Aetna Dental PPO

		Aetna Dental PPO
Plan Facts	Member Services	1-800-589-4811
	Website	www.aetna.com
	Hours of operations	8:00 a.m. to 6:00 p.m., Local Time Monday -Friday
General Dental Expenses	In Network/Out of Network	Coverage available in- and out-of-network
	Pretreatment estimate	Recommended for treatment exceeding $350
	Annual Deductible: Individual/Family	**In Network:** $50 Individual; per plan year **Out of Network:** $50 Individual; per plan year
	Exclusions/Limitations	Some frequency limitations and exclusions may apply; check with Plan for details
	Annual maximum coverage per person	**In Network:** $1,500; per plan year **Out of Network:** $1,500; per plan year
	Lifetime maximum dental coverage	**In Network:** Limit does not apply **Out of Network:** Limit does not apply
	Reasonable & Customary	**In Network:** Limit does not apply **Out of Network:** Benefits are subject to reasonable and customary limits (R&C). Charges above R&C, if any, are not covered and does not count toward deductibles.

Effective 7/1/19

The above information provides a summary of plan provisions. In all cases, benefits will be paid in accordance with the plans' official documents, insurance contracts, and government regulations in effect at the time of payment. The Company reserves the right in its sole discretion to terminate, modify, discontinue, or otherwise change its benefit plans at any time with or without notice, pursuant to applicable law.

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Preventive Care	Primary covered services	**In Network:** Oral exams, Cleanings, X-Rays, Fluoride, Sealants and Space Maintainers; limits apply **Out of Network:** Oral exams, Cleanings, X-Rays, Fluoride, Sealants and Space Maintainers; limits apply
	Preventive care benefits	**In Network:** 100% covered; no deductible **Out of Network:** 100% covered; no deductible
	Service limits Preventive care	Oral exams and cleanings allowed 1 every 6 months; Bitewing X-rays allowed 1 every 12 months. X-rays (1 full mouth series or 1 panoramic, but not both) – 1 every 5 years; Sealants (children under age 16) – 1 every 3 years on permanent molars; Fluorides – 1 per plan year to age 17.
Basic Services	Fillings	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Routine extractions	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Endodontics (root canal therapy)	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Periodontics	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met

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Basic Services (continued)	Gingivoplasty or gingivectomy	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Service Limits – basic services	Periodontal maintenance is allowed only following active periodontal therapy. Scaling and root planing is allowed once pre-quadrant every 2 years.
Major Services	Inlays/Onlays	**In Network:** 50% covered after deductible is met **Out of Network:** 50% covered after deductible is met
	Crowns	**In Network:** 50% covered after deductible is met **Out of Network:** 50% covered after deductible is met
	Dentures	**In Network:** 50% covered after deductible is met **Out of Network:** 50% covered after deductible is met
	Bridges	**In Network:** 50% covered after deductible is met **Out of Network:** 50% covered after deductible is met
	Osseous surgery	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Oral surgery	**In Network:** 80% covered after deductible is met; restrictions may apply **Out of Network:** 70% covered after deductible is met
	Bruxism	**In Network:** 50% covered after deductible is met; subject to orthodontic benefits and eligibility **Out of Network:** Not covered

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Major Services (continued)	Anesthesia for dental care	**In Network:** 80% covered after deductible is met **Out of Network:** 70% covered after deductible is met
	Dental implants	**In Network:** 50% covered after deductible is met **Out of Network:** 50% covered after deductible is met
	Service Limits – Major Services	Dentures, bridges or other prosthodontics are eligible to be replaced only if over 5 years old. Teeth extracted prior to your effective date are not eligible for replacement
Orthodontia Services	Primary covered orthodontia services	**In Network:** Orthodontic services for employees, spouse and dependent children (dependent children are only eligible under the age of 19) **Out of Network:** Not covered
	Orthodontia benefits	**In Network:** 50% covered after deductible is met; limited to $1,500 per lifetime **Out of Network:** Not covered
Policies/ Requirements	Dentist Choice	Check with plan regarding network restrictions; Non-contracted providers fee subject to Reasonable & Customary rates
	General Care	Not applicable

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