



## Dental Benefits Summary

|                                                         | <b>Passive PPO</b>                                 |                                 |
|---------------------------------------------------------|----------------------------------------------------|---------------------------------|
|                                                         | <b>With PPOII and Extend<sup>SM</sup> Networks</b> |                                 |
|                                                         | <b><u>Participating</u></b>                        | <b><u>Non-participating</u></b> |
| <b>Annual Deductible*</b>                               |                                                    |                                 |
| Individual                                              | \$50                                               | \$50                            |
| Family                                                  | \$150                                              | \$150                           |
| Preventive Services                                     | 100%                                               | 100%                            |
| Basic Services                                          | 90%                                                | 90%                             |
| Major Services                                          | 60%                                                | 60%                             |
| Annual Benefit Maximum                                  | \$2000                                             | \$2000                          |
| Office Visit Copay                                      | N/A                                                | N/A                             |
| Orthodontic Services (Adult and Child)                  | 50%                                                | 50%                             |
| Orthodontic Deductible                                  | None                                               | None                            |
| Orthodontic Lifetime Maximum                            | \$1000                                             | \$1000                          |
| *The deductible applies to: Basic & Major services only |                                                    |                                 |
| <b>Preventive</b>                                       |                                                    |                                 |
| Oral examinations (a)                                   | 100%                                               | 100%                            |
| Cleanings (a) Adult/Child                               | 100%                                               | 100%                            |
| Fluoride (a)                                            | 100%                                               | 100%                            |
| Sealants (permanent molars only) (a)                    | 100%                                               | 100%                            |
| Bitewing Images (a)                                     | 100%                                               | 100%                            |
| Full mouth series Images (a)                            | 100%                                               | 100%                            |
| Space Maintainers                                       | 100%                                               | 100%                            |
| <b>Basic</b>                                            |                                                    |                                 |
| Root canal therapy, anterior teeth and bicuspid teeth   | 90%                                                | 90%                             |
| Root canal therapy, molar teeth                         | 90%                                                | 90%                             |
| Scaling and root planing (a)                            | 90%                                                | 90%                             |
| Gingivectomy (a)*                                       | 90%                                                | 90%                             |
| Amalgam (silver) fillings                               | 90%                                                | 90%                             |
| Composite fillings                                      | 90%                                                | 90%                             |
| Stainless steel crowns                                  | 90%                                                | 90%                             |

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|----------------------------------------------------------------------------------------------------|-----|-----|
| Incision and drainage of abscess*                                                                  | 90% | 90% |
| Uncomplicated extractions                                                                          | 90% | 90% |
| Surgical removal of erupted tooth*                                                                 | 90% | 90% |
| Surgical removal of impacted tooth (soft tissue)*                                                  | 90% | 90% |
| Osseous surgery (a)*                                                                               | 90% | 90% |
| Surgical removal of impacted tooth (partial bony/ full bony)*                                      | 90% | 90% |
| General anesthesia/intravenous sedation*                                                           | 90% | 90% |
| Crown Lengthening                                                                                  | 90% | 90% |
| <b>Major</b>                                                                                       |     |     |
| Inlays                                                                                             | 60% | 60% |
| Onlays                                                                                             | 60% | 60% |
| Crowns                                                                                             | 60% | 60% |
| Full & partial dentures                                                                            | 60% | 60% |
| Pontics                                                                                            | 60% | 60% |
| Denture repairs                                                                                    | 60% | 60% |
| Crown Build-Ups                                                                                    | 60% | 60% |
| Implants                                                                                           | 60% | 60% |
| *Certain services may be covered under the Medical Plan. Contact Member Services for more details. |     |     |
| (a) Frequency and/or age limitations may apply. Limits are described in the booklet/certificate.   |     |     |

### Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service a PPO participating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates.

Out-of-Network plan payments are based on the 95th percentile of allowed amount for the geographic area.

### Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

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When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

**Partial List of Exclusions and Limitations\* - Coverage is not provided for the following (unless otherwise noted in the member booklet):**

1. Charges for services or supplies
  - Provided by a network provider in excess of the negotiated charge.
  - Provided by an out-of-network provider in excess of the recognized charge.
  - Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
  - Provided in connection with treatment or care that is not covered under the plan
  - Cancelled or missed appointment charges or charges to complete claim forms
  - Charges for which you have no legal obligation to pay
  - Charges that would not be made if you did not have coverage, including:
    - Care in charitable institutions
    - Care for conditions related to current or previous military service
    - Care while in the custody of a governmental authority
2. Any charge in excess of any benefit, dollar, visit, or frequency limit stated in the schedule of benefits.
3. Cosmetic services and supplies.
4. Court-ordered services and supplies - Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.
5. Acupuncture, acupressure and acupuncture therapy
6. Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge.
7. Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
8. Dental work that began before you were covered by the plan.
9. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered.
10. General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service.
11. Instruction for diet, tobacco counseling and oral hygiene.

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12. Orthodontic treatment except as covered in the Eligible Dental Services section of the schedule of benefits.
13. Dental services and supplies made with high noble metals (gold or titanium) except as covered in the Eligible Dental Services section of the schedule of benefits.
14. Services and supplies provided in connection with treatment or care that is not covered under the plan.
15. Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
16. Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.
17. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
18. Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons.
19. Temporomandibular joint dysfunction/disorder
20. Dental services and supplies that are covered in whole or in part:
  - Under any other part of this plan
  - Under any other plan of group benefits provided by the policyholder
21. Experimental or investigational drugs, devices, treatments or procedures.
22. Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
23. Payment for a portion of the charge that another party is responsible for as the primary payer.
24. Prescribed drugs, pre-medication or analgesia.
25. Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride.
26. Work related illness or injuries.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

\*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

**Your Dental Care Plan Coverage Is Subject to the Following Rules:**

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Alternate treatment rule Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

- If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.
- If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.
- You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Replacement rule Some eligible dental services are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
  - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

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- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)

- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Late entrant rule (Does not apply to Maine contract state and Maine residents): The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

- The first 31 days the person is eligible for this coverage or
- Any period of open enrollment agreed to by the employer and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of injuries sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (excludes services related to orthodontia).

### Finding Participating Providers

Consult Aetna Dentals online provider search for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider search available at [www.aetna.com](http://www.aetna.com).

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

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

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

Telehealth Services: the plan will reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of an enrollee via telehealth on the same basis and to the same extent that the plan would reimburse the same covered in-person service.

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In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705),

[CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

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|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hawaiian             | No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.                                          |
| Hindi                | बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।                                                                     |
| Hmong                | Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.                                                             |
| Igbo                 | Inweta enyemaka asụsụ na akwughi ugwo obula, kpoo nomba no na kaadi njirimara gi                                                                                 |
| Ilocano              | Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.                                                    |
| Indonesian           | Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.                                                      |
| Italian              | Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.                                                    |
| Japanese             | 無料の言語サービスは、IDカードにある番号にお電話ください。                                                                                                                                   |
| Karen                | လၢတၢ်ကမၤန့ၢ်တၢ်မၤစၢၤအတၢ်တံးတၢ်မၤတၢ်တံး<br>လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်ဒီးအဂီၢ်, ကိးတၢ်လီၤတၢ်စီၣ်နီၣ်ဂီၢ်လၢအိၣ်လၢနခိၣ်ဂီၢ် (ID) အလီၤန့ၣ်တက့ၢ်.                     |
| Korean               | 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.                                                                                                                    |
| Kru-Bassa            | I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla                                                       |
| Kurdish              | بو دەستگیراگەشتن بە خزمەتگوزاری زمان بەی تێچوون یۆ تو، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.                                                         |
| Lao                  | ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບທາງເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.                                                                                    |
| Marathi              | आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.                                                           |
| Marshallese          | Nan bōk jipañ kōn kajin ilo an ejjelōk wōñean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am.                                                                |
| Micronesia-Ponapean  | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.                                                                       |
| Mon-Khmer, Cambodian | ដើម្បីទទួលបានសេវាកម្មភាសាដែលគិតតម្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។                                                   |
| Navajo               | T'áá ni nizaad k'éhjí bee níká a'doowol doo b'ááh ílínígóó naaltsoos bee atah nílíggo nanitinígíí bee néého'dólinígíí béesh bee hane'í biká'ígíí áajj' hólne'.   |
| Nepali               | भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।                                                                          |
| Nilotic-Dinka        | Të koor yin ran de wëër de thokic ke cîn wëu kor keek tēnɔŋ yîn. Ke yin col ran ye koc kuony nē namba de abac tö nē ID kard duön de tiit de nyin de panakim köu. |
| Norwegian            | For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.                                                                                     |

