

## DMO OPTION

The **DMO** option offers dental services through participating **providers**. The **DMO** covers almost all the same services as the **PPO** option, with these added features:

- There is no annual benefit maximum or deductible.
- You generally pay less for basic restorative and major restorative **covered** services than you would under the **PPO option**.
- You do not need to file claim forms.

The **DMO** is available to participants who live in eligible zip codes. See Appendix B for a list of **covered** services.

The following chart summarizes how the **DMO** option covers expenses.

	Percent of Eligible Charges Covered by the DMO	Amount You Pay (Your DMO Copayment)
Annual Deductible	N/A	None
Type A Services - Diagnostic and Preventative	100%	0%
Type B Services - Basic Restorative	100%	0%
Type C Services - Major Restorative	75%	25%
Orthodontia	50%	50%

### ***Electing a Personal DMO Participating Dentist***

You and your **covered dependents** each need to designate and use a **Primary Care Dentist (PCD)**. You may designate your **PCD** through **Aetna Navigator** ([www.AetnaNavigator.com](http://www.AetnaNavigator.com)) or by calling the **Claims Administrator** (see “Important Contacts”).

### ***Planning Your Care***

Your participating personal dentist will provide all basic dental services and, if you need specialty services, must arrange for a specialist. You may self-refer to a participating

**DMO** orthodontist without an initial consultation with your **primary care dentist** or a referral to obtain services.

### ***Changing Your Primary Care Dentist***

You may change your **primary care dentist** at any time by contacting the **Claims Administrator** (see “Important Contacts”). If you call by the 15th of the month, the change will take effect on the first day of the following month.

### ***Emergency DMO Care***

Emergency care consists of dental services provided by any licensed dentist, other than your **primary care dentist**, more than a 50 mile distance from where you live. To qualify for payment under the **DMO** when you see a dentist other than your **primary care dentist**, the services must be necessary to relieve pain or to prevent the worsening of the condition. The 50 mile distance rule does not apply to residents of Texas.

### ***DMO Coverage for Orthodontia***

When you use a **DMO** participating specialist for orthodontic treatment, the **DMO** covers 50% of eligible charges with no maximum.

There is an exception for Massachusetts residents, for whom the **DMO** covers 30% of eligible charges after a \$1,000 deductible with no maximum.

Coverage is limited to one complete course of treatment in a lifetime for procedures that are required to correct:

- Faulty position of teeth (malposition), or
- Abnormal bite (malocclusion).

The orthodontist is paid directly. You are responsible for the copayment.

### ***Orthodontic Treatment Plan***

Orthodontia services must be approved prior to beginning treatment. Your dentist should submit a treatment plan including:

- A description of the recommended treatment,
- An estimate of how long the care will last,

- The cost, and
- Supporting X-rays, study models and other evidence.

The treatment plan will be reviewed and your dentist will be notified as to what benefits will be paid.

### ***Your Share of Eligible Expenses***

The **DMO** makes payments directly to personal and specialty dentists according to pre-negotiated fee schedules. You are responsible for any copayments required by the **DMO**. The copayment is determined by applying the copayment percentage to the personal or specialty dentist's usual fee, as approved by the **Claims Administrator** (see "Important Contacts"). (If the dentist is paid on a discounted fee-for-service basis, then that discounted fee is also used to determine your copayment.)

See Appendix B for a list of the services **covered** under the **DMO**. If a service is not listed in the Appendix, but the Dental Plan does cover a service that is equally suitable for the condition being treated, then the Dental Plan will provide an alternate benefit for that service. If you wish to have the non-covered service provided instead of the alternate service, you will be responsible for any charges in excess of the charge that would have applied for the alternate service. If there is no alternate service, you will be responsible for the full cost of treatment for any non-covered service.

See Appendix C for a list of the services not **covered** under the **DMO**.