Aetna Dental presents

A Dental Benefit Summary for

California; Freedom-of-Choice Plus; No Ortho

	DMO®	PPO with PPO II
Annual Deductible*		
Individual	**None**	**$50**
Family	**None**	**$150**
Preventive Service Copay	**See Schedule**	**100%**
Basic Service Covered Copay	**See Schedule**	**80%**
Major Service Covered Copay	**See Schedule**	**50%**
Annual Benefit Maximum	**None**	**$1,000**
Office Visit Copay	**$5**	**None**
Orthodontic Services	**None**	**None**
Orthodontic Deductible	**N/A**	**N/A**
Orthodontic Lifetime Maximum	**N/A**	**N/A**

***The deductible applies to: Basic & Major services only**

Partial List of Plan Provisions	Patient CoPay	PPO with PPO II
Preventive**		
Oral examinations (a)	No Charge	100%
Cleanings, Adult/Child including scaling and polishing (2 per year)	No Charge	100%
Fluoride (1 application per year for children under age 16)	No Charge	100%
Sealants (1 treatment per tooth every 3 years on permanent molars only for children under age 16)	$5	100%
Bitewing X-rays (1 set per year)	No Charge	100%
Full mouth series X-rays (1 set every 3 years)	No Charge	100%
Space Maintainers, fixed	$60	100%
Basic		
Amalgam (silver) fillings (2 surfaces)	No Charge	80%
Composite fillings (2 surfaces, anterior)	No Charge	80%
Composite fillings (2 surfaces, posterior)	No Charge	80%
Stainless steel crowns – primary teeth (child)	$35	80%
Root canal therapy, with cultures		
Anterior teeth	$70	80%
Bicuspid teeth	$85	80%
Scaling and root planning, per quadrant (4 separate quadrants every 2 years)	$55	80%
Gingivectomy (1 per quadrant every 3 years)	$100	80%
Incision and drainage of abscess	$20	80%
Extraction, erupted tooth or exposed root	No Charge	80%
Surgical removal of erupted tooth	$28	80%
Surgical removal of impacted tooth (soft tissue)	$46	80%
Major		
Root canal therapy, molar teeth, with cultures	$240	50%
Osseous surgery, per quadrant (1 per quadrant every 3 years)	$300	50%
Surgical removal of impacted tooth (full bony)	$100	50%
(b) Inlays (metallic; three or more surfaces)	$180	50%
(b) Onlays (metallic; three or more surfaces)	$180	50%
(b) Crowns (porcelain with noble metal)	$210	50%
Complete upper or lower denture	$275	50%
Partial upper or lower denture (cast metal base)	$350	50%
(b) Pontics (porcelain with noble metal)	$210	50%

(a) PPO oral exams limited to 2 "routine" exams (comprehensive or periodic) and 2 problem-focused exams per year. *

***The frequency limits for preventive services do not apply to DMO plans if needed more frequently due to medical necessity.*

(b) There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures. All DMO copays for crown and bridge are per unit.

Other Important Information

This Aetna Dental Benefit Summary provides information on Aetna Dental Maintenance Organization (DMO®) benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, covered dental services must be provided by a primary care dentist selected from the network of participating DMO dentists.

This Benefit summary of Aetna Dental Preferred Provider Organization (PPO) coverage is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO or PPO II participating dentist or any non-participating dentist. With the PPO Plan, savings are possible because the participating dentists have agreed to provide care at a negotiated fee schedule.

Non-Participating benefits are subject to reasonable and customary charge limits.

Coverage for Major services is subject to a waiting period and will take effect after 12 months of continuous coverage under the PPO Plan. The waiting period does not apply to the DMO.

Specialty Referrals

Under the DMO Dental Plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental.

*Emergency Dental Care**

If you are covered under the DMO plan and 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. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist.

If you are covered under the PPO and need emergency dental care for 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. Covered emergency services may vary, based on state law.

*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.

Some of the Services not covered under the plan are:

1. Those for services or supplies which are covered in whole or in part:
   (a) Under any other part of this Dental Care Plan; or
   (b) Under any other plan of group benefits provided by or through your Employer.
2. Those for services and supplies to diagnose or treat a disease or injury that is not:
   (a) A non-occupational disease; or
   (b) A non-occupational injury.
3. Those for services not listed in the Dental Care Schedule that applies unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing, or stolen appliance; and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
5. Those for: plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which are primarily intended to improve, alter, or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. Those for or in connection with: services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for: dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion or correcting attrition, abrasion, or erosion (does not apply to DMO)..
8. Those for any of the following services:
   (a) An appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;
   (c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Those for services that Aetna defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician or dentist.
10. Those for services intended for treatment of any Jaw Joint Disorder unless otherwise specified in the Booklet-Certificate.
11. Those for Space Maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than: (a) during the first 31 days the person is eligible for this coverage; or (b) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:
    (a) After the end of the twelve month period starting on the date the person became a covered person; or
    (b) As a result of accidental injuries sustained while the person was a covered person; or
    (c) For a primary care service in the Dental Care Schedule that applies shown under the headings Visits and Exams, and X-rays and Pathology.
16. Those for services given by a non-participating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast, or processed restoration unless:
    (a) It is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
    (b) The tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high noble metals unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons unless otherwise specified in the Booklet-Certificate.
20. Those for services needed solely in connection with non-covered services.
21. Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services (does not apply to DMO).

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

Your Dental Care Plan coverage is subject to the following rules:

Replacement Rule: The replacement of, addition to, or modification of: existing dentures, crowns, casts or processed restorations, removable dentures, fixed bridgework, or other prosthetic services is covered only if one of the following terms is met:

(a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental Care Plan coverage must have been in force for the covered person when the extraction took place.

(b) The existing denture, crown, cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable; and was installed at least 8 years under the PPO Dental Plan or 5 years under the DMO Dental Plan before its replacement.

(c) The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent; and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule (does not apply to DMO): Coverage for the first installation of removable dentures, fixed bridgework, and other prosthetic services is subject to the requirements that such removable dentures, fixed bridgework, and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture, removable bridge, or fixed bridge installed during the prior 8 years under the PPO Dental plan.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) The service must be listed on the Dental Care Schedule;

(b) The service selected must be deemed by the dental profession to be an appropriate method of treatment; and

(c) The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved; the specific copayment for such service will consist of:

(a) The copayment for the approved less costly service; plus

(b) The difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dental's on-line provider directory that can be found at www.aetna.com 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. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO as known to Aetna Dental at the time this provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or member services at the toll-free number on your ID card or use our Internet based provider directory DocFind®.

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

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. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. 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, Certificate-booklet, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.