



**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: 08/01/2022-07/31/2023    Insurer Website: [www.aetna.com](http://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](http://www.aetna.com) OR CALL 1-877-238-6200.**

**THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

**Part II: DEDUCTIBLES**

<b>Deductible</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Dental	\$50 per individual up to \$150 per family combined with Out-of-Network	\$75 per individual up to \$225 per family combined with In-Network

- 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**

<b>Maximums</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Annual Maximum	\$1,500 per individual combined with Out-of-Network	\$1,000 per individual combined with In-Network
Lifetime Maximum for Orthodontia	Not covered	Not covered

- **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.
- **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 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.**

<b>Common Dental Procedures</b>	<b>Category</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Benefit Limitations and Exclusions</b>
<i>Oral Exam</i>	Preventive & Diagnostic	No charge	20%	Two routine & two problem-focused exams per year. For more information about limitations & exceptions, see your policy documents.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	No charge	20%	One set per year.
<i>Cleaning</i>	Preventive & Diagnostic	No charge	20%	Two per year.

<b>Common Dental Procedures</b>	<b>Category</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Benefit Limitations and Exclusions</b>
<i>Filling</i>	Basic	20% for anterior resin composite	30% for anterior resin composite	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	20%	30%	
<i>Root Canal</i>	Basic	20% for molar	30% for molar	
<i>Scaling and Root Planing</i>	Basic	20%	30%	Four separate quadrants per 2 rolling years.
<i>Ceramic Crown</i>	Major	50%	60%	Replacement of existing crown limited to once every 8 years.
<i>Removable Partial Denture</i>	Major	50%	60%	Replacement of existing dentures limited to once every 8 years.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	20%	30%	
<i>Orthodontia</i>	Orthodontia	Not covered	Not covered	

### **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 policy to other dental policies 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.

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

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
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: \$75	Deductible	In-network: \$50 Out-of-network: \$75
Annual Maximum (Plan Will Pay)	In-network: \$1,500 Out-of-network: \$1,000	Annual Maximum (Plan Will Pay)	In-network: \$1,500 Out-of-network: \$1,000	Annual Maximum (Plan Will Pay)	In-network: \$1,500 Out-of-network: \$1,000
Patient Cost (copayment or coinsurance)	In-network: \$0 Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 30%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 60%

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
<b>In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$0  <b>Out-of-network:</b> \$110	<b>In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$70  <b>Out-of-network:</b> \$113	<b>In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$675  <b>Out-of-network:</b> \$1,080
Summary of what is not covered or subject to a limitation:	Annual Maximum applies. Oral Exam: Two routine exams per year. Xrays (FMX): One set per 3 rolling years. Cleaning: Two per year.	Summary of what is not covered or subject to a limitation:	Annual Maximum applies.	Summary of what is not covered or subject to a limitation:	Annual Maximum applies. Replacement once every 8 years.

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

You can also file a complaint with the California Department of Insurance at [www.insurance.ca.gov](http://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).

**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).**



- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-238-6200. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लिए, 1-877-238-6200 पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-238-6200.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-877-238-6200 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-238-6200 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-238-6200.
- Japanese - 日本語で援助をご希望の方は、1-877-238-6200 まで無料でお電話ください。
- Karen - လာတာဝန်များကိုကူညီရန်အကူအညီ 877-238-6200 လာတာဝန်များကိုကူညီရန်အကူအညီ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-238-6200 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Baśwó-wuđuuñ wěε, dǎ 1-877-238-6200
- Kurdish - **برای راهنمایی به زبان فارسی، با شماره 1-877-238-6200 به خورایی یه یومندی بکهن.**
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-877-238-6200 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशुभिय भाषा सेवा प्राप्त करण्यासाठी, 1-877-238-6200 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-238-6200 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-238-6200 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-238-6200 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-238-6200
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-877-238-6200 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuony ë thok ë Thuonjäñ col 1-877-238-6200 kecin ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-877-238-6200 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-238-6200 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-877-238-6200 aa. Es Aaruf koschtet nix.
- Persian - **برای راهنمایی به زبان فارسی، با شماره 1-877-238-6200 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-238-6200.
- Portuguese - Para obter assistência linguística em português ligue para o 1-877-238-6200 gratuitamente.



- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-238-6200
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-238-6200.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-238-6200 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-238-6200.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-238-6200.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-238-6200. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-238-6200 bila malipo.
- Syriac - ܟܠ ܥܡܟܢ ܟܠ ܗܘܢܐܝܢ ܕܗܘܢܐ ܥܠܝܗܘܢ ܟܠ ܗܘܢܐܝܢ ܕܗܘܢܐ ܥܠܝܗܘܢ ܟܠ ܗܘܢܐܝܢ ܕܗܘܢܐ ܥܠܝܗܘܢ 1-877-238-6200ܐܘܪܝܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-238-6200 nang walang bayad.
- Telugu - భూషణత్రో సాయం క్కొరకు ఎలాంటి ఖర్చు లోకుండా 1-877-238-6200 కు కాల్ చేయండి. (తృలగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-238-6200 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-238-6200 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-238-6200 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-877-238-6200.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-238-6200.
- Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-238-6200 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-238-6200.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-238-6200 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-877-238-6200 láí san owó kankan rárá.