Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Aetna Dental of CA Inc.
Type of Product Line: DMO
Effective Date: 01/01/2023-12/31/2023
Name of Product: Aetna Dental® DMO®
Plan Phone #: 1-877-238-6200
Plan Website: 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 PLAN WEBSITE AT www.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	None	Not covered

- There is no deductible.
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan 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 plan to provide 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 plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not covered
Lifetime Maximum for Orthodontia	None	Not covered

- **Annual maximum** is the maximum dollar amount your plan 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 plan 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.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	No charge	Not covered	For more information about dental limitations & exceptions, see your policy documents.
Bitewing X-ray	Preventive & Diagnostic	No charge	Not covered	
Cleaning	Preventive & Diagnostic	No charge	Not covered	

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Basic	No charge for anterior resin composite	Not covered	
Extraction, Erupted Tooth or Exposed Root	Basic	No charge	Not covered	
Root Canal	Major	$125 for molar	Not covered	
Scaling and Root Planing	Basic	$25	Not covered	Four separate quadrants per 2 rolling years.
Ceramic Crown	Major	$150	Not covered	Replacement of existing crown limited to once every 5 years.
Removable Partial Denture	Major	$185	Not covered	Replacement of existing denture limited to once every 5 years.
Extraction, Erupted Tooth with Bone Removal	Basic	No charge	Not covered	
Orthodontia	Orthodontia	$2,300	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 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: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: 100%	Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: 100%	Patient Cost (copayment or coinsurance)	In-network: $150 Out-of-network: 100%

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:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $0 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $150 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered.	Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered.	Summary of what is not covered or subject to a limitation:	Replacement once every 5 years. Out-of-Network: Not covered.

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

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705
CRCoordinator@aetna.com

You can also file a complaint with the California Department of Insurance at 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).

DMO plans are insured by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-238-6200 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-238-6200.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-877-238-6200 በነጻ ይደውሉ
Arabic -	1-877-238-6200 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-238-6200 առանց զնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-238-6200 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-238-6200 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-238-6200-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-238-6200 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-238-6200ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-238-6200.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-238-6200 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏫᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏓᎳᏫᎢᏕ 1-877-238-6200 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᏡᎡᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-877-238-6200，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-877-238-6200.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-238-6200 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-238-6200.
French -	Pour une assistance linguistique en français appeler le 1-877-238-6200 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-238-6200 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-238-6200 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-238-6200 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-238-6200 પર કૉલ કરો.

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 -	हिन्दी 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 akwụghị ụgwọ 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 -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် ထိး 877-238-6200 လၢတအိဉ်ဒီးတက်လၢာ်ဘျာ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-238-6200 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́-wùdùǔn wɛ̃ɛ, dá 1-877-238-6200
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-238-6200 به خۆرایی یەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-238-6200ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय 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 निःशुल्क भाषा सहायता पाउनका लागि 1-877-238-6200 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-877-238-6200 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-238-6200 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-238-6200 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, 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 asistenţă lingvistică în româneşte telefonaţi 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 totogi.
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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 -	[illegible] 1-877-238-6200 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-238-6200 nang walang bayad.
Telugu -	భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-877-238-6200 కు కాల్ చేయండి. (తెలుగు)
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 ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-238-6200 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 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 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-877-238-6200 lái san owó kankan rárá.