Dental Benefits Summary

	Indemnity
Annual Deductible*	
Individual	**$50**
Family	**$150**
Preventive Services	**100%**
Basic Services	**80%**
Major Services	**50%**
Annual Benefit Maximum	**$1500**
Office Visit Copay	**N/A**
Orthodontic Services**	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	**$1000**
***The deductible applies to: Basic & Major services only**	
****Orthodontia is covered only for children (appliance must be placed prior to age 20).**	
Partial List of Services	**Indemnity**
Preventive	
Oral examinations (a)	**100%**
Cleanings (a) Adult/Child	**100%**
Fluoride (a)	**100%**
Sealants (permanent molars only) (a)	**100%**
Bitewing Images (a)	**100%**
Full mouth series Images (a)	**100%**
Space Maintainers	**100%**
Basic	
Root canal therapy, anterior teeth and bicuspid teeth	**80%**
Root canal therapy, molar teeth	**80%**
Scaling and root planing (a)	**80%**
Gingivectomy (a)*	**80%**
Amalgam (silver) fillings	**80%**

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Composite fillings (anterior teeth only)	**80%**
Stainless steel crowns	**80%**
Incision and drainage of abscess*	**80%**
Uncomplicated extractions	**80%**
Surgical removal of erupted tooth*	**80%**
Surgical removal of impacted tooth (soft tissue)*	**80%**
Osseous surgery (a)*	**80%**
Surgical removal of impacted tooth (partial bony/ full bony)*	**80%**
Crown Lengthening	**80%**
Major	
Inlays	**50%**
Onlays	**50%**
Crowns	**50%**
Full & partial dentures	**50%**
Pontics	**50%**
General anesthesia/intravenous sedation*	**50%**
Denture repairs	**50%**
Crown Build-Ups	**50%**
***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 benefits summary of the Aetna Dental® Indemnity Dental coverage is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Our dental Indemnity plan gives you the freedom to visit any licensed dentist for covered expenses. You do not need a referral, or an ID card. Benefits under the Indemnity dental plan are subject to usual and prevailing charge limits, as determined by Aetna.

Coverage for Major and Orthodontic services may be subject to a 12 month waiting period (does not apply to Maine contract state and Maine residents). Refer to plan documents for details.

Dental Benefits Summary

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 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.(Does not apply to New Hampshire contract state)

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. Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

8. 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.

9. Dental work that began before you were covered by the plan.(Does not apply to California contract state)

10. 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.(Does not apply to California contract state)

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11. General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service.

12. Instruction for diet, tobacco counseling and oral hygiene.

13. Orthodontic treatment except as covered in the Eligible Dental Services section of the schedule of benefits.

14. 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.

15. Services and supplies provided in connection with treatment or care that is not covered under the plan.

16. 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.

17. Replacement of teeth beyond the normal complement of 32.

18. Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

19. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

20. Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons.

21. Temporomandibular joint dysfunction/disorder

22. 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

23. Experimental or investigational drugs, devices, treatments or procedures.

24. Services, including but not limited to, treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna)

25. Payment for a portion of the charge that another party is responsible for as the primary payer.

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26. Prescribed drugs, pre-medication or analgesia.

27. 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.

28. 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:

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.(Does not apply to New Hampshire contract state)

- 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

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

• While you were covered by the plan (Does not apply to California contract state):
- 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 8 years before its replacement.
- An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 8 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 (Does not apply to California contract state) :

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

• 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 8 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).

Dental Benefits Summary

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.

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.

In Arizona, DMO®, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc. In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and Indemnity Dental plans are provided or 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 Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

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If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
This notice is available at Aetna Inc.'s website:https://www.aetna.com/

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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TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավելի լավ իրազեկվածություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով հեռախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu,ågang i numiru gi iyo-**mu kard aidentifikasion.**
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	**તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.**
Hindi	**बिना किसी की**मत 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.
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	လၵ်ာတၢ်ကမ္ၢကျိာတၢ်မၢ်စၵ်းအတၢ်ဖံးတၢ်မၢ်တဖုာ လၵ်ာတအိၣ်ဒီးအပ္ၢ်လၵ်နကဘာဟ့ဉ်အီၤအကျိးကိးဘာလီတဲစိနီဉ်ဂၤ်လၵ်အအိၣ်လၵ်နခိဉ်ဂီၤ ၀ (၅၅) အလိၣ်တက့ၢ်၅၅
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອຂໍ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគ្មានតម្លៃ សូមហៅទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ **ដើម្បីទទួលបានសេវាកម្មភាសាដែលគ្មានតម្លៃ សូមហៅទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។**
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bąąh ílínígóó naaltsoos bee atah nilíjgo nanitínígíí bee nééhó'dólzinígíí béésh bee hane'í biká'ígíí áají' hółne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ **ਬਿਨਾਂ** ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ **ਸੇਵਾਵਾਂ** ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ **ਫ਼ੋਨ** ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܐܬܝ ܡܫܘܬܦܘܬ ܡܠܐ ܕܚܠܦ ܠܐ ܡܬܚܫܒ ܠܡܐܬܝ ܐܢ ܡܟܬܘܒ ܡܫܘܬܦܘܬ ܡܬܝܠܐ ܕܚܠܦ ܠܐ ܡܬܚܫܒ ܠܡܐܬܝ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	**หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย** **โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน**
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.