



Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Aetna Life Insurance Company Plan Name: Aetna Dental® PPO
Policy Type: PPO Insurer Phone #: 1-877-238-6200
Effective Date: 01/01/2024-12/31/2024 Insurer Website: www.aetna.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT www.aetna.com OR CALL 1-877-238-6200.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	\$50 per individual up to \$150 per family combined with Out-of-Network	\$50 per individual up to \$150 per family combined with In-Network
Orthodontia	None	None

- The **deductible** applies to the following services: Basic & Major.
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rate of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	\$2,000 per individual combined with Out-of-Network	\$2,000 per individual combined with In-Network
Lifetime or Annual Maximum for Orthodontia	\$1,000 per individual per lifetime combined with Out-of-Network	\$1,000 per individual per lifetime combined with In-Network

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Does not apply.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Oral Exam</i>	Preventive & Diagnostic	No charge	No charge	Two routine & two problem-focused exams per year. For more information about dental limitations & exceptions, see your policy documents.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	No charge	No charge	One set per year.
<i>Cleaning</i>	Preventive & Diagnostic	No charge	No charge	Two per year.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Filling</i>	Basic	10% for anterior resin composite	10% for anterior resin composite	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	10%	10%	
<i>Root Canal</i>	Basic	10% for molar	10% for molar	
<i>Scaling and Root Planing</i>	Basic	10%	10%	Four separate quadrants per 2 rolling years.
<i>Ceramic Crown</i>	Major	40%	40%	Replacement of existing crown limited to once every 5 years.
<i>Removable Partial Denture</i>	Major	40%	40%	Replacement of existing denture limited to once every 5 years.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	10%	10%	
<i>Orthodontia</i>	Orthodontia	50%	50%	

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
<i>New patient exam, x-rays (FMX) and cleaning</i>	<i>Resin-based composite - one surface, posterior</i>	<i>Crown - porcelain/ceramic substrate</i>

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: \$400 Out-of-network: \$550	Total Cost of Care	In-network: \$150 Out-of-network: \$200	Total Cost of Care	In-network: \$1,300 Out-of-network: \$1,750
Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: \$50 Out-of-network: \$50	Deductible	In-network: \$50 Out-of-network: \$50
Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000
Patient Cost (copayment or coinsurance)	In-network: \$0 Out-of-network: \$0	Patient Cost (copayment or coinsurance)	In-network: 10% Out-of-network: 10%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 40%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$0 Out-of-network: \$0	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$60 Out-of-network: \$65	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$550 Out-of-network: \$730
Summary of what is not covered or subject to a limitation:	Annual maximum applies. Oral Exam: Two routine exams per year. X-rays (FMX): One set per 3 rolling years. Cleaning: Two per year. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Annual maximum applies. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Annual maximum applies. Replacement once every 5 years. For more information about dental limitations & exceptions, see your policy documents.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation 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 the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705
CRCoordinator@aetna.com

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can 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).

Dental policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna). Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-238-6200 at no cost.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-877-238-6200.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-238-6200 ይደውሉ።
Arabic -	مقررلا ىلع لاصتالاء اجرلا، ؤفلكت يأ نود ؤيولل امدخلال ىلع لوصحلل 1-877-238-6200
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-238-6200 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-238-6200 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-238-6200.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবকিসাি পপকে হকয এই নম্বকি পবেযক ান ব্রুন: 1-877-238-6200।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-238-6200.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-877-238-6200 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-238-6200.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-238-6200.
Cherokee -	Ⴄႃႉႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ 1-877-238-6200.
Chinese -	如欲使用免費語言服務，請致電 1-877-238-6200。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-238-6200.
Cushite -	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-238-6200.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-877-238-6200.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-238-6200.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-877-238-6200.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-238-6200 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-238-6200.

Gujarati -	તમારે કોઇ જાતના ખર્ચ વાનિ ભાષાની સેવિઓની પહોર માટે, કોલ કરો 1-877-238-6200.
Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-238-6200 Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लएि, 1-877-238-6200 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-238-6200.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-877-238-6200.
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-238-6200.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-238-6200.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-238-6200.
Japanese -	言語サービスを無料でご利用いただくには、1-877-238-6200 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-238-6200 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-238-6200 번으로 전화해 주십시오.
Kru-Bassa -	M dyi wuḍu-dù kà kò dò bě dyi móuṇ nì Pídyi ní, nîí, dá nòbà nìà ke: 1-877-238-6200.
Kurdish -	1-877-238-6200 یەرامژ مە مەکەب یەدەنەوی مە پ، وە ت و ب نو و چ ئێ ت ئێ ب مە نامز یراز و گەتەمەز مە ب ن ت ش ی ه گ ا ر ئ پ س ه د و ب
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕົວກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-877-238-6200.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-877-238-6200 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlök 1-877-238-6200.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-238-6200.
Mon-Khmer Cambodian -	ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកកម្ពុជា មុនពេលទូរស័ព្ទសេវាភាសាសូម 1-877-238-6200។.
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo b'ááh ílínígóó kojí' hólne 1-877-238-6200.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-877-238-6200 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të koor yin wëër de thokic ke cîn wëu kor keek tënɔŋ yîn. Ke cɔl koc ye koc kuony ne nɔmba 1-877-238-6200.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-877-238-6200.

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