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: 01/01/2024-12/31/2024
Name of Product: Aetna Dental® DMO® CA
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
Orthodontia	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 or Annual 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. **Not all services accrue to the annual maximum.**
- **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 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	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	
Filling	Basic	No charge for anterior resin composite	Not covered	
Extraction, Erupted Tooth or Exposed Root	Basic	No charge	Not covered	
Root Canal	Major	50% for molar	Not covered	
Scaling and Root Planing	Basic	No charge	Not covered	Four separate quadrants per 24 months.
Ceramic Crown	Major	50%	Not covered	Replacement of existing crown limited to once every 5 years.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Removable Partial Denture	Major	50%	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	50%	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 (full-mouth x-ray) 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: 50% 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:** $650 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Replacement once every 5 years. Out-of-Network: Not covered. For more information about dental limitations & exceptions, 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.

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 shërbime përkthimi falas për ju, telefononi 1-877-238-6200.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-238-6200 ይደውሉ፡፡
Arabic -	1-877-238-6200 للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-238-6200 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-238-6200 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-238-6200.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবকিষাি পপকে হকয এই নম্বকি পবেযক ান ক্লেন: 1-877-238-6200।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-238-6200.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-877-238-6200 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-238-6200.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-238-6200.
Cherokee -	ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᏅᏣᎾᏓᎸᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏟᎡᏩᎳᏁᏗ ᏲᎩ, ᎾᏂᎯᏏᏔᎸᏏ 1-877-238-6200.
Chinese -	如欲使用免費語言服務，請致電 1-877-238-6200。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-238-6200.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-238-6200.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-877-238-6200.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-238-6200.
French Creole -	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 -	તમારે કોઇ જાતના ખર્ચ વગિ ભાષાની સેાઓિની પહોંચ માટે, કોલ કરો 1-877-238-6200.
Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-238-6200 Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 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.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-877-238-6200.
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-238-6200.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 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 -	လၢတၢ်ကမၤန့ၢ်ကျိဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပှၤလၢကဘဉ်ဟ့ဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-877-238-6200 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-238-6200 번으로 전화해 주십시오.
Kru-Bassa -	Ṁ dyi wuɖu-dù kà kò ɖò bě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀bà nìà kɛ: 1-877-238-6200.
Kurdish -	1-877-238-6200 بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕິ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-877-238-6200.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-877-238-6200 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-238-6200.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-238-6200.
Mon-Khmer Cambodian -	ដ ើម្បីទទួលបានដំណោកម្មការដ លឥតគិតថ្លៃម្រៅប់ដំណោកអ្នកប្រ ម្ដដ ៅទូរព័ទដ ៅកាន់ដលខ 1-877-238-6200។.
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį' hólne 1-877-238-6200.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-877-238-6200 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-877-238-6200.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-877-238-6200.

Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-238-6200.
Persian-	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 ਬਨਿਾਂ ਬਸਿੇ ਿਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-877-238-6200 'ਤੇ ਫ਼ੋਨ ਰਿੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-877-238-6200.
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, vala'au 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.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-238-6200.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-877-238-6200.
Syriac-	[illegible] 1-877-238-6200 .
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-238-6200.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-877-238-6200 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-238-6200.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-238-6200.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-238-6200.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-238-6200 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-238-6200.
Urdu-	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-877-238-6200 پر بات کریں-.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-238-6200.
Yiddish -	צו צוטריט ךארפשַ באדַינונגען אין קיין פרייַז צו איר, רופן 1-877-238-6200
Yoruba -	Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-877-238-6200.