6000-D6199	**VIII. Implant Services**	
D6191	Semi-precision abutment – placement	Not Covered
D6192	Semi-precision attachment – placement	Not Covered
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7961	Buccal / labial frenectomy (frenulectomy)	100% of negotiated fee for D7960
D7962	Lingual frenectomy (frenulectomy)	100% of negotiated fee for D7960

Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - M

ADA Code[1]	A	B	C	D	E	F	G	H	I	J Ji	K	L -LM Li	M Mi
D0604	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	0	0	0	0	0	0	0	0	0	0	0	0	0
D0702	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	0	0	0	0	0	0	0	0	0	0	0	0	0
D0706	0	0	0	0	0	0	0	0	0	0	0	0	0
D0707	0	0	0	0	0	0	0	0	0	0	0	0	0
D0708	0	0	0	0	0	0	0	0	0	0	0	0	0
D0709	0	0	0	0	0	0	0	0	0	0	0	0	0
D1321	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1355	0	0	0	0	0	0	0	0	0	0	0	0	0
D2928	0	0	0	0	0	0	0	0	0	0	0	0	0
D3471	0	0	0	0	0	0	0	0	0	0	0	0	0
D3472	0	0	0	0	0	0	0	0	0	0	0	0	0
D3473	0	0	0	0	0	0	0	0	0	0	0	0	0
D3501	0	0	0	0	0	0	0	0	0	0	0	0	0
D3502	0	0	0	0	0	0	0	0	0	0	0	0	0
D3503	0	0	0	0	0	0	0	0	0	0	0	0	0
D5995	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	0	0	0	0	0	0	0	0	0	0	0	0	0
D7962	0	0	0	0	0	0	0	0	0	0	0	0	0

COINSURANCE PLAN CODES
Q - U

ADA Code[1]	Q	R	U Ui	UAB	UNJ
D0604	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C
D0701	0	0	0	0	0
D0702	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C
D0705	0	0	0	0	0
D0706	0	0	0	0	0
D0707	0	0	0	0	0
D0708	0	0	0	0	0
D0709	0	0	0	0	0
D1321	N/C	N/C	N/C	N/C	N/C
D1355	0	0	0	0	0
D2928	0	0	0	0	0
D3471	0	0	0	0	0
D3472	0	0	0	0	0
D3473	0	0	0	0	0
D3501	0	0	0	0	0
D3502	0	0	0	0	0
D3503	0	0	0	0	0
D5995	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C
D7961	0	0	0	0	0
D7962	0	0	0	0	0

COINSURANCE PLAN CODES
1 – 14

ADA Code[1]	1 1i	2 2i	2BA	3	4	5	6	7	8 8i	10 10i	12	14i
D0604	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	0	0	0	0	0	0	0	0	0	0	0	0
D0702	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	0	0	0	0	0	0	0	0	0	0	0	0
D0706	0	0	0	0	0	0	0	0	0	0	0	0
D0707	0	0	0	0	0	0	0	0	0	0	0	0
D0708	0	0	0	0	0	0	0	0	0	0	0	0
D0709	0	0	0	0	0	0	0	0	0	0	0	0
D1321	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1355	0	0	0	0	0	0	0	0	0	0	0	0
D2928	0	0	0	0	0	0	0	0	0	0	0	0
D3471	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D3472	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D3473	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D3501	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D3502	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D3503	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D5995	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D7962	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%

COINSURANCE PLAN CODES
21 – 26

ADA Code[1]	21	22	23	24	25	26
D0604	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C
D0701	0	0	10%	20%	0	0
D0702	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C
D0705	0	0	10%	20%	0	0
D0706	0	0	10%	20%	0	0
D0707	0	0	10%	20%	0	0
D0708	0	0	10%	20%	0	0
D0709	0	0	10%	20%	0	0
D1321	N/C	N/C	N/C	N/C	N/C	N/C
D1355	0	0	10%	20%	0	0
D2928	0	0	0	0	0	0
D3471	10%	20%	10%	20%	0	0
D3472	10%	20%	10%	20%	0	0
D3473	10%	20%	10%	20%	0	0
D3501	10%	20%	10%	20%	0	0
D3502	10%	20%	10%	20%	0	0
D3503	10%	20%	10%	20%	0	0
D5995	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C
D7961	10%	20%	10%	20%	0	0
D7962	10%	20%	10%	20%	0	0

FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D0604	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C
D0701	$0	$0	$0	$0
D0705	$0	$0	$0	$0
D0706	$0	$0	$0	$0
D0707	$0	$0	$0	$0
D0708	$0	$0	$0	$0
D0709	$0	$0	$0	$0
D1321	N/C	N/C	N/C	N/C
D1355	$0	$0	$0	$0
D2928	$49	N/C	$69	$69
D3471	$54	N/C	N/C	$81
D3472	$72	N/C	N/C	$108
D3473	$90	N/C	N/C	$135
D3501	$54	N/C	N/C	$78
D3502	$72	N/C	N/C	$104
D3503	$90	N/C	N/C	$130
D5995	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C
D7961	$60	N/C	N/C	$90
D7962	$60	N/C	N/C	$90

FIXED COPAY PLAN CODES
41 – 58

ADA Code[1]	41	42	51	52	53 53i	54	55 55A	56	56H	56X	57	58
D0604	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0702	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0706	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0707	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0708	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0709	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D1321	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1355	$8	$8	$8	$8	$6	$0	$0	$0	$0	$0	$8	$4
D2928	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3471	$70	$70	$70	$63	$59	$38	$27	$0	$0	$0	$59	$38
D3472	$94	$94	$94	$84	$78	$51	$36	$0	$0	$0	$78	$51
D3473	$117	$117	$117	$105	$98	$64	$45	$0	$0	$0	$98	$64
D3501	$120	$120	$120	$96	$84	$66	$54	$42	$0	$42	$84	$66
D3502	$160	$160	$160	$128	$112	$88	$72	$56	$0	$56	$112	$88
D3503	$200	$200	$200	$160	$140	$110	$90	$70	$0	$70	$140	$110
D5995	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	$128	$128	$128	$110	$90	$34	$24	$24	$0	$0	$90	$34
D7962	$128	$128	$128	$110	$90	$34	$24	$24	$0	$0	$90	$34

FIXED COPAY PLAN CODES
63 – 68i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i
D0604	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C
D0701	$0	$0	$0	$0	$0	$0
D0702	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C
D0705	$0	$0	$0	$0	$0	$0
D0706	$0	$0	$0	$0	$0	$0
D0707	$0	$0	$0	$0	$0	$0
D0708	$0	$0	$0	$0	$0	$0
D0709	$0	$0	$0	$0	$0	$0
D1321	N/C	N/C	N/C	N/C	N/C	N/C
D1355	$6	$0	$0	$0	$8	$4
D2928	$0	$0	$0	$0	$0	$0
D3471	$64	$41	$29	$0	$77	$41
D3472	$85	$55	$39	$0	$102	$55
D3473	$106	$69	$49	$0	$128	$69
D3501	$84	$66	$54	$42	$84	$66
D3502	$112	$88	$72	$56	$112	$88
D3503	$140	$110	$90	$70	$140	$110
D5995	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C
D7961	$90	$34	$24	$24	$90	$34
D7962	$90	$34	$24	$24	$90	$34

FIXED COPAY PLAN CODES
73 – 78i, SFI – CLI

ADA Code[1]	73 73i	74 74i	75F	75 75i	76 76i	77 77i	78 78i	CAM CMi	CAL CLi	SFL SFi
D0604	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0702	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0704	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0706	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0707	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0708	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0709	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D1321	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1355	$0	$0	$0	$0	$0	$0	$0	$4	$8	$0
D2928	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3471	$67	$44	$31	$31	$0	$80	$44	$0	$0	$43
D3472	$89	$58	$41	$41	$0	$107	$58	$0	$0	$57
D3473	$111	$73	$51	$51	$0	$134	$73	$0	$0	$71
D3501	$88	$70	$57	$57	$44	$88	$70	$36	$54	$99
D3502	$118	$93	$76	$76	$59	$118	$93	$48	$72	$132
D3503	$147	$116	$95	$95	$74	$147	$116	$60	$90	$165
D5995	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	$99	$37	$26	$26	$26	$99	$37	$30	$50	$50
D7962	$99	$37	$26	$26	$26	$99	$37	$30	$50	$50

Network Bulletin

Date: May 1, 2020

From: Michelle Neuman, Senior Director, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. The following changes will start on **August 1, 2020** for all Aetna Dental® plans:

D0431 - ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES.

We consider the use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.

D4355 - DEBRIDEMENT, FULL MOUTH TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS

To align with the ADA descriptor of D4355, the following changes are being made to our claim processing policies:

- D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355.
- D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.

We're here to help
If you have questions, call us at **1-800-451-7715.** You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: October 2019

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: CDT 2020 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2020[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2020**. We've listed them below.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0419	Assessment of salivary flow by measurement	Not Covered
D1000 - D1999	**II. Preventive**	
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	100% of negotiated fee for D1550
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	100% of negotiated fee for D1550
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	50% of negotiated fee for D1550
D1556	Removal of fixed unilateral space maintainer – per quadrant	50% of negotiated fee for D1555
D1557	Removal of fixed bilateral space maintainer – maxillary	100% of negotiated fee for D1555
D1558	Removal of fixed bilateral space maintainer – mandibular	100% of negotiated fee for D1555
D2000-D2999	**III. Restorative**	
D2753	Crown - porcelain fused to titanium and titanium alloys	100% of negotiated fee for D2751

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.
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CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D5000-D5999	**VI. Prosthodontics (Removable)**	
D5284	Removable unilateral partial denture – one-piece flexible base (including clasps and teeth) – per quadrant	50% of negotiated fee for D5225
D5286	Removable unilateral partial denture – one-piece resin (including clasps and teeth) – per quadrant	50% of negotiated fee for D5211
D6000-D6199	**VIII. Implant Services**	
D6082	Implant supported crown – porcelain fused to predominantly base alloys	100% of negotiated fee for D6060
D6083	Implant supported crown – porcelain fused to noble alloys	100% of negotiated fee for D6061
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6066
D6086	Implant supported crown – predominantly base alloys	100% of negotiated fee for D6063
D6087	Implant supported crown – noble alloys	100% of negotiated fee for D6061
D6088	Implant supported crown – titanium and titanium alloys	100% of negotiated fee for D6063
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6751
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	100% of negotiated fee for D6073
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	100% of negotiated fee for D6061
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6084
D6121	Implant supported retainer for metal FPD – predominantly base alloys	100% of negotiated fee for D6086
D6122	Implant supported retainer for metal FPD – noble alloys	100% of negotiated fee for D6087
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	100% of negotiated fee for D6088
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6120
D6200-D6999	**IX. Prosthodontics, fixed**	
D6243	Pontic – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6241
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6751
D6784	Retainer crown ¾ – titanium and titanium alloys	100% of negotiated fee for D6781
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the primary service; Patient cannot be billed

CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D8000-D8999	**XI. Orthodontics**	
D8696	Repair of orthodontic appliance – maxillary	100% of negotiated fee for D8691
D8697	Repair of orthodontic appliance – mandibular	100% of negotiated fee for D8691
D8698	Re-cement or re-bond fixed retainer – maxillary	100% of negotiated fee for D8693
D8699	Re-cement or re-bond fixed retainer – mandibular	100% of negotiated fee for D8693
D8701	Repair of fixed retainer, includes reattachment – maxillary	100% of negotiated fee for D8694
D8702	Repair of fixed retainer, includes reattachment – mandibular	100% of negotiated fee for D8694
D8703	Replacement of lost or broken retainer – maxillary	Not Covered
D8704	Replacement of lost or broken retainer – mandibular	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service; Patient cannot be billed

Patient coinsurance/copay information for the new codes

Follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - M

ADA Code[1]	A	B	C	D	E	F	G	H	I	J Ji	K	L Li	M Mi
D0419	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1551	0	0	0	0	0	0	0	0	0	0	0	0	0
D1552	0	0	0	0	0	0	0	0	0	0	0	0	0
D1553	0	0	0	0	0	0	0	0	0	0	0	0	0
D1556	0	0	0	0	0	0	0	0	0	0	0	0	0
D1557	0	0	0	0	0	0	0	0	0	0	0	0	0
D1558	0	0	0	0	0	0	0	0	0	0	0	0	0
D2753	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D5284	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D5286	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6082	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6083	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6084	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6086	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6087	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6088	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6097	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6098	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6099	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6120	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6121	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6122	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6123	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6195	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6243	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6753	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D6784	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%
D7922	0	0	0	0	0	0	0	0	0	0	0	0	0
D9997	0	0	0	0	0	0	0	0	0	0	0	0	0

COINSURANCE PLAN CODES
Q - U

ADA Code[1]	Q	R	U Ui	UAB	UNJ
D0419	N/C	N/C	N/C	N/C	N/C
D1551	0	0	0	0	0
D1552	0	0	0	0	0
D1553	0	0	0	0	0
D1556	0	0	0	0	0
D1557	0	0	0	0	0
D1558	0	0	0	0	0
D2753	25%	N/C	0	0	0
D5284	25%	N/C	0	0	0
D5286	25%	N/C	0	0	0
D6082	25%	N/C	0	0	0
D6083	25%	N/C	0	0	0
D6084	25%	N/C	0	0	0
D6086	25%	N/C	0	0	0
D6087	25%	N/C	0	0	0
D6088	25%	N/C	0	0	0
D6097	25%	N/C	0	0	0
D6098	25%	N/C	0	0	0
D6099	25%	N/C	0	0	0
D6120	25%	N/C	0	0	0
D6121	25%	N/C	0	0	0
D6122	25%	N/C	0	0	0
D6123	25%	N/C	0	0	0
D6195	25%	N/C	0	0	0
D6243	25%	N/C	0	0	0
D6753	25%	N/C	0	0	0
D6784	25%	N/C	0	0	0
D7922	0	0	0	0	0
D9997	0	0	0	0	0

COINSURANCE PLAN CODES
1 – 14

ADA Code[1]	1 1i	2 2i	2BA	3	4	5	6	7	8 8i	10 10i	12	14i
D0419	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1551	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D1552	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D1553	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D1556	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D1557	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D1558	20%	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%
D2753	40%	50%	50%	50%	40%	75%	75%	20%	40%	40%	50%	40%
D5284	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D5286	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6082	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6083	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6084	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6086	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6087	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6088	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6097	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6098	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6099	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6120	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6121	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6122	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6123	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6195	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6243	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6753	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D6784	40%	50%	50%	50%	40%	75%	75%	50%	40%	40%	50%	40%
D7922	0	0	0	0	0	0	0	0	0	0	0	0
D9997	0	0	0	0	0	0	0	0	0	0	0	0

COINSURANCE PLAN CODES
21 – 26

ADA Code[1]	21	22	23	24	25	26
D0419	N/C	N/C	N/C	N/C	N/C	N/C
D1551	10%	20%	10%	20%	0	0
D1552	10%	20%	10%	20%	0	0
D1553	10%	20%	10%	20%	0	0
D1556	10%	20%	10%	20%	0	0
D1557	10%	20%	10%	20%	0	0
D1558	10%	20%	10%	20%	0	0
D2753	10%	20%	10%	20%	25%	40%
D5284	10%	20%	10%	20%	25%	40%
D5286	10%	20%	10%	20%	25%	40%
D6082	10%	20%	10%	20%	25%	40%
D6083	10%	20%	10%	20%	25%	40%
D6084	10%	20%	10%	20%	25%	40%
D6086	10%	20%	10%	20%	25%	40%
D6087	10%	20%	10%	20%	25%	40%
D6088	10%	20%	10%	20%	25%	40%
D6097	10%	20%	10%	20%	25%	40%
D6098	10%	20%	10%	20%	25%	40%
D6099	10%	20%	10%	20%	25%	40%
D6120	10%	20%	10%	20%	25%	40%
D6121	10%	20%	10%	20%	25%	40%
D6122	10%	20%	10%	20%	25%	40%
D6123	10%	20%	10%	20%	25%	40%
D6195	10%	20%	10%	20%	25%	40%
D6243	10%	20%	10%	20%	25%	40%
D6753	10%	20%	10%	20%	25%	40%
D6784	10%	20%	10%	20%	25%	40%
D7922	0	0	0	0	0	0
D9997	0	0	0	0	0	0

FIXED COPAY PLAN CODES
34 – 34C

ADA Code[1]	34	34A	34B	34C
D0419	N/C	N/C	N/C	N/C
D1551	$0	$0	$0	$0
D1552	$0	$0	$0	$0
D1553	$0	$0	$0	$0
D1556	$0	$0	$0	$0
D1557	$0	$0	$0	$0
D1558	$0	$0	$0	$0
D2753	$200	N/C	$295	$295
D5284	$150	N/C	N/C	$223
D5286	$125	N/C	N/C	$185
D6082	N/C	N/C	N/C	N/C
D6083	N/C	N/C	N/C	N/C
D6084	N/C	N/C	N/C	N/C
D6086	N/C	N/C	N/C	N/C
D6087	N/C	N/C	N/C	N/C
D6088	N/C	N/C	N/C	N/C
D6097	$200	N/C	N/C	$295
D6098	N/C	N/C	N/C	N/C
D6099	N/C	N/C	N/C	N/C
D6120	N/C	N/C	N/C	N/C
D6121	N/C	N/C	N/C	N/C
D6122	N/C	N/C	N/C	N/C
D6123	N/C	N/C	N/C	N/C
D6195	N/C	N/C	N/C	N/C
D6243	$200	N/C	N/C	$295
D6753	$200	N/C	N/C	$295
D6784	$200	N/C	N/C	$295
D7922	$0	$0	$0	$0
D9997	$0	$0	$0	$0

FIXED COPAY PLAN CODES
41 – 58

ADA Code[1]	41	42	51	52	53 53i	54	55 55A	56	56H	56X	57	58
D0419	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1551	$15	$15	$15	$15	$15	$12	$12	$12	$0	$0	$15	$12
D1552	$15	$15	$15	$15	$15	$12	$12	$12	$0	$0	$15	$12
D1553	$8	$8	$8	$8	$8	$6	$6	$6	$0	$0	$8	$6
D1556	$8	$8	$8	$8	$8	$6	$6	$6	$6	$6	$8	$6
D1557	$15	$15	$15	$15	$15	$12	$12	$12	$12	$12	$15	$12
D1558	$15	$15	$15	$15	$15	$12	$12	$12	$12	$12	$15	$12
D2753	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D5284	$307	$307	$225	$192	$180	$165	$150	$111	$83	$83	$180	$165
D5286	$257	$257	$188	$160	$150	$138	$125	$93	$83	$83	$150	$138
D6082	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6083	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6084	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D6086	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6087	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6088	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6097	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D6098	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6099	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6120	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D6121	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6122	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6123	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6195	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D6243	$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210
D6753	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D6784	$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210
D7922	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9997	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

FIXED COPAY PLAN CODES
63 – 78i, SFI – CLI

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i	CAM CMi	CAL CLi	SFL SFi
D0419	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1551	$15	$12	$12	$12	$15	$12	$15	$12	$12	$12	$15	$12	$10	$15	$12
D1552	$15	$12	$12	$12	$15	$12	$15	$12	$12	$12	$15	$12	$10	$15	$12
D1553	$8	$6	$6	$6	$8	$6	$8	$6	$6	$6	$8	$6	$5	$8	$6
D1556	$8	$6	$6	$6	$8	$6	$8	$6	$6	$6	$8	$6	$5	$8	$6
D1557	$15	$12	$12	$12	$15	$12	$15	$12	$12	$12	$15	$12	$10	$15	$12
D1558	$15	$12	$12	$12	$15	$12	$15	$12	$12	$12	$15	$12	$10	$15	$12
D2753	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D5284	$180	$165	$165	$120	$192	$165	$198	$182	$182	$132	$211	$182	$75	$88	$197
D5286	$150	$138	$138	$100	$160	$138	$174	$159	$159	$116	$185	$159	$63	$88	$195
D6082	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6083	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6084	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6086	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6087	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6088	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6097	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6098	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6099	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6120	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6121	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6122	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6123	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$200	$200	$250
D6195	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6243	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6753	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D6784	$315	$255	$225	$180	$315	$255	$362	$293	$259	$207	$362	$293	$125	$175	$250
D7922	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9997	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Network Bulletin

Date: December 2018

Subject: Pre-Determination of Benefits for All Aetna California DMO® Providers

From: Michelle Neuman, Senior Director, Dental Network Management

To: Participating DMO Dentists

Applies to: Dental Office Guide and Specialty Dental Office Guide

This bulletin is part of your Dental Office Guide or Specialty Dental Office Guide. After you review this information, place it in the Network Bulletin section of your guide for future reference.

No More Pre-Determinations for Aetna California DMO® plans

Starting January 1, 2019, we'll no longer accept pre-determination requests for dental benefits for members in Aetna Dental of California, Inc.'s DMO plans. Any claim received with undated claim lines (signifying a request for pre-determination) will be rejected.

The Dental Office Guide and Specialty Dental Office Guide have detailed information about members' DMO® benefits, including exclusions, limitations and co-payment amounts.

We're here to help

If you have questions, call us at **1-800-451-7715.** You can also visit **aetnadental.com** to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: September 2018

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: CDT 2019 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Aetna DMO® (Dental Maintenance Organization) plans

This bulletin is part of your *Dental Office Guide*.

New CDT® 2019[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2019**. We've listed them below.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2019 Code[1]	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0412	Blood glucose level test – in-office using a glucose meter	Not covered
D1000 - D1999	**II. Preventive**	
D1516	Space maintainer – fixed – bilateral, maxillary	100% of negotiated fee for D1515
D1517	Space maintainer – fixed – bilateral, mandibular	100% of negotiated fee for D1515
D1526	Space maintainer – removable – bilateral, maxillary	100% of negotiated fee for D1525
D1527	Space maintainer – removable – bilateral, mandibular	100% of negotiated fee for D1520
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	100% of negotiated fee for D5281
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	100% of negotiated fee for D5281

CDT 2019 Code[1]	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D5876	Add metal substructure to acrylic full denture (per arch)	100% of negotiated fee for D5512
D9000-D9999	**XII. Adjunctive General Services**	
D9130	Temporomandibular joint dysfunction – non-invasive physical therapies	Not covered
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$170.00
D9944	Occlusal guard – hard appliance, full arch	115% of negotiated fee for D9940
D9945	Occlusal guard – soft appliance, full arch	100% of negotiated fee for D9940
D9946	Occlusal guard – hard appliance, partial arch	60% of negotiated fee for D9940
D9961	Duplicate/copy patient's records	Not covered
D9990	Certified translation or sign-language services per visit	Not covered

Patient coinsurance/copay information for the new codes

Please follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES
A - U

ADA Code[1]		A	B	C	D	E	F	G	H	I	J	K	L Li	M Mi	Q	R	U
D0412		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1516	* #	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	N/C N/C	0 0
D1517	* #	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	N/C N/C	0 0
D1526	* #	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	N/C N/C	0 0
D1527	* #	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	N/C N/C	0 0
D5282		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5283		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5876		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D9130		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D9944		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D9945		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D9946		10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D9961		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

* Pre-Nov 2000 Plans (*) = 1st Copay
# DMO Standard Plans (#) = 2nd Copay

COINSURANCE PLAN CODES
1 – 26

ADA Code[1]		1	2 2i	3	4	5	6	7	8 8i	10 10i	12	21	22	23	24	25	26
D0412		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1516	* #	40% 0	50% 0	50% 0	40% 0	75% 0	75% 0	50% 0	40% 0	40% 0	50% 0	10% 0	20% 0	10% 0	20% 0	25% 0	40% 0
D1517	* #	40% 0	50% 0	50% 0	40% 0	75% 0	75% 0	50% 0	40% 0	40% 0	50% 0	10% 0	20% 0	10% 0	20% 0	25% 0	40% 0
D1526	* #	40% 0	50% 0	50% 0	40% 0	75% 0	75% 0	50% 0	40% 0	40% 0	50% 0	10% 0	20% 0	10% 0	20% 0	25% 0	40% 0
D1527	* #	40% 0	50% 0	50% 0	40% 0	75% 0	75% 0	50% 0	40% 0	40% 0	50% 0	10% 0	20% 0	10% 0	20% 0	25% 0	40% 0
D5282		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5283		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5876		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9130		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9944		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9945		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9946		40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9961		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

* Pre-Nov 2000 Plans (*) = 1st Copay
# DMO Standard Plans (#) = 2nd Copay

FIXED COPAY PLAN CODES
41 – 58

ADA Code[1]	41	42	51	52	53	54	55	56	57	58
D0412	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1516	$100	$100	$100	$85	$65	$60	$0	$0	$65	$60
D1517	$100	$100	$100	$85	$65	$60	$0	$0	$65	$60
D1526	$100	$100	$100	$85	$65	$60	$0	$0	$65	$60
D1527	$100	$100	$100	$85	$65	$60	$0	$0	$65	$60
D5282	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275
D5283	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275
D5876	$45	$45	$35	$30	$30	$25	$25	$25	$30	$25
D9130	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9944	$210	$210	$104	$81	$81	$81	$81	$81	$81	$81
D9945	$183	$183	$90	$70	$70	$70	$70	$70	$70	$70
D9946	$110	$110	$54	$42	$42	$42	$42	$42	$42	$42
D9961	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

FIXED COPAY PLAN CODES
63 – 78i, SFI – CLI

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i	SFL SFI	CAM CMI	CAL CLI
D0412	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1516	$80	$75	$0	$0	$80	$75	$92	$86	$0	$0	$92	$86	$0	$25	$60
D1517	$80	$75	$0	$0	$80	$75	$92	$86	$0	$0	$92	$86	$0	$25	$60
D1526	$80	$70	$0	$0	$80	$70	$92	$86	$0	$0	$92	$80	$0	$25	$60
D1527	$80	$70	$0	$0	$80	$70	$92	$86	$0	$0	$92	$80	$0	$25	$60
D5282	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318	$390	$125	$175
D5283	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318	$390	$125	$175
D5876	$36	$30	$30	$30	$40	$30	$40	$40	$40	$35	$45	$40	$40	$20	$30
D9130	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9944	$150	$115	$115	$115	$150	$115	$224	$173	$173	$173	$224	$173	$184	$144	$201
D9945	$130	$100	$100	$100	$130	$100	$195	$150	$150	$150	$195	$150	$160	$125	$175
D9946	$78	$60	$60	$60	$78	$60	$117	$90	$90	$90	$117	$90	$96	$75	$105
D9961	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

Network Bulletin

Date: **June 18, 2018**

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® plans

From time to time, we update our dental claims administration policies. The following changes will start on September 18, 2018 for all Aetna Dental® plans:

D2940* – Protective Restoration Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

> D2940 is no longer a separately eligible procedure when performed in conjunction with endodontic therapy on the same date of service. This procedure is included in the primary procedure and is therefore considered incidental to that procedure and does not warrant separate reimbursement. Members should not be billed for this service.

D7260* -- Oroantral Fistula Closure Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

> According to ADA CDT code nomenclature, D7260 - Oroantral Fistula Closure should not be billed when repairing a perforation on the same date as an extraction. The correct code would be D7261 – Primary Closure of a Sinus Perforation. Aetna will not reimburse D7260 when billed in conjunction with extraction(s) on the same date of service.

D7261* -- Primary Closure of a Sinus Perforation Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulus tract.

> D7261 is a separately eligible procedure when performed in conjunction with extraction(s) on the same date of service.

D4320* – Provisional Splinting- Intracoronal - This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved.
D4321* -- Provisional Splinting- Extracoronal - This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved.

> D4320 and D4321 will no longer be reimbursed per tooth, but per span. Please include the teeth numbers within the span when submitting either of these codes.

* Washington state providers: Starred (*) items are subject to Washington state insurance regulatory requirements. Washington providers will receive a separate communication.

We’re here to help

If you have questions, call us at **1-800-451-7715.** You can visit **aetnadental.com** to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: September 2017

From: Lisa Stepanian - Executive Director, Dental Network Operations

Subject: CDT 2018 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Dental Maintenance Organization (DMO®) plans

This bulletin is part of your *Dental Office Guide*. After reviewing this information, please keep it with your guide for future reference.

New CDT® 2018 codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes effective January 1, 2018. We've listed them below.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2018 Code	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0411	HbA1c in-office point of service testing	Not covered
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5511	repair broken complete denture base, mandibular	100% of negotiated fee for D5510
D5512	repair broken complete denture base, maxillary	100% of negotiated fee for D5510
D5611	repair resin partial denture base, mandibular	100% of negotiated fee for D5610
D5612	repair resin partial denture base, maxillary	100% of negotiated fee for D5610
D5621	repair cast partial framework, mandibular	100% of negotiated fee for D5620
D5622	repair cast partial framework, maxillary	100% of negotiated fee for D5620

CDT 2018 Code	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D6000-D6999	**VIII. Implant Services**	
D6096	remove broken implant retaining screw	50% of negotiated fee for D6090, with a minimum allowance of $50.00
D6118	implant/abutment supported interim fixed denture for edentulous arch – mandibular	100% of negotiated fee for D5811
D6119	implant/abutment supported interim fixed denture for edentulous arch – maxillary	100% of negotiated fee for D5810
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	Not covered
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	Not covered
D7979	non-surgical sialolithotomy	50% of negotiated fee for D7980
D8000-D8999	**XI. Orthodontics**	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	Not covered
D9000-D9999	**XII. Adjunctive General Services**	
D9222	deep sedation/general anesthesia – first 15 minutes	125% of negotiated fee for D9223
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	125% of negotiated fee for D9243
D9995	teledentistry – synchronous; real-time encounter	Inclusive to the procedure performed
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	Inclusive to the procedure performed

Patient coinsurance/copay information for the new codes

Please follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES A - U

ADA Code	A	B	C	D	E	F	G	H	I	J	K	L Li	M Mi	Q	R	U
D0411	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5511	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5512	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5611	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5612	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5621	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D5622	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D6096	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	N/C	0
D6118	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6119	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7296	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7297	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7979	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
D8695	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9222	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	50%	0
D9239	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	50%	0
D9995	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9996	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

COINSURANCE PLAN CODES 1 – 26

ADA Code	1	2 2i	3	4	5	6	7	8 8i	10 10i	12	21	22	23	24	25	26
D0411	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5511	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5512	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5611	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5611	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5621	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5622	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6096	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6118	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6119	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7296	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7297	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7979	20%	20%	50%	20%	75%	50%	20%	10%	20%	0	10%	20%	10%	20%	0	0
D8695	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9222	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	20%	20%
D9239	40%	50%	50%	20%	75%	75%	20%	40%	20%	0	10%	20%	10%	20%	20%	20%
D9995	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9996	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

FIXED COPAY PLAN CODES 41 – 58

ADA Code	41	42	51	52	53	54	55	56	57	58
D0411	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5511	$45	$45	$35	$30	$30	$25	$25	$25	$30	$25
D5512	$45	$45	$35	$30	$30	$25	$25	$25	$30	$25
D5611	$63	$63	$45	$30	$35	$35	$35	$30	$35	$35
D5612	$63	$63	$45	$30	$35	$35	$35	$30	$35	$35
D5621	$68	$68	$45	$30	$35	$35	$35	$30	$35	$35
D5622	$68	$68	$45	$30	$35	$35	$35	$30	$35	$35
D6096	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6118	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6119	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7296	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7297	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7979	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D8695	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9222	$104	NC[6]	$104	$104	$104	$104	$104	$104	$104	$104
D9239	$104	NC[6]	$104	$104	$104	$104	$104	$104	$104	$104
D9995	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9996	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[6] Copay applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist's negotiated fee.

FIXED COPAY PLAN CODES 63 – 78i, SFI – CLI

ADA Code	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i	SFL SFI	CAM CMI	CAL CLI
D0411	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5511	$36	$30	$30	$30	$40	$30	$40	$40	$40	$35	$45	$40	$40	$20	$30
D5512	$36	$30	$30	$30	$40	$30	$40	$40	$40	$35	$45	$40	$40	$20	$30
D5611	$35	$35	$35	$30	$40	$35	$40	$40	$40	$35	$45	$40	$40	$20	$30
D5512	$35	$35	$35	$30	$40	$35	$40	$40	$40	$35	$45	$40	$40	$20	$30
D5621	$35	$35	$35	$30	$40	$35	$40	$40	$40	$35	$45	$40	$40	$20	$30
D5622	$35	$35	$35	$30	$40	$35	$40	$40	$40	$35	$45	$40	$40	$20	$30
D6096	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6118	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6119	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7296	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7297	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D7979	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D8695	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9222	$104	$104	$104	$104	$104	$104	$109	$109	$109	$109	$109	$109	$94	$100	$104
D9239	$104	$104	$104	$104	$104	$104	$109	$109	$109	$109	$109	$109	$94	$100	$104
D9995	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9996	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

Network Bulletin

Date: **April 17, 2017**

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following changes that will take effect for all Aetna Dental® plans on **July 17, 2017**:

D4355 - Debridement, full mouth to enable comprehensive periodontal evaluation and diagnosis

To align with the ADA descriptor of D4355, the following changes are being made to our claim processing policies:

- D4355 will be denied when performed on the same date of service as D0120.
- D0145, D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355.
- D1110, D1120, D4910, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.

D0210 - Intraoral - complete series of radiographic images

To align with the ADA descriptor of D0210, additional intraoral periapical D0220 & D0230 and bitewing radiographic images D0270, D0272, D0273, D0274 and D0277 will not be separately eligible when performed on the same date of service as D0210.

D0277 - Vertical bitewings - 7 to 8 radiographic images

Bitewing radiographic images D0270, D0272, D0273 and D0274 will be denied when performed on the same date of service as D0277.

D3310, D3320, D3330, D3331, D3332 and D3333 – Endodontic therapy with intraoral periapical radiographic images

To align with the ADA nomenclature for endodontic therapy, periapical radiographic images D0230 will be denied when performed in conjunction with endodontic therapy on the same date of service. D0230 is part of the endodontic therapy. Diagnostic evaluation and images are not part of the endodontic therapy.

D3310, D3320 and D3330 – Endodontic therapy

Claims submitted for D3310, D3320 or D3330 will be denied if there is a history of Root Canal Therapy on the same tooth. Endodontic retreatment should be submitted under codes D3346, D3347 and D3348 for consideration.

D4910 - Periodontal maintenance and D4341/D4342 - Periodontal scaling and root planing

The descriptor for D4910 periodontal maintenance includes removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing as well as polishing where indicated. D4341/D4342 periodontal scaling and root planing is not separately eligible when performed on the same day as a D4910.

Reminder - D2950 - Core build up, including any pins when required

To assure that benefits are being applied appropriately, and to gather data on submitted buildups to inform future plan designs, we now require pre-and post-operative radiographic images or photographs that illustrates the need for and placement of a buildup.

We're here to help

If you have questions, call us at **1-800-451-7715.** You can visit **aetnadental.com** to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: January 2017

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: Changes to the provider appeal process

Applies to: All Aetna Dental® Plans

Starting May 1, 2017, the provider appeal policy for members enrolled in commercial plans is changing. Here are the changes:

- Elimination of Level 2 appeals for practitioner
- Require the use of a specific form when submitting appeal requests

If you want to appeal a claim

Submit it in writing using the Practitioner and Provider Complaint and Appeal Request form. There is only **one** opportunity to appeal, so be sure to include all supporting documentation.

The form will not be required until **May 1, 2017**, but we encourage you to start using it now.

Why the changes

This will eliminate unnecessary steps and help ensure that we have the information we need to do a full review of the request. These changes apply to all providers, participating and nonparticipating.

What's not changing

You can still ask for an informal reconsideration of your claim before you file a formal appeal.

Also, the member's appeal rights have not changed. If you are filing an appeal as a member's designated representative, the member still has the number of appeals set forth in the member's plan documents.

We're here to help

If you have questions, call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: **12/01/2016**

From: Joel Hodge, Head of Dental Networks and Administration

Subject: **DMO Pediatric Protocols – Change in Age Limit**

Applies to: DMO® plans

DMO plans – add this to your Dental Office Guide

This bulletin is part of your *Dental Office Guide*. After reviewing this information, it should be placed in your guide for future reference.

What's changing?

Starting January 1, 2017, the age limit for direct referral of a child to a pediatric dental specialist is changing from under age 6 to under age 7.

Here are the new guidelines:

Pediatric protocols

The Primary Care Dentist may directly refer to a participating specialty dentist for consultation or problem-focused examination of children under age 7 if (a)the Primary Care Dentist has documented at least one unsuccessful attempt to treat the child, and (b)at least one of the following conditions is present. The child:

- Has an existing medical condition or is developmentally disabled. (Please include a physician's statement of condition, such as multiple sclerosis, Down's syndrome, etc.)
- Presents a behavioral management problem
- Has rampant caries
- Requires emergency care that is beyond the scope or ability of the Primary Care Dentist

Once a child is referred by the Primary Care Dentist to a contracted pediatric dentist, the child may continue to be treated by the pediatric dentist until the age of 7, without additional referrals from the Primary Care Dentist.

All other conditions or procedures not indicated must be approved in advance by Aetna. This includes referrals for children age 7 or older with a medical condition, significant behavioral management problem and/or severe caries that may require referral to a specialty dentist. **The parent should be instructed that until the referral is approved, only the consultation will be covered.**

We're here to help

If you have questions, call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental® plans.

Network Bulletin

Date: September 2016

From: Joel Hodge, Head of Dental Networks and Administration

Subject: CDT 2017 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Dental Maintenance Organization (DMO®) plans

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2017[1] codes
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2017[1] codes starting January 1, 2017.

Fee information for the new CDT-2017[1] codes
Your contracted fees for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your contracted fees for the new CDT codes.

We're here to help
If you have questions, please call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2017 Code[1]	Nomenclature	Contracted Fees for CDT 2017 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not covered
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not covered
D1000-D1999	**II. Preventive**	
D1575	distal shoe space maintainer – fixed – unilateral	110% of negotiated fee for D1510
D4000-D4999	**V. Periodontics**	
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50% of negotiated fee for D4355

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

CDT 2017 Code[1]	Nomenclature	Contracted Fees for CDT 2017 codes are based on the following:
D6000-D6199	**VIII. Implant Services**	
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	50% of negotiated fee for D4342
D9000-D9999	**XII. Adjunctive General Services**	
D9311	consultation with a medical health care professional	100% of negotiated fee for D9310
D9991	dental case management - addressing appointment compliance barriers	Not covered
D9992	dental case management – care coordination	Not covered
D9993	dental case management – motivational interviewing	Not covered
D9994	dental case management – patient education to improve oral health literacy	Not covered

[1] Current Dental Terminology. ©American Dental Association. All rights reserved.

Patient coinsurance/copay information for the new codes

Please follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES A - U

ADA Code[1]	A	B	C	D	E	F	G	H	I	J	K	L Li	M Mi	Q	R	U
D0414	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0600	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1575	10% $0	20% $0	25% $0	30% $0	40% $0	50% $0	30% $0	10% $0	20% $0	25% $0	30% $0	40% $0	50% $0	$0 $0	NC NC	$0 $0
D4346	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6081	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC 40%	NC 50%	NC	NC	NC
D6085	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9311	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9991	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9992	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9993	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

COINSURANCE PLAN CODES 1 – 26

ADA Code[1]	1	2 2i	3	4	5	6	7	8 8i	10 10i	12	21	22	23	24	25	26
D0414	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0600	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1575	40% $0	50% $0	50% $0	40% $0	75% $0	75% $0	0% 0%	40% $0	0% 0%	50% $0	10% 0%	20% 0%	10% 10%	20% 20%	25% $0	40% $0
D4346	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	20%	$0	$0
D6081	NC	NC 50%	NC	NC	NC	NC	NC	NC 40%	NC 40%	NC	NC	NC	NC	NC	NC	NC
D6085	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9311	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	20%	$0	$0
D9991	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9992	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9993	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

FIXED COPAY PLAN CODES 41 – 58

ADA Code[1]	41	42	51	52	53	54	55	56	57	58
D0414	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0600	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1575	$110	$110	$110	$94	$72	$66	$0	$0	$72	$66
D4346	$30	$30	$30	$30	$30	$30	$30	$30	$30	$30
D6081	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6085	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9311	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9991	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9992	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9993	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[1] Current Dental Terminology.

FIXED COPAY PLAN CODES 63 – 78i, SFI – CLI

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i	SFL SFI	CAM CMI	CAL CLI
D0414	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0600	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1575	$88	$83	$0	$0	$88	$83	$101	$95	$0	$0	$101	$95	$0	$28	$66
D4346	$30	$30	$30	$30	$30	$30	$35	$35	$35	$35	$35	$35	$8	$18	$25
D6081	NC $17	NC $16	NC $15	NC $11	NC $18	NC $19	NC $18	NC $17	NC $16	NC $11	NC $19	NC $20	NC $15	NC $5	NC $10
D6085	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9311	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5	$10
D9991	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9992	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9993	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[1]Current Dental Terminology.

Network Bulletin

Date: September 2015

From: Joel Hodge, Head of Dental Networks and Administration

Subject: CDT 2016 updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Dental Maintenance Organization (DMO®) plans

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2016[1] codes
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2016[1] codes effective January 1, 2016.

Fee information for the new CDT-2016[1] codes
Your contracted fees for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your contracted fees for the new CDT codes.

We're here to help
If you have questions, please call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2016 Code[1]	Nomenclature	Contracted Fees for CDT 2016 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0251	**extra-oral posterior dental radiographic image**	75% of negotiated fee for D0250
D0422	**collection and preparation of genetic sample material for laboratory analysis and report**	Not covered
D0423	**genetic test for susceptibility to diseases – specimen analysis**	Not covered
D1000-D1999	**II. Preventive**	
D1354	**interim caries arresting medicament application**	100% of negotiated fee for D1351
D4000-D4999	**V. Periodontics**	
D4283	**autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site**	55% of negotiated fee for D4273

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

CDT 2016 Code[1]	Nomenclature	Contracted Fees for CDT 2016 codes are based on the following:
D4285	**non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site**	55% of negotiated fee for D4275
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5221	**immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5211
D5222	**immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5212
D5223	**immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) Includes limited follow-up care only; does not include future rebasing**	115% of negotiated fee for D5213
D5224	**immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5214
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7881	**occlusal orthotic device adjustment**	Not covered
D8000-D8999	**XI. Orthodontics**	
D8681	**removable orthodontic retainer adjustment**	100% of negotiated fee for D5421
D9000-D9999	**XII. Adjunctive General Services**	
D9223	**deep sedation/general anesthesia – each 15 minute increment**	50% of negotiated fee for D9220
D9243	**intravenous moderate (conscious) sedation/analgesia – each 15 minute increment**	50% of negotiated fee for D9241
D9932	**cleaning and inspection of removable complete denture, maxillary**	100% of negotiated fee for D9931
D9933	**cleaning and inspection of removable complete denture, mandibular**	100% of negotiated fee for D9931
D9934	**cleaning and inspection of removable partial denture, maxillary**	100% of negotiated fee for D9931
D9935	**cleaning and inspection of removable partial denture, mandibular**	100% of negotiated fee for D9931
D9943	**occlusal guard adjustment**	12.5% of negotiated fee for D9940

[1] Current Dental Terminology.

Patient coinsurance/copay information for the new codes

Please follow the guides below to determine members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES A - U

ADA Code[1]	A	B	C	D	E	F	G	H	I	J	K	L Li	M Mi	Q	R	U
D0251	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0422	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0423	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1354	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D4283[2]	$0 10%	$0 20%	$0 25%	$0 30%	$0 40%	$0 50%	$0 10%	$0 10%	$0 20%	$0 25%	$0 30%	$0 40%	$0 50%	$0 25%	$0 NC	$0 $0
D4285[2]	$0 10%	$0 20%	$0 25%	$0 30%	$0 40%	$0 50%	$0 10%	$0 10%	$0 20%	$0 25%	$0 30%	$0 40%	$0 50%	$0 25%	$0 NC	$0 $0
D5221	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5222	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5223	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5224	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D7881	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9223	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	50%	$0
D9243	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	50%	$0
D9932	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9933	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9934	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9935	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9943	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0

[1] Current Dental Terminology.

[2] Soft Tissue Graft Procedures – Covered as Basic under "Pre November 1, 2000 Plans" (*) and as a Major Services under "DMO Standard Plans" (#).
First copayment shown = "Pre November 1, 2000 Plan" (*)
Second copayment = "DMO Standard Plan" (#)

COINSURANCE PLAN CODES 1 – 26

ADA Code[1]	1	2 2i	3	4	5	6	7	8 8i	10	12	21	22	23	24	25	26
D0251	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	20%	$0	$0
D0422	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0423	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1354	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	20%	$0	$0
D4283	20% 40%	20% 50%	50% 50%	20% 20%	75% 75%	50% 75%	20% 20%	10% 40%	20% 20%	$0 $0	10% 10%	20% 20%	10% 10%	20% 20%	$0 25%	$0 40%
D4285	20% 40%	20% 50%	50% 50%	20% 20%	75% 75%	50% 75%	20% 20%	10% 40%	20% 20%	$0 $0	10% 10%	20% 20%	10% 10%	20% 20%	$0 25%	$0 40%
D5221	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5222	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5223	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5224	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D7881	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9223	40%	50%	50%	20%	75%	75%	20%	40%	20%	$0	10%	20%	10%	20%	20%	20%
D9243	40%	50%	50%	20%	75%	75%	20%	40%	20%	$0	10%	20%	10%	20%	20%	20%
D9932	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9933	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9934	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9935	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9943	40%	50%	50%	40%	75%	75%	20%	40%	40%	50%	10%	20%	10%	20%	25%	40%

[2] Soft Tissue Graft Procedures – Covered as Basic under "Pre November 1, 2000 Plans" (*) and as a Major Services under "DMO Standard Plans" (#).
First copayment shown = "Pre November 1, 2000 Plan" (*)
Second copayment = "DMO Standard Plan" (#)

FIXED COPAY PLAN CODES 41 – 58

ADA Code[1]	41	42	51	52	53	54	55	56	57	58
D0251	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0422	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0423	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1354	$10	$10	$10	$10	$8	$0	$0	$0	$10	$5
D4283	$85	$85	$85	$88	$83	$76	$63	$36	$83	$76
D4285	$264	$264	$171	$176	$165	$151	$127	$72	$165	$151
D5221	$590	$590	$431	$368	$345	$316	$288	$213	$345	$316
D5222	$590	$590	$431	$368	$345	$316	$288	$213	$345	$316
D5223	$719	$719	$546	$518	$460	$403	$345	$230	$460	$403
D5224	$719	$719	$546	$518	$460	$403	$345	$230	$460	$403
D7881	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9223	$83	$83	$83	$83	$83	$83	$83	$83	$83	$83
D9243	$83	$83	$83	$83	$83	$83	$83	$83	$83	$83
D9932	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9933	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9934	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9935	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9943	$23	$23	$11	$9	$9	$9	$9	$9	$9	$9

[1] Current Dental Terminology.

FIXED COPAY PLAN CODES 63 – 78i, SFI – CLI

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i	SFL SFI	CAM CMI	CAL CLI
D0251	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0422	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0423	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1354	$8	$0	$0	$0	$10	$5	$0	$0	$0	$0	$0	$0	$0	$5	$10
D4283	$83	$76	$63	$36	$95	$76	$87	$80	$67	$37	$100	$79	$44	$41	$41
D4285	$165	$151	$127	$72	$190	$151	$191	$182	$188	$130	$191	$183	$199	$94	$116
D5221	$345	$316	$316	$230	$368	$316	$399	$366	$366	$266	$426	$366	$449	$144	$201
D5222	$345	$316	$316	$230	$368	$316	$399	$366	$366	$266	$426	$366	$449	$144	$201
D5223	$460	$403	$374	$259	$460	$403	$483	$423	$393	$273	$484	$423	$472	$178	$230
D5224	$460	$403	$374	$259	$460	$403	$483	$423	$393	$273	$484	$423	$472	$178	$230
D7881	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9223	$83	$83	$83	$83	$83	$83	$87	$87	$87	$87	$87	$87	$75	$80	$83
D9243	$83	$83	$83	$83	$83	$83	$87	$87	$87	$87	$87	$87	$75	$80	$83
D9932	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9933	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9934	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9935	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9943	$16	$13	$13	$13	$16	$13	$24	$19	$19	$19	$24	$19	$20	$16	$22

Network Bulletin

Date: May, 2015

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New Southern California (Dental Maintenance Organization) DMO® Copay plans – CAM, CMI, CAL, CLI Series

Applies to: DMO® plan

New DMO plans – add this to your Dental Office Guide

This bulletin is part of your *Dental Office Guide*. After reviewing this information, it should be placed in your guide for future reference.

Starting August 1, 2015

We're offering four new DMO Copay plans in Southern California (CAM, CMI, CAL, and CLI)

Attached are the new copay schedules.

We're here to help

If you have questions, please call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental® plans.

ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D0120	Periodic Oral Evaluation - Established Patient	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	$0	$0
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	$0	$0
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0	$0
D0160	Detailed and Extensive Oral Evaluation – Problem Focused, by Report	$0	$0
D0170	Reevaluation - Limited, Problem Focused	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	$0	$0
D0210	Intraoral – Complete Series of Radiographic Images	$0	$0
D0220	Intraoral – Periapical First Radiographic Image	$0	$0
D0230	Intraoral - Periapical Each Additional Radiographic Image	$0	$0
D0240	Intraoral – Occlusal Radiographic Image	$0	$0
D0250	Extraoral – First Radiographic Image	$0	$0
D0260	Extraoral – Each Additional Radiographic Image	$0	$0
D0270	Bitewing - Single Radiographic Image	$0	$0
D0272	Bitewings - Two Radiographic Images	$0	$0
D0273	Bitewings - Three Radiographic Images	$0	$0
D0274	Bitewings - Four Radiographic Images	$0	$0
D0277	Vertical Bitewings – 7 to 8 Radiographic Images	$0	$0
D0330	Panoramic Radiographic Image	$0	$0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including Report	$2	$4
D0460	Pulp Vitality Tests	$0	$0
D0470	Diagnostic Casts	$0	$0
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report	$0	$0
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	$0	$0
D0474	Accession of Tissue, Gross and Microscopic Exam, Including Assessment of Surgical Margins for Presence of Disease, Preparation & Transmission of Written Report	$0	$0
D1110	Prophylaxis - Adult	$0	$0
D1120	Prophylaxis - Child	$0	$0
D1206	Topical Application of Fluoride Varnish	$0	$0
D1208	Topical Application of Fluoride	$0	$0
D1330	Oral Hygiene Instructions	$0	$0
D1351	Sealant - Per Tooth	$5	$10
D1352	Preventive Resin Restoration in a Moderate to High Risk Caries Patient – Permanent Tooth	$5	$10
D1510	Space Maintainer - Fixed - Unilateral	$25	$60
D1515	Space Maintainer - Fixed - Bilateral	$25	$60
D1520	Space Maintainer - Removable - Unilateral	$25	$60
D1525	Space Maintainer - Removable - Bilateral	$25	$60
D1550	Re-Cementation of Space Maintainer	$10	$15
D1555	Removal of Fixed Space Maintainer	$10	$15
D2140	Amalgam - 1 Surface, Primary or Permanent	$0	$0
D2150	Amalgam - 2 Surfaces, Primary or Permanent	$0	$0
D2160	Amalgam - 3 Surfaces, Primary or Permanent	$0	$0
D2161	Amalgam - 4 or More Surfaces, Primary or Permanent	$0	$0

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ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D2330	Resin Based Composite – 1 Surface, Anterior	$8	$20
D2331	Resin Based Composite – 2 Surfaces, Anterior	$8	$20
D2332	Resin Based Composite – 3 Surfaces, Anterior	$8	$20
D2335	Resin Based Composite – 4 or More Surfaces or Involving Incisal Angle (Anterior)	$20	$35
D2390	Resin-Based Composite Crown, Anterior	$20	$35
D2391	Resin-Based Composite - One Surface, Posterior	$20	$35
D2392	Resin-Based Composite - Two Surfaces, Posterior	$45	$75
D2393	Resin-Based Composite - Three Surfaces, Posterior	$50	$75
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$60	$90
D2510	Inlay - Metallic - One Surface	$125	$175
D2520	Inlay - Metallic - Two Surfaces	$125	$175
D2530	Inlay - Metallic - Three or More Surfaces	$125	$175
D2542	Onlay - Metallic - Two Surfaces	$120	$170
D2543	Onlay - Metallic - Three Surfaces	$120	$170
D2544	Onlay - Metallic – Four Or More Surfaces	$120	$170
D2610	Inlay - Porcelain/Ceramic – One Surface	$125	$175
D2620	Inlay - Porcelain/Ceramic – Two Surfaces	$125	$175
D2630	Inlay - Porcelain/Ceramic – Three Or More Surfaces	$125	$175
D2642	Onlay - Porcelain/Ceramic – Two Surfaces	$120	$170
D2643	Onlay - Porcelain/Ceramic – Three Surfaces	$120	$170
D2644	Onlay - Porcelain/Ceramic – Four or More Surfaces	$120	$170
D2650	Inlay – Resin-Based Composite – One Surface	$125	$175
D2651	Inlay - Resin-Based Composite – Two Surfaces	$125	$175
D2652	Inlay - Resin-Based Composite – Three Surfaces	$125	$175
D2662	Onlay - Resin-Based Composite – Two Surfaces	$120	$170
D2663	Onlay - Resin-Based Composite – Three Surfaces	$120	$170
D2664	Onlay - Resin-Based Composite – Four or More Surfaces	$120	$170
D2710	Crown - Resin-Based Composite (Indirect)	$125	$175
D2712	Crown – ¾ Resin-Based Composite (Indirect)	$65	$95
D2720	Crown - Resin with High Noble Metal	$125	$175
D2721	Crown - Resin with Predominantly Base Metal	$125	$175
D2722	Crown - Resin with Noble Metal	$125	$175
D2740	Crown - Porcelain/Ceramic Substrate	$125	$175
D2750	Crown - Porcelain Fused to High Noble Metal	$125	$175
D2751	Crown -Porcelain Fused to Predominantly Base Metal	$125	$175
D2752	Crown - Porcelain Fused to Noble Metal	$125	$175
D2780	Crown - ¾ Cast High Noble Metal	$125	$175
D2781	Crown - ¾ Cast Predominantly Base Metal	$125	$175
D2782	Crown - ¾ Cast Noble Metal	$125	$175
D2783	Crown - ¾ Cast Porcelain/Ceramic	$125	$175
D2790	Crown - Full Cast High Noble Metal	$125	$175
D2791	Crown - Full Cast Predominantly Metal	$125	$175
D2792	Crown - Full Cast Noble Metal	$125	$175
D2794	Crown - Titanium	$125	$175
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$5	$10

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ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D2915	Recement Cast or Prefabricated Post And Core	$5	$10
D2920	Recement Crown	$5	$10
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp	$5	$5
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	$5	$10
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$20	$40
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$20	$40
D2932	Prefabricated Resin Crown	Alternate Benefit D2930 or D2931	Alternate Benefit D2930 or D2931
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate Benefit D2930 or D2931	Alternate Benefit D2930 or D2931
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$20	$40
D2940	Protective Restoration	$5	$15
D2941	Interim Therapeutic Restoration - Primary Dentition	$0	$0
D2950	Core Buildup, Including Any Pins When Required	$60	$90
D2951	Pin Retention - Per Tooth, In Addition to Restoration	$10	$15
D2952	Cast Post and Core In Addition to Crown, Indirectly Fabricated	$30	$60
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	$30	$60
D2954	Prefabricated Post and Core, in Addition to Crown	$25	$40
D2957	Each Additional Prefabricated Post - Same Tooth	$25	$40
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	$15	$20
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$5	$10
D3110	Pulp Cap – Direct (Excluding Final Restoration)	$0	$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$5	$5
D3221	Pulpal Debridement, Primary and Permanent Teeth	$10	$15
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development	$10	$20
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	$15	$25
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)	$15	$25
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	$45	$75
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	$60	$105
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	$135	$180
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	$45	$75
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$34	$56
D3333	Internal Root Repair of Perforation Defects	$34	$56
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$80	$120
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$80	$120
D3348	Retreatment of Previous Root Canal Therapy - Molar	$125	$175
D3410	Apicoectomy – Anterior	$55	$95
D3421	Apicoectomy - Bicuspid (First Root)	$55	$95
D3425	Apicoectomy - Molar (First Root)	$55	$95
D3426	Apicoectomy (Each Additional Root)	$55	$95
D3427	Periradicular Surgery Without Apicoectomy	$0	$0
D3430	Retrograde Filling – per Root	$30	$60
D3450	Root Amputation - per Root	$60	$90

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ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D4210	Gingivectomy/Gingivoplasty - 4 or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$75	$120
D4211	Gingivectomy/Gingivoplasty, 1 - 3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$20	$25
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	$10	$15
D4240	Gingival Flap Procedure Including Root Planing, 4 or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$75	$120
D4241	Gingival Flap Procedure, Including Root Planing - 1 - 3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$45	$75
D4245	Apically Positioned Flap	$60	$90
D4249	Clinical Crown Lengthening - Hard Tissue	$100	$200
D4260	Osseous Surgery (including flap entry and closure) – Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$150	$205
D4261	Osseous Surgery (including flap entry and closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$100	$200
D4268	Surgical Revision Procedure, per Tooth	$100	$100
D4270	Pedicle Soft Tissue Graft Procedure	$105	$140
D4273	Subepithelial Connective Tissue Graft Procedures, per Tooth	$75	$75
D4275	Soft Tissue Allograft	$170	$210
D4276	Combined Connective Tissue and Double Pedicle Graft – per Tooth	$75	$75
D4277	Free Soft Tissue Graft Procedure, First Tooth or Edentulous Tooth Position in Graft	$165	$165
D4278	Free Soft Tissue Graft Procedure, Each Additional Contiguous Tooth or Edentulous Tooth Position in Same Graft Site	$85	$85
D4341	Periodontal Scaling And Root Planing, Four or More Teeth per Quadrant	$20	$35
D4342	Periodontal Scaling And Root Planing, One to Three Teeth per Quadrant	$10	$20
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	$35	$50
D4910	Periodontal Maintenance	$20	$30
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist or Their Staff)	$10	$10
D5110	Complete Denture - Maxillary	$125	$175
D5120	Complete Denture - Mandibular	$125	$175
D5130	Immediate Denture - Maxillary	$155	$200
D5140	Immediate Denture - Mandibular	$155	$200
D5211	Maxillary Partial Denture - Resin Base	$125	$175
D5212	Mandibular Partial Denture - Resin Base	$125	$175
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases	$155	$200
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases	$155	$200
D5225	Maxillary Partial Denture – Flexible Base	$150	$175
D5226	Mandibular Partial Denture – Flexible Base	$150	$175
D5281	Removable Unilateral Partial Denture – One Piece Cast Metal	$125	$175
D5410	Adjust Complete Denture - Maxillary	$10	$15
D5411	Adjust Complete Denture - Mandibular	$10	$15
D5421	Adjust Partial Denture - Maxillary	$10	$15
D5422	Adjust Partial Denture - Mandibular	$10	$15
D5510	Repair Broken Complete Denture Base	$20	$30
D5520	Replace Missing or Broken Teeth, Complete Denture (Each Tooth)	$15	$25
D5610	Repair Resin Denture Base	$20	$30
D5620	Repair Cast Framework	$20	$30

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ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D5630	Repair Or Replace Broken Clasp	$20	$30
D5640	Replace Broken Teeth – per Tooth	$15	$25
D5650	Add Tooth to Existing Partial Denture	$20	$30
D5660	Add Clasp to Existing Partial Denture	$20	$30
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$125	$175
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$125	$175
D5710	Rebase Complete Maxillary Denture	$50	$95
D5711	Rebase Complete Mandibular Denture	$50	$95
D5720	Rebase Maxillary Partial Denture	$50	$95
D5721	Rebase Mandibular Partial Denture	$50	$95
D5730	Reline Complete Maxillary Denture (Chairside)	$20	$40
D5731	Reline Complete Mandibular Denture (Chairside)	$20	$40
D5740	Reline Maxillary Partial Denture (Chairside)	$20	$40
D5741	Reline Mandibular Partial Denture (Chairside)	$20	$40
D5750	Reline Complete Maxillary Denture (Laboratory)	$40	$50
D5751	Reline Complete Mandibular Denture (Laboratory)	$40	$50
D5760	Reline Maxillary Partial Denture (Laboratory)	$40	$50
D5761	Reline Mandibular Partial Denture (Laboratory)	$40	$50
D5820	Interim Partial Denture - (Maxillary)	$70	$100
D5821	Interim Partial Denture - (Mandibular)	$70	$100
D5850	Tissue Conditioning, Maxillary	$15	$25
D5851	Tissue Conditioning, Mandibular	$15	$25
D5863	Overdenture – Complete Maxillary	$125	$175
D5864	Overdenture – Partial Maxillary	$125	$175
D5865	Overdenture – Complete Mandibular	$125	$175
D5866	Overdenture – Partial Mandibular	$125	$175
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$200	$200
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	$200	$200
D6058	Abutment Supported Porcelain/Ceramic Crown	$200	$200
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$200	$200
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$200	$200
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$200	$200
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$200	$200
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$200	$200
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$200	$200
D6065	Implant Supported Porcelain/Ceramic Crown	$200	$200
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$200	$200
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$200	$200
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$200	$200
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	$200	$200
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	$200	$200
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	$200	$200
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	$200	$200

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ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	$200	$200
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	$200	$200
D6075	Implant Supported Retainer for Ceramic FPD	$200	$200
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)	$200	$200
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)	$200	$200
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch	$125	$175
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch	$125	$175
D6092	Recement Implant/Abutment Supported Crown	$40	$60
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$40	$60
D6094	Abutment Supported Crown (Titanium)	$200	$200
D6194	Abutment Supported Retainer Crown for FPD - (Titanium)	$200	$200
D6205	Pontic - Indirect Resin Based Composite	$125	$175
D6210	Pontic - Cast High Noble Metal	$125	$175
D6211	Pontic - Cast Predominantly Base Metal	$125	$175
D6212	Pontic - Cast Noble Metal	$125	$175
D6214	Pontic – Titanium	$125	$175
D6240	Pontic - Porcelain Fused to High Noble Metal	$125	$175
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$125	$175
D6242	Pontic - Porcelain Fused to Noble Metal	$125	$175
D6245	Pontic - Porcelain/Ceramic	$125	$175
D6250	Pontic - Resin with High Noble Metal	$125	$175
D6251	Pontic - Resin with Predominantly Base Metal	$125	$175
D6252	Pontic - Resin with Noble Metal	$125	$175
D6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis	$125	$175
D6548	Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis	$125	$175
D6600	Inlay – Porcelain/Ceramic, 2 Surfaces	$125	$175
D6601	Inlay – Porcelain/Ceramic, 3 or More Surfaces	$125	$175
D6602	Inlay - Cast High Noble Metal, 2 Surfaces	$115	$160
D6603	Inlay - Cast High Noble Metal, 3 or More Surfaces	$115	$160
D6604	Inlay - Cast Predominantly Base Metal, 2 Surfaces	$125	$175
D6605	Inlay - Cast Predominantly Base Metal, 3 or More Surfaces	$125	$175
D6606	Inlay - Cast Noble Metal, 2 Surfaces	$125	$175
D6607	Inlay - Cast Noble Metal, 3 or More Surfaces	$125	$175
D6608	Onlay – Porcelain/Ceramic, 2 Surfaces	$120	$170
D6609	Onlay - Porcelain/Ceramic, 3 or More Surfaces	$120	$170
D6610	Onlay - Cast High Noble Metal, 2 Surfaces	$120	$160
D6611	Onlay - Cast High Noble Metal, 3 or More Surfaces	$120	$160
D6612	Onlay - Cast Predominantly Base Metal, 2 Surfaces	$120	$170
D6613	Onlay - Cast Predominantly Base Metal, 3 or More Surfaces	$120	$170
D6614	Onlay - Cast Noble Metal, 2 Surfaces	$115	$160
D6615	Onlay - Cast Noble Metal, 3 or More Surfaces	$115	$160
D6624	Inlay – Titanium	$115	$160
D6634	Onlay – Titanium	$120	$170
D6710	Crown – Indirect Resin Based Composite	$125	$175
D6720	Crown - Resin with High Noble Metal	$125	$175

ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D6721	Crown - Resin with Predominantly Base Metal	$125	$175
D6722	Crown - Resin with Noble Metal	$125	$175
D6740	Crown - Porcelain/Ceramic	$125	$175
D6750	Crown - Porcelain Fused to High Noble Metal	$125	$175
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$125	$175
D6752	Crown - Porcelain Fused to Noble Metal	$125	$175
D6780	Crown - ¾ Cast High Noble Metal	$125	$175
D6781	Crown - ¾ Cast Predominantly Base Metal	$125	$175
D6782	Crown - ¾ Cast Noble Metal	$125	$175
D6783	Crown - ¾ Porcelain/Ceramic	$125	$175
D6790	Crown - Full Cast High Noble Metal	$125	$175
D6791	Crown - Full Cast Predominantly Base Metal	$125	$175
D6792	Crown - Full Cast Noble Metal	$125	$175
D6794	Crown – Titanium	$125	$175
D6930	Recement Fixed Partial Denture	$20	$45
D6985	Pediatric Partial Denture, Fixed	$70	$100
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$5	$10
D7140	Extraction - Erupted Tooth or Exposed Root	$5	$10
D7210	Surgical Removal of Erupted Tooth	$10	$20
D7220	Removal of Impacted Tooth - Soft Tissue	$20	$40
D7230	Removal Of Impacted Tooth - Partially Bony	$45	$75
D7240	Removal Of Impacted Tooth - Completely Bony	$60	$90
D7241	Removal Of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	$60	$90
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$20	$45
D7251	Coronectomy – Intentional Partial Tooth Removal	$20	$30
D7280	Surgical Access of an Unerupted Tooth	$25	$40
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$20	$25
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$10	$10
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth)	$35	$50
D7286	Biopsy of Oral Tissue – Soft	$35	$50
D7287	Exfoliative Cytological Sample Collection	$15	$25
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, per Quadrant	$30	$50
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, per Quadrant	$20	$35
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, per Quadrant	$20	$50
D7321	Alveoloplasty Not In Conjunction with Extractions - One to Three Teeth or Tooth Spaces, per Quadrant	$20	$35
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$10	$20
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue, Complicated	$40	$60
D7960	Frenulectomy	$30	$50
D7963	Frenuloplasty	$20	$50
D9110	Palliative (Emergency) Treatment of Dental Pain, Minor Procedure	$10	$15
D9220	Deep Sedation / General Anesthesia - First 30 Minutes	$160	$165
D9221	Deep Sedation / General Anesthesia - Each Additional 15 Minutes	$60	$90
D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	$160	$165

[1] Current Dental Terminology ©American Dental Association. All rights reserved.

ADA Code[1]	Description	Plans CAM & CMI	Plans CAL & CLI
D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	$60	$90
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	$5	$10
D9940	Occlusal Guard, by Report	$125	$175
D9942	Repair and/or Reline of Occlusal Guard	$50	$60
D9951	Occlusal Adjustment - Limited	$10	$20
D9952	Occlusal Adjustment - Complete	$30	$40

The Plans include the following additional services:

ADA Code[1]	Description	Plan CMI	Plan CLI
D6010	Surgical Placement of Implant Body: Endosteal Implant	$1,375	$1375
D6013	Surgical Placement of Mini Implant	$756	$756
D6056	Prefabricated Abutment – Includes Modification and Placement	$785	$785
D6080	Implant Maintenance Procedures when Prostheses are Removed and Inserted, Including Cleansing of Prostheses and Abutments	$88	$88

[1] Current Dental Terminology ©American Dental Association. All rights reserved.

Network Bulletin

Date: March, 2015

From: Joel Hodge, Head of Dental Networks and Administration

Subject: Aetna Dental – DMO® is now DNO (Dental Network Only) in Virginia

Applies to: DMO® plan

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in your guide for future reference.

DMO® is now DNO in Virginia

The State of Virginia requires the use of DNO instead of DMO®.

Starting now

The term DMO® will be replaced with DNO on all member materials for Virginia customers. DNO will also be referenced on provider documents next to or in place of the term DMO®.

There is no change in your participation

The name change from DMO® to DNO for Virginia does not impact your participation.

We're here to help

If you have questions, please call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental® plans.

*DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary care dentist to coordinate their care with in-network providers.

Network Bulletin

Date: October 2014

From: Joel Hodge, Head of Dental Networks and Administration

Subject: CDT 2015 Updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Dental Maintenance Organization (DMO®) Plans

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

If you have questions, please call our National Dentist Line at **1-800-451-7715**. Thank you for your continued participation and support of Aetna Dental plans.

Below are the new CDT-2015[1] codes

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2015* codes starting January 1, 2015.

Fee information for the new CDT-2015[1] Codes

Your contracted fees for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your contracted fees for the new CDT codes.

CDT 2015[1] Code	Nomenclature	Contracted Fees for CDT-2015 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0171	Re-evaluation – post-operative visit	Inclusive to surgery
D0351	3D photographic image	Not covered
D1000-D1999	**II. Preventive**	
D1353	Sealant repair	50% of contracted fee for D1351
D6000-D6199	**VIII. Implant Services**	
D6110	Implant/abutment supported removable denture for completely edentulous arch - maxillary	100% of contracted fee for D6053

[1] Current Dental Terminology. ©American Dental Association. All rights reserved.

CDT 2015[1] Code	Nomenclature	Contracted Fees for CDT-2015 codes are based on the following:
D6111	Implant/abutment supported removable denture for completely edentulous arch - mandibular	100% of contracted fee for D6053
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	100% of contracted fee for D6054
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	100% of contracted fee for D6054
D6114	Implant/abutment supported fixed denture for completely edentulous arch - maxillary	100% of contracted fee for D6078
D6115	Implant/abutment supported fixed denture for completely edentulous arch - mandibular	100% of contracted fee for D6078
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	100% of contracted fee for D6079
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	100% of contracted fee for D6079
D6200-D6999	**IX. Prosthodontics, fixed**	
D6549	Resin retainer – for resin bonded fixed prosthesis	50% of contracted fee for D6722
D9000-D9999	**XII. Adjunctive General Services**	
D9219	Evaluation for deep sedation or general anesthesia	Covered only when performed by anesthesiologist in conjunction with medically necessary deep sedation or general anesthesia
D9931	Cleaning and inspection of a removable appliance	25% of contracted fee for D1110
D9986	Missed appointment	Not covered
D9987	Cancelled appointment	Not covered

[1] Current Dental Terminology.
[2] Not separately eligible - the patient cannot be billed for these services.
[3] Covered only when performed by anesthesiologist

Patient Coinsurance / Copay Information for the new codes

Please follow the guides below to determine the members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES A - U

ADA Code[1]	A	B	C	D	E	F	G	H	I	J	K	L Li	M Mi	Q	R	U
D0171[2]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0351	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1353	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6110	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6111	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6112	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6113	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6114	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6115	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6116	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6117	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D6549	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9219[3]	50%	50%	50%	50%	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	50%	$0
D9931	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D9986	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9987	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[1] Current Dental Terminology.

[2] Not separately eligible - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist

COINSURANCE PLAN CODES 1 – 26

ADA Code[1]	1	2 2i	3	4	5	6	7	8 8i	10	12	21	22	23	24	25	26
D0171[2]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0351	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1353	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	20%	$0	$0
D6110	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6111	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6112	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6113	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6114	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6115	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6116	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6117	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D6549	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9219[3]	40%	50%	50%	20%	75%	75%	20%	40%	20%	$0	10%	20%	10%	20%	20%	20%
D9931	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D9986	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9987	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[1] Current Dental Terminology.

[2] Not separately eligible - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist

FIXED COPAY PLAN CODES 41 – 68

ADA Code[1]	41	42	51	52	53	54	55	56	57	58
D0171[2]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0351	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1353	$5	$5	$5	$5	$4	$0	$0	$0	$5	$3
D6110	$500	$500	$350	$325	$300	$275	$250	$185	$320	$275
D6111	$500	$500	$350	$325	$300	$275	$250	$185	$320	$275
D6112	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275
D6113	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275
D6114	$500	$500	$350	$325	$300	$275	$250	$185	$300	$275
D6115	$500	$500	$350	$325	$300	$275	$250	$185	$300	$275
D6116	$475	$475	$475	$345	$400	$275	$250	$200	$400	$275
D6117	$475	$475	$475	$345	$400	$275	$250	$200	$400	$275
D6549	$244	$244	$163	$150	$130	$105	$93	$75	$130	$105
D9219[3]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9931	$0	$0	$3	$3	$2	$0	$0	$0	$0	$0
D9986	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9987	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

[1] Current Dental Terminology.

[2] Not separately eligible - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist

FIXED COPAY PLAN CODES 63 – 78i

ADA Code[1]	63 63i	64 64i	65 65i	66 66i	67 67i	68 68i	73 73i	74 74i	75 75i	76 76i	77 77i	78 78i
D0171[2]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0351	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1353	$4	$0	$0	$0	$5	$3	$0	$0	$0	$0	$0	$0
D6110	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6111	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6112	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6113	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6114	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6115	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6116	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6117	$300	$275	$275	$200	$320	$275	$347	$318	$318	$231	$370	$318
D6549	$158	$128	$113	$90	$158	$128	$181	$147	$130	$104	$181	$147
D9219[3]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9931	$2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9986	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9987	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

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[2] Not separately eligible - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist

Network Bulletin

Date: December 2013

From: Joel Hodge, Head of Networks and Administration

Subject: Dental card suppression

Applies to: All contracted Aetna dental providers

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in your guide for future reference.

Important change

Starting **January 1, 2014**, as a standard practice, Aetna will stop mailing Dental PPO and DMO® only member ID cards. This will include ID cards for new and previous members of our dental plans.

Instead of receiving an ID card, members may get a letter explaining that they no longer need an ID card for dental care. The letter will provide instructions on how to access or request a copy of their member ID card from Aetna Navigator®, our Aetna Mobile app and/or by calling Member Services.

What this means for you

Nothing changes. You will continue to verify benefits online, on your monthly eligibility report (DMO) or by calling our National Dentist Hotline at **1-800-451-7715**.

We're here to help

If you have questions, please call us at **1-800-451-7715.** Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: October 2013

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2014 Codes

Applies to: PPO, Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2014 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2014* codes effective January 1, 2014.

Fee information for the new CDT-2014 Codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

Code	Nomenclature	Negotiated Rates for CDT-2014 codes are based on the following:
	D0100 - D0999 I. Diagnostic	
D0393	treatment simulation using 3-D image volume	Medical - not on fee schedule
D0394	digital subtraction of two or more images or image volumes of the same modality	Medical - not on fee schedule
D0395	fusion of two or more 3D image volumes of one or more modalities	Medical - not on fee schedule
D0601	caries risk assessment and documentation, with a finding of low risk	Inclusive to oral evaluation
D0602	caries risk assessment and documentation, with a finding of moderate risk	Inclusive to oral evaluation

D0603	caries risk assessment and documentation, with a finding of high risk	Inclusive to oral evaluation
	D1000-D1999 II. Preventive	
D1999	unspecified preventive procedure, by report	Not covered
	D2000-D2999 III. Restorative	
D2921	reattachment of tooth fragment, incisal edge or cusp	10% of negotiated rate for D2335
D2941	interim therapeutic restoration – primary dentition	45% of negotiated rate for D2940
D2949	restorative foundation for an indirect restoration	Inclusive to permanent restoration.
	D3000-D3999 IV. Endodontics	
D3355	pulpal regeneration - initial visit	50% of negotiated rate for D3354
D3356	pulpal regeneration – interim medication replacement	15% of negotiated rate for D3354
D3357	pulpal regeneration – completion of treatment	25% of negotiated rate for D3354
D3427	periradicular surgery without apicoectomy	75% of negotiated rate for D3421
D3428	bone graft in conjunction with periradicular surgery - per tooth, single site	100% of negotiated rate for D4263
D3429	bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	100% of negotiated rate for D4264
D3431	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	100% of negotiated rate for D4265
D3432	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	100% of negotiated rate for D4266
	D4000-D4999 V. Periodontics	
D4921	gingival irrigation – per quadrant	25% of negotiated rate for D4355
	D5000-D5899 VI. Prosthodontics (Removable)	
D5863	overdenture – complete maxillary	100% of negotiated rate for D5860
D5864	overdenture - partial maxillary	100% of negotiated rate for D5861

D5865	overdenture - complete mandibular	100% of negotiated rate for D5860
D5866	overdenture – partial mandibular	100% of negotiated rate for D5861
	D5900-D5999 VII. Maxillofacial Prosthetics	
D5994	periodontal medicament carrier with peripheral seal – laboratory processed	Medical - not on fee schedule
	D6000-D6199 VIII. Implant Services	
D6011	second stage implant surgery	Inclusive to implant D6010
D6013	Surgical placement of mini implant	55% of negotiated rate for D6010
D6052	semi-precision attachment abutment	50% of negotiated rate for D6056
	D8000-D8999 XI. Orthodontics	
D8694	**repair of fixed retainers, includes reattachment**	100% of negotiated rate for D8693
	D9000-D9999 XII. Adjunctive General Services	
D9985	sales tax	Inclusive to service being taxed.

We are here to help

If you have any questions, please contact our Dentist Contracting Hotline at 1-800-776-0537.
Thank you for your participation in our dental network and your continued support of Aetna Dental® Plans.

Network Bulletin

Date: September 2013

From: Joel Hodge, Head of Dental Networks and Administration

Subject: CDT 2014 Updates to the Dental Office Guide for DMO Specialist Dentists

Applies to: Dental Maintenance Organization (DMO®) Plans

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2014 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2014* codes effective January 1, 2014.

Fee information for the new CDT-2014 Codes

Your contracted fees for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your contracted fees for the new CDT codes.

Code	Nomenclature	Contracted Fees for CDT-2014 codes are based on the following:
	D0100 - D0999 I. Diagnostic	
D0393	treatment simulation using 3-D image volume	Medical
D0394	digital subtraction of two or more images or image volumes of the same modality	Medical
D0395	fusion of two or more 3D image volumes of one or more modalities	Medical
D0601	caries risk assessment and documentation, with a finding of low risk	Inclusive to oral evaluation
D0602	caries risk assessment and documentation, with a finding of moderate risk	Inclusive to oral evaluation
D0603	caries risk assessment and documentation, with a finding of high risk	Inclusive to oral evaluation
	D1000-D1999 II. Preventive	
D1999	unspecified preventive procedure, by report	Not covered

	D2000-D2999 III. Restorative	
D2921	reattachment of tooth fragment, incisal edge or cusp	10% of contracted fee for D2335
D2941	interim therapeutic restoration – primary dentition	45% of contracted fee for D2940
D2949	restorative foundation for an indirect restoration	Inclusive to permanent restoration
	D3000-D3999 IV. Endodontics	
D3355	pulpal regeneration - initial visit	50% of contracted fee for D3354
D3356	pulpal regeneration – interim medication replacement	15% of contracted fee for D3354
D3357	pulpal regeneration – completion of treatment	25% of contracted fee for D3354
D3427	periradicular surgery without apicoectomy	75% of contracted fee for D3421
D3428	bone graft in conjunction with periradicular surgery - per tooth, single site	Not covered
D3429	bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	Not covered
D3431	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Not covered
D3432	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not covered
	D4000-D4999 V. Periodontics	
D4921	gingival irrigation – per quadrant	Not covered
	D6000-D6199 VIII. Implant Services	
D6011	second stage implant surgery	Not covered. If plan covers implants, this is inclusive to surgical placement of implant.
D6013	surgical placement of mini implant	Not covered unless plan covers implants - 55% of contracted fee for D6010
D6052	semi-precision attachment abutment	Not covered

	D8000-D8999 XI. Orthodontics	
D8694	**repair of fixed retainers, includes reattachment**	100% of contracted fee for D8693
	D9000-D9999 XII. Adjunctive General Services	
D9985	sales tax	Inclusive to service being taxed.

Patient Coinsurance / Copay Information for the new codes

Please follow the guides below to determine the members' coinsurance percentages and fixed copayment amounts, by plan code, for the new CDT codes.

COINSURANCE PLAN CODES

A - U

ADA Code	A	B	C	D	E	F	G	H	I	J	K	L	M	Q	R	U
D0393	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0394	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0395	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0601[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0602[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0603[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1999	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D2921	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2949[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3356	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3357	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3427	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3428	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3429	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3431	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3432	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D4921	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5863[2]	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5864[3]	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5865[4]	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5866[5]	10%	20%	25%	30%	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	NC	$0
D5994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6011	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6013	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6052	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9985[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

COINSURANCE PLAN CODES
1 – 26

ADA Code	1	2	3	4	5	6	7	8	10	12	21	22	23	24	25	26
D0393	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0394	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0395	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0601[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0602[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0603[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1999	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D2921	20%	20%	50%	20%	75%	50%	$0	10%	20%	$0	10%	20%	10%	20%	$0	$0
D2941	20%	20%	50%	20%	75%	50%	20%	10%	20%	$0	10%	20%	10%	20%	$0	$0
D2949[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3355	20%	20%	50%	20%	75%	50%	20%	10%	20%	$0	10%	20%	10%	20%	$0	$0
D3356	20%	20%	50%	20%	75%	50%	20%	10%	20%	$0	10%	20%	10%	20%	$0	$0
D3357	20%	20%	50%	20%	75%	50%	20%	10%	20%	$0	10%	20%	10%	20%	$0	$0
D3427	20%	20%	50%	20%	75%	50%	20%	10%	20%	$0	10%	20%	10%	20%	$0	$0
D3428	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3429	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3431	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3432	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D4921	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5863[2]	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5864[3]	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5865[4]	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5866[5]	40%	50%	50%	40%	75%	75%	50%	40%	40%	50%	10%	20%	10%	20%	25%	40%
D5994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6011	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6013	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6052	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9985[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

FIXED COPAY PLAN CODES
41 – 68

ADA Code	41	42	51	52	53	54	55	56	57	58	63	64	65	66	67	68
D0393	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0394	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0395	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0601[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0602[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0603[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D1999	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D2921	$7	$7	$7	$7	$5	$4	$0	$0	$0	$0	$6	$5	$4	$4	$6	$5
D2941	$7	$7	$7	$7	$4	$1	$0	$0	$4	$1	$4	$1	$0	$0	$4	$1
D2949[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3355	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3356	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3357	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3427	$117	$117**	$117	$105	$98	$64	$45	$0	$98	$64	$106	$69	$49	$0	$128	$69
D3428	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3429	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3431	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3432	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D4921	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D5863[2]	$500	$500	$350	$325	$300	$275	$250	$185	$320	$275	$300	$275	$275	$200	$320	$275
D5864[3]	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275	$300	$275	$275	$200	$320	$275
D5865[4]	$500	$500	$350	$325	$300	$275	$250	$185	$320	$275	$300	$275	$275	$200	$320	$275
D5866[5]	$513	$513	$375	$320	$300	$275	$250	$185	$300	$275	$300	$275	$275	$200	$320	$275
D5994	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6011	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6013	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D6052	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D9985[1]	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

FIXED COPAY PLAN CODES
63i – 68i

ADA Code	63i	64i	65i	66i	67i	68i
D0393	NC	NC	NC	NC	NC	NC
D0394	NC	NC	NC	NC	NC	NC
D0395	NC	NC	NC	NC	NC	NC
D0601[1]	NC	NC	NC	NC	NC	NC
D0602[1]	NC	NC	NC	NC	NC	NC
D0603[1]	NC	NC	NC	NC	NC	NC
D1999	NC	NC	NC	NC	NC	NC
D2921	$6	$5	$4	$4	$6	$5
D2941	$4	$1	$0	$0	$0	$1
D2949[1]	NC	NC	NC	NC	NC	NC
D3355	NC	NC	NC	NC	NC	NC
D3356	NC	NC	NC	NC	NC	NC
D3357	NC	NC	NC	NC	NC	NC
D3427	$106	$69	$49	$0	$128	$69
D3428	NC	NC	NC	NC	NC	NC
D3429	NC	NC	NC	NC	NC	NC
D3431	NC	NC	NC	NC	NC	NC
D3432	NC	NC	NC	NC	NC	NC
D4921	NC	NC	NC	NC	NC	NC
D5863[2]	$300	$275	$275	$200	$320	$275
D5864[3]	$300	$275	$275	$200	$320	$275
D5865[4]	$300	$275	$275	$200	$320	$275
D5866[5]	$300	$275	$275	$200	$320	$275
D5994	NC	NC	NC	NC	NC	NC
D6011[1]	NC	NC	NC	NC	NC	NC
D6013	$756	$756	$756	$756	$756	$756
D6052	NC	NC	NC	NC	NC	NC
D9985[1]	NC	NC	NC	NC	NC	NC

[*] Current Dental Terminology.
[**] Copay noted applies only when performed by the PCD. This procedure is not covered when performed by a Specialist; it is available to the member at the Specialist's negotiated fee.
[1] Not separately eligible - the patient cannot be billed for these services.
[2] Not covered – Alternate benefit based on D5110
[3] Not covered – Alternate benefit based on D5211
[4] Not covered – Alternate benefit based on D5120
[5] Not covered – Alternate benefit based on D5212

If you have questions, please call our National Dentist Line at **1-800-451-7715**. Thank you for your continued participation and support of Aetna Dental plans.

Network Bulletin

Date: June 2010

From: Larry Walsh, Head of Dental Network Operations

Subject: D4355 Full Mouth Debridement

Applies to: Dental Maintenance Organization (DMO®) Plans

This bulletin is part of your *Dental Office Guide.* After reviewing this information, it should be placed in the *Network Bulletin* section of your guide for future reference.

Starting October 1, 2010 Full Mouth Debridement (*D4355) will be covered once per lifetime.
D4355 will be:

- A standard benefit for all DMO plans.
- Covered as a major service for all DMO plans.

Collection of the appropriate DMO copayment or coinsurance:
Depending on the type of DMO plan your patient has, you would collect the patient copayment of $60 or coinsurance for this major service.

- On all DMO Plan 50 and 60 fixed copay series the copayment will be $60
- On DMO coinsurance plans you would collect the appropriate percent of your approved UCR for major services

If you have questions, please call our National Dentist Line at **1-800-451-7715**.

Thank you for your continued participation in and support of Aetna Dental® plans.

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Network Bulletin

Date: October 2009

From: Larry Walsh, Head of Dental Network Operations

Subject: 2009 Corrections for the *Dental Office Guide for Specialty Dentists*

Applies to: Dental Maintenance Organization (DMO®) Plans

This bulletin is part of your Dental Office Guide. After reviewing this information, it should be placed in the *Network Bulletin* section of your guide for future reference.

Please make the following correction directly to the chart on page Appendix II-19 of your Dental Office Guide. This correction is effective immediately.

- **D7510* - For Plan Code 66 the copay is $20**

If you have questions about this change, please call our National Dentist Line at **1-800-451-7715**.

Thank you for your continued participation in and support of Aetna Dental® plans.

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Network Bulletin

Date: September 2008

From: Larry Walsh, Head of Dental Network Operations

Subject: Revised Copay Charts and Other Updates to the *Specialty Dental Office Guide*

Applies to: Dental Maintenance Organization (DMO®) Plans

This bulletin is part of your Dental Office Guide. After reviewing this information, it should be placed in your guide for future reference.

New CDT-2009 update to copayment charts for Appendix II of your Dental Office Guide below
In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, the following CDT-2009* code revision should be marked in the copayment charts.

Please mark the charts in Appendix II of your *Specialty Dental Office Guide* with the following CDT 2009 revisions, effective January 1, 2009.

ADA Code	51	52	53	54	55	56	57	58	63	64	65	66	67	68
D0417	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D0418	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
D3222	45	36	32	13	0	0	32	13	50	20	0	0	50	20
D5991	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

Please mark the following correction in your *Dental Office Guide*
Finally, we wish to note the following correction to the Dental Office Guide. Please annotate the correct page in your guide with the information below.

- The coinsurance level for D4249, Clinical Crown Lengthening, will be the same as D4260, Osseous Surgery, for DMO coinsurance plans.

If you have questions, please call our National Dentist Line at **1-800-451-7715**.

Thank you for your continued participation in and support of Aetna Dental® plans.

4/D./SP

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23.05.801.1 A (08/08)