aetna®

Aetna Dental Insurance

Be prepared with dental care

Aetna Dental® Plan

Protect your smile today and tomorrow

If you had a cavity, would you have the money available to take care of it? Now you can be ready with an Aetna Dental plan.

The dental insurance plan is affordable and a great way to help you and your loved ones keep your smiles healthy. The plan provides:

- Benefits to help you pay for checkups, cleanings and common dental services
- The flexibility to see any dentist you like
- Access to discounted rates through Aetna's broad network of dentists
- Group rates which are typically lower than those you can find on your own
- Easy payroll deduction

How the plan works

Once the annual deductible is met, the plan helps pay for many of the most common dental services up to its stated annual limit. These include:

- Preventive services like checkups and cleanings
- Basic services like fillings and oral surgery
- Major services like crowns, bridges, dentures and root canals (benefits vary by plan)

Waiting periods may apply to some services. See your enrollment information for details.

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Locate a local preferred Dental provider by visiting: www.aetna.com/dse/custom/avp

Exclusions and limitations

The dental PPO network is not available in **Idaho, Hawaii, Montana, New Mexico or Puerto Rico.** To locate a preferred provider, call toll-free **1-888-772-9682**.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the necessary treatment of injury or disease. A service or supply is necessary if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved. The plan requires that a deductible is met before a benefit is paid except for preventive services.

A deductible is the amount you must pay for eligible expenses before the plan begins to pay benefits.

This plan does not cover all dental care expenses and has exclusions and limitations. Your plan may contain exceptions to this list based on state mandates or the plan design purchased.

The following is a partial list of services and supplies that are generally not covered. However, your plan may contain exceptions to this list based on state mandates or the plan design purchased. The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount:

- Cosmetic procedures unless needed as a result of injury
- Any procedure, service or supply that is included as covered medical expenses under another group medical expense benefit plan
- Prescribed drugs, premedication, analgesia or general anesthesia
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain
- Charges in excess of the *Recognized Charge*

In case of emergency, call 911 or your local emergency hotline; or go directly to an emergency care facility.

Did you know there's a link between dental health and overall health?

Research has shown that diseases of the teeth and gums are risk factors for diabetes, kidney disease, heart disease and even cancer. Poor gum health in the extreme can also lead to low birth weight. So going to the dentist twice a year is about more than having a nice smile.[1]

Enroll Today. Follow the instructions provided in your enrollment materials.

[1] Author, Kate Lowenstein. Healthy mouth, healthy body: The link between them may surprise you [article online]. February 2016. Available at: www.everydayhealth.com/dental-health/101.aspx. Accessed May 18, 2016.

Dental insurance plans are underwritten by Aetna Life Insurance Company (Aetna).

This material is for information only. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Policies are subject to United States economic and trade sanctions. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Policy forms issued in Oklahoma and Idaho include: GR-9/9N, GR-29/29N, GR-23.
Policy forms issued in Missouri include: AL HGrpPol-Dental 01.

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More Aetna Voluntary coverages available to enroll in:

Dental Plan	
Annual benefit maximum *Plan pays per coverage year*	$500
Annual deductible *Per individual per coverage year*	$50
Preventive services (includes checkups and cleanings)	You are responsible for paying up to **20%** of the **Recognized Charges**†. These services have **no waiting period.**
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for paying up to **40%** of the **Recognized Charges**†. You must be covered under the dental plan without interruption for **3 months** before the plan begins to pay for these services.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for paying up to **50%** of the **Recognized Charges**†. You must be covered under the dental plan without interruption for **12 months** before the plan begins to pay for these services.

The plan requires that a deductible is met before a benefit is paid. A deductible is the amount a member must pay for eligible expenses before the plan begins to pay benefits**.**

†The percentage of the cost that you are responsible for paying a provider is based on a **Recognized Charge**. A **Recognized Charge** is the amount that Aetna recognizes as payable by the plan for a visit, service, or supply. For preferred providers, the **Recognized Charge** equals the **Negotiated Charge.** A **Negotiated Charg**e is the maximum amount that a preferred provider has agreed to charge for a covered visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the **Negotiated Charge**. For non—preferred providers (except inpatient and outpatient facilities and pharmacies), the **Recognized Charge** generally equals the 80% of what providers in that geographic area charge for that service, based on the FAIR Health RV Benchmarks database from FAIR Health, Inc. This means that 80th percentile of the charges in the database for geographic area are that amount or less – and 20% are that amount or more – for that service or supply. A non—preferred provider may require that a member pay more than the **Recognized Charge**, and this additional amount would be member's responsibility.

This health plan does not meet Massachusetts Minimum Creditable Coverage standards. To locate a preferred provider, call toll-free **1-888-772-9682** or visit **www.aetna.com/docfind/custom/avp.**

In Texas, the Preferred Provider Organization (PPO) network is known as the Participating Dental Network (PDN).

Dental exclusions:

This dental plan does not cover all dental care expenses and has exclusions and limitations. You should refer to your certificate to determine which dental care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.

1. Cosmetic procedures unless needed as a result of injury.
2. Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
3. Prescribed drugs, pre—medication, analgesia or general anesthesia.
4. Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
5. Charges in excess of the Recognized Charge, based on the 80th percentile of the FAIR Health RV Benchmarks.

Vision care	
Eye exams	Reimbursements of up to $100 every 12 months for an exam, frames, lenses, or contact lenses.

Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan.

EyeMed Vision Care Select Network is not available in **Puerto Rico.**

This health plan does not meet Massachusetts Minimum Creditable Coverage standards.

Vision care exclusions

This plan does not cover all vision care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which vision care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, member's plan may contain exceptions to this list based on state mandates or the plan design purchased.

1. Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
2. Medical and/or surgical treatment of the eyes or supporting structure.
3. Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.