## Dental Benefits Summary - Proposed EPP Plan

**Effective Date:** 10/01/2018

### Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral examinations (a)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Cleanings (a) Adult/Child</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Fluoride (a)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sealants (permanent molars only) (a)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bitewing Images (a)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Full mouth series Images (a)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Basic Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam (silver) fillings</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Composite fillings (anterior teeth only)</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Stainless steel crowns</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Incision and drainage of abscess*</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Uncomplicated extractions</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgical removal of erupted tooth*</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (soft tissue)*</td>
<td>50%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Major Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root canal therapy</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Anterior teeth / Bicuspid teeth</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Scaling and root planing (a)</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Gingivectomy*</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inlays</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Onlays</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Crowns</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Crown lengthening</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Full &amp; partial dentures</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pontics</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Root canal therapy, molar teeth</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Osseous surgery (a)*</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (partial bony/ full bony)*</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>General anesthesia/intravenous sedation*</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Denture repairs</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Crown Build-Ups</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Implants</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*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.
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 EPP dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, coverage isn't applicable. Refer to your plan documents for details. Subject to state requirements.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that 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. 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. 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 dental services or supplies, that 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 to correct attrition, abrasion or erosion.

8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (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. 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.


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:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating 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.


20. Services needed solely in connection with non-covered services.

21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

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:**

**Replacement Rule**

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

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

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 before its replacement.

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.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

**Tooth Missing But Not Replaced Rule**

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.

**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.

**Reinstatement Rule:** If your Employee and Dependents coverage terminates because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage terminates. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be effective as described in the Effective date of Coverage section of the Booklet-Certificate. Your dental coverage will be subject to any rules that apply to a person who enrolls after the first 31 days the person is eligible for the coverage.

**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.

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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

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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 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)

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

Pou jwenn assistans 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)

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

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)