Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Aetna Life Insurance Company
Policy Type: PPO
Effective Date: 01/01/2027 - 12/31/2027

Plan Name: Aetna Dental® PPO
Insurer Phone #: 1-877-238-6200
Insurer Website: 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 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 & Preventive & Diagnostic.
- 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	$1,250 per individual combined with Out-of-Network	$1,250 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
Oral Exam	Preventive & Diagnostic	20%	20%	Two routine & two problem-focused exams per year. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, see your policy documents.
Bitewing X-ray	Preventive & Diagnostic	20%	20%	One set per year.
Cleaning	Preventive & Diagnostic	20%	20%	Two per year.
Filling	Basic	40% for anterior resin composite	40% for anterior resin composite	
Extraction, Erupted Tooth or Exposed Root	Basic	40%	40%	
Root Canal	Major	50% for molar	50% for molar	
Scaling and Root Planing	Basic	40%	40%	Four separate quadrants per 2 rolling years.
Ceramic Crown	Major	50%	50%	Replacement of existing crown limited to once every 8 years.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Removable Partial Denture	Major	50%	50%	Replacement of existing denture limited to once every 8 years.
Extraction, Erupted Tooth with Bone Removal	Basic	40%	40%	
Orthodontia	Orthodontia	50%	50%	Limited to dependent children & treatment must start prior to age 20.

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
New patient exam, x-rays (FMX) and cleaning	Resin-based composite - one surface, posterior	Crown - porcelain/ceramic substrate

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: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $1,250 Out-of-network: $1,250	Annual Maximum (Plan Will Pay)	In-network: $1,250 Out-of-network: $1,250	Annual Maximum (Plan Will Pay)	In-network: $1,250 Out-of-network: $1,250
Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 40%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%

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:** $120 **Out-of-network:** $150	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $90 **Out-of-network:** $110	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $675 **Out-of-network:** $900
Summary of what is not covered or subject to a limitation:	Annual maximum applies. Oral Exam: Two routine exams per year. Cleaning: Two per year. X-rays (FMX): One set per 3 rolling years. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, 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, including balance billing by out-of-network dentists, see your policy documents.	Summary of what is not covered or subject to a limitation:	Annual maximum applies. Replacement once every 8 years. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, 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.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified sign language interpreters
  - Information written in other languages.

If you need reasonable medications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332, (HMO customers: P.O. Box 24030 Fresno, CA 93779)
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to

help you.

Please visit https://www.aetna.com/individuals-families/member-rights-resources/complaints- grievances-appeals.html#california for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna's website: https://www.aetna.com/

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").

TTY: 711

English -	**To access language services at no cost to you, call 1-877-238-6200.**
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-238-6200 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-877-238-6200.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-238-6200 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-238-6200.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-238-6200.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-877-238-6200.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-238-6200.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-238-6200.
French Creole (Haitian)-	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 -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોંર્ માટે, કોલ કરોr 1-877-238-6200·
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 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.
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 -	လၢတၢ်ကမၤန့ၢ်ကျဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖာ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟုဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-877-238-6200 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-238-6200 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-877-238-6200.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-238-6200 ។

Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ 1-877-238-6200.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-238-6200.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-238-6200 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-238-6200.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-238-6200.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-238-6200 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-238-6200.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, valaʾau le 1-877-238-6200.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-877-238-6200.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-877-238-6200.
Syriac-Assyrian -	ܠܡܒܚܪ ،ܒܠܫܢܐ ܕܡܬܝܠܐ ܠܟ ܠܓܒܝܐ ܕܠܐ ܚܝܠܐ ܕܡܬܝܠ ܠܟ ܠܡܐ ܕܫܒܩ ܠܟ 1-877-238-6200.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-238-6200.
Thai -	**หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร** 1-877-238-6200**.**
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-238-6200.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-238-6200.