Dental Benefits Summary

	Passive PPO With PPOII Network
Annual Deductible*	
Individual	**$50**
Family	**$150**
Preventive Services	**100%**
Basic Services	**80%**
Major Services	**50%**
Annual Benefit Maximum	**$1,000**
Office Visit Copay	**N/A**
Orthodontic Services**	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	**$1,000**

***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	Passive PPO With PPOII Network
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 / Bicuspid teeth	80%
Scaling and root planing (a)	80%
Gingivectomy*	80%
Amalgam (silver) fillings	80%
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%
Major	
Inlays	50%
Onlays	50%
Crowns	50%
Crown lengthening	50%
Full & partial dentures	50%
Pontics	50%
Root canal therapy, molar teeth	50%
Osseous surgery (a)*	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	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 to these services. These 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 either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to recognized charge limits.

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.

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.

A partial list of what your plan doesn't cover* – some eligible dental service exceptions and exclusions

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 including:
• Plastic surgery
• Reconstructive surgery
• Cosmetic surgery
• Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
• Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach or alter the appearance of teeth whether or not for psychological or emotional reasons
• Facings on molar crowns and pontics will always be considered cosmetic.

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. This means that the following dental work is not covered:
• An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
• A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
• Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

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.

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, 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.

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

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.
• 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 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:

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. (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: 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

• For services listed as visits and exams, images and pathology in the schedule of benefits.

Finding Participating Providers

Consult Aetna Dentals online provider directory, DocFind®, 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 directory (DocFind) available at 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.

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.

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).

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TTY: 711

For language assistance in your language call 877-238-6200 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-238-6200. (Spanish)

欲取得繁體中文語言協助，請撥打877-238-6200，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-238-6200 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-238-6200 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-238-6200 an. (German)

(Arabic) .6200-238-877 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-238-6200 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-238-6200. (Italian)

日本語で援助をご希望の方は、877-238-6200 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-238-6200 번으로 전화해 주십시오. (Korean)

(Persian) برای راهنمایی به زبان فارسی با شماره 877-238-6200. بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-238-6200. (Polish)

Para obter assistência linguística em português ligue para o 877-238-6200 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-238-6200. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-238-6200. (Vietnamese)