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Contributory dental (2-9)

Idaho 2016

Plan name	Option 1 Indemnity schedule	Option 2 Indemnity 80/60/0 70th	Option 3 Indemnity 80/60/0 80th	Option 4 Indemnity 100/80/0 80th	Option 5 Indemnity 80/60/40 80th	Option 6 Indemnity 90/70/40 80th
	Schedule plan	80/60/0	80/60/0	100/80/0	80/60/40	90/70/40
Annual deductible per member (does not apply to diagnostic & preventive services)	none	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	none	$750	$1,000	$1,000	$1,000	$1,000
Diagnostic services						
Oral exams						
Periodic oral exam	$13	80%	80%	100%	80%	90%
Comprehensive oral exam	$22	80%	80%	100%	80%	90%
Problem-focused oral exam	$20	80%	80%	100%	80%	90%
X-rays						
Bitewing - single film	$7	80%	80%	100%	80%	90%
Complete series	$41	80%	80%	100%	80%	90%
Preventive services						
Adult cleaning	$29	80%	80%	100%	80%	90%
Child cleaning	$22	80%	80%	100%	80%	90%
Sealants - per tooth	$18	80%	80%	100%	80%	90%
Fluoride application - child	$10	80%	80%	100%	80%	90%
Space maintainers	$60	80%	80%	100%	80%	90%
Basic services						
Amalgam fillings	$29	60%	60%	80%	60%	70%
Resin fillings, anterior	$33	60%	60%	80%	60%	70%
Oral surgery						
Extraction - exposed root or erupted tooth	$19	60%	60%	80%	60%	70%
Extraction of impacted tooth - soft tissue	$51	60%	60%	80%	60%	40%
Major services (Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service)						
Complete upper denture	$220	Not covered	Not covered	Not covered	40%	40%
Partial upper denture (resin base)	$180	Not covered	Not covered	Not covered	40%	40%
Crown - Porcelain with noble metal	$180	Not covered	Not covered	Not covered	40%	40%
Pontic - Porcelain with noble metal	$170	Not covered	Not covered	Not covered	40%	40%
Inlay - Metallic (3 or more surfaces)	$177	Not covered	Not covered	Not covered	40%	40%
Oral surgery						
Removal of impacted tooth - partially bony	$66	Not covered	Not covered	Not covered	40%	40%
Endodontic services						
Bicuspid root canal therapy	$140	Not covered	Not covered	Not covered	40%	40%
Molar root canal therapy	$167	Not covered	Not covered	Not covered	40%	40%
Periodontic services						
Scaling & root planing - per quadrant	$39	Not covered	Not covered	Not covered	40%	40%
Osseous surgery - per quadrant	$183	Not covered	Not covered	Not covered	40%	40%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Dental insurance plans are offered and/or underwritten Aetna Life Insurance Company (Aetna). Policy forms include: GR-9N, GR-23 and/or GR-29N.

14.02.059.1-ID (4/15)

Contributory dental (2-9)

Idaho 2016

Plan name	Option 7 Indemnity 100/80/50 70th	Option 8 Indemnity 100/80/50 80th	Option 9 Indemnity 1000 90th	Option 10 Indemnity 1500 80th	Option 11 Indemnity 1500 90th
	100/80/50	100/80/50	100/80/50	100/80/50	100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	$750	$1,000	$1,000	$1,500	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
X-rays					
Bitewing - single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
Preventive services					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%	100%
Fluoride application - child	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
Basic services					
Amalgam fillings	80%	80%	80%	80%	80%
Resin fillings, anterior	80%	80%	80%	80%	80%
Oral surgery					
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	80%
Major services (Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Ma					
Complete upper denture	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	50%	50%
Oral surgery					
Removal of impacted tooth - partially bony	50%	50%	50%	50%	50%
Endodontic services					
Bicuspid root canal therapy	50%	50%	80%	50%	80%
Molar root canal therapy	50%	50%	50%	50%	50%
Periodontic services					
Scaling & root planing - per quadrant	50%	50%	80%	50%	80%
Osseous surgery - per quadrant	50%	50%	50%	50%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Contributory dental (2-9)

Idaho 2016

Plan name	Notes
	Most Oral Surgery, Endodontic and Periodontic procedures are covered as Basic Services in Plan Options 9 & 11 and are not subject to the Coverage Waiting Period.
Annual deductible per member (does not apply to diagnostic & preventive services)	All dollar amounts and percentages indicate what the plan will pay. Actual plan payments are limited by geographic area prevailing fees at the 70th percentile for Plan Options 2 & 7, the 80th percentile on Plan Options 3- 6, 8 & 10 and the 90th percentile on Plan Options 9 & 11.
Annual maximum benefit	Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.
Diagnostic services	Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.
Oral exams	This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. 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**.
Periodic oral exam	
Comprehensive oral exam	
Problem-focused oral exam	
X-rays	
Bitewing - single film	
Complete series	
Preventive services	
Adult cleaning	
Child cleaning	
Sealants - per tooth	
Fluoride application - child	
Space maintainers	
Basic services	
Amalgam fillings	
Resin fillings, anterior	
Oral surgery	
Extraction - exposed root or erupted tooth	
Extraction of impacted tooth - soft tissue	
Major services (Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Ma	
Complete upper denture	
Partial upper denture (resin base)	
Crown - Porcelain with noble metal	
Pontic - Porcelain with noble metal	
Inlay - Metallic (3 or more surfaces)	
Oral surgery	
Removal of impacted tooth - partially bony	
Endodontic services	
Bicuspid root canal therapy	
Molar root canal therapy	
Periodontic services	
Scaling & root planing - per quadrant	
Osseous surgery - per quadrant	
Orthodontic services	
Orthodontic lifetime maximum	

14.02.059.1-ID (4/15)

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Voluntary dental (3-9)

Idaho 2016

Plan name	Voluntary Option 1 Indemnity schedule	Voluntary Option 2 Indemnity 80/60/0 70th	Voluntary Option 3 Indemnity 80/60/0 80th	Voluntary Option 4 Indemnity 100/80/0 80th	Voluntary Option 5 Indemnity 80/60/40 80th	Voluntary Option 6 Indemnity 90/70/40 80th
	schedule plan	80/60/0	80/60/0	100/80/0	80/60/40	90/70/40
Annual deductible per member (does not apply to diagnostic & preventive services)	none	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual maximum benefit	none	$750	$1,000	$1,000	$1,000	$1,000
Diagnostic services						
Oral exams						
Periodic oral exam	$13	80%	80%	100%	80%	90%
Comprehensive oral exam	$22	80%	80%	100%	80%	90%
Problem-focused oral exam	$20	80%	80%	100%	80%	90%
X-rays						
Bitewing - single film	$7	80%	80%	100%	80%	90%
Complete series	$41	80%	80%	100%	80%	90%
Preventive services						
Adult cleaning	$29	80%	80%	100%	80%	90%
Child cleaning	$22	80%	80%	100%	80%	90%
Sealants - per tooth	$18	80%	80%	100%	80%	90%
Fluoride application - child	$10	80%	80%	100%	80%	90%
Space maintainers	$60	80%	80%	100%	80%	90%
Basic services						
Amalgam fillings	$29	60%	60%	80%	60%	70%
Resin fillings, anterior	$33	60%	60%	80%	60%	70%
Oral surgery						
Extraction - exposed root or erupted tooth	$19	60%	60%	80%	60%	70%
Extraction of impacted tooth - soft tissue	$51	60%	60%	80%	60%	40%
Major services (Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service)						
Complete upper denture	$220	Not covered	Not covered	Not covered	40%	40%
Partial upper denture (resin base)	$180	Not covered	Not covered	Not covered	40%	40%
Crown - Porcelain with noble metal	$180	Not covered	Not covered	Not covered	40%	40%
Pontic - Porcelain with noble metal	$170	Not covered	Not covered	Not covered	40%	40%
Inlay - Metallic (3 or more surfaces)	$177	Not covered	Not covered	Not covered	40%	40%
Oral surgery						
Removal of impacted tooth - partially bony	$66	Not covered	Not covered	Not covered	40%	40%
Endodontic services						
Bicuspid root canal therapy	$140	Not covered	Not covered	Not covered	40%	40%
Molar root canal therapy	$167	Not covered	Not covered	Not covered	40%	40%
Periodontic services						
Scaling & root planing - per quadrant	$39	Not covered	Not covered	Not covered	40%	40%
Osseous surgery - per quadrant	$183	Not covered	Not covered	Not covered	40%	40%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna). Policy forms include: GR-9N, GR-23 and/or GR-29N.

14.02.059.1-ID (4/15)

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Voluntary dental (3-9)

Idaho 2016

Plan name	Voluntary Option 7 Indemnity 100/80/50 70th	Voluntary Option 8 Indemnity 100/80/50 80th	Voluntary Option 9 Indemnity 1000 90th	Voluntary Option 10 Indemnity 1500 80th	Voluntary Option 11 Indemnity 1500 90th
	100/80/50	100/80/50	100/80/50	100/80/50	100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual maximum benefit	$750	$1,000	$1,000	$1,500	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
X-rays					
Bitewing - single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
Preventive services					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%	100%
Fluoride application - child	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
Basic services					
Amalgam fillings	80%	80%	80%	80%	80%
Resin fillings, anterior	80%	80%	80%	80%	80%
Oral surgery					
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	80%
Major services (Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eli					
Complete upper denture	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	50%	50%
Oral surgery					
Removal of impacted tooth - partially bony	50%	50%	50%	50%	50%
Endodontic services					
Bicuspid root canal therapy	50%	50%	80%	50%	80%
Molar root canal therapy	50%	50%	50%	50%	50%
Periodontic services					
Scaling & root planing - per quadrant	50%	50%	80%	50%	80%
Osseous surgery - per quadrant	50%	50%	50%	50%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

14.02.059.1-ID (4/15)

Voluntary dental (3-9)

Idaho 2016

Plan name	Notes
	Most Oral Surgery, Endodontic and Periodontic procedures are covered as Basic Services in Voluntary Plan Options 9 & 11 and are not subject to the Coverage Waiting Period.
Annual deductible per member (does not apply to diagnostic & preventive services)	
Annual maximum benefit	All dollar amounts and percentages indicate what the plan will pay. Actual plan payments are limited by geographic area prevailing fees at the 70th percentile for Voluntary Plan Options 2 & 7, the 80th percentile on Voluntary Plan Options 3- 6, 8 & 10 and the 90th percentile on Voluntary Plan Options 9 & 11.
Diagnostic services	
Oral exams	
Periodic oral exam	
Comprehensive oral exam	
Problem-focused oral exam	
X-rays	Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.
Bitewing - single film	
Complete series	
Preventive services	
Adult cleaning	Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.
Child cleaning	
Sealants - per tooth	
Fluoride application - child	
Space maintainers	This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. 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.
Basic services	
Amalgam fillings	
Resin fillings, anterior	
Oral surgery	
Extraction - exposed root or erupted tooth	
Extraction of impacted tooth - soft tissue	
Major services (Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming el	
Complete upper denture	
Partial upper denture (resin base)	
Crown - Porcelain with noble metal	
Pontic - Porcelain with noble metal	
Inlay - Metallic (3 or more surfaces)	
Oral surgery	
Removal of impacted tooth - partially bony	
Endodontic services	
Bicuspid root canal therapy	
Molar root canal therapy	
Periodontic services	
Scaling & root planing - per quadrant	
Osseous surgery - per quadrant	
Orthodontic services	
Orthodontic lifetime maximum	

14.02.059.1-ID (4/15)

Voluntary and contributory dental (10-50)

Idaho 2016

Plan name	Option 1A Indemnity schedule	Option 2A Indemnity preventive 80th	Option 3A Indemnity 80/60/0 70th	Option 4A Indemnity 100/80/0 70th	Option 5A Indemnity 80/60/40 70th	Option 6A Indemnity 1000M 80th
	Schedule 100/100/100	Indemnity 100/0/0	Indemnity 80/60/0	Indemnity 100/80/0	Indemnity 80/60/40	Indemnity 100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	None	None	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	None	None	$1,500	$1,500	$1,500	$1,000
Diagnostic services						
Oral exams						
Periodic oral exam	$13	100%	80%	100%	80%	100%
Comprehensive oral exam	$22	100%	80%	100%	80%	100%
Problem-focused oral exam	$20	100%	80%	100%	80%	100%
X-rays						
Bitewing - single film	$7	100%	80%	100%	80%	100%
Complete series	$41	100%	80%	100%	80%	100%
Preventive services						
Adult cleaning	$29	100%	80%	100%	80%	100%
Child cleaning	$22	100%	80%	100%	80%	100%
Sealants - per tooth	$18	100%	80%	100%	80%	100%
Fluoride application - child	$10	100%	80%	100%	80%	100%
Space maintainers	$60	100%	80%	100%	80%	100%
Basic services						
Amalgam fillings	$29	Not covered	60%	80%	60%	80%
Resin fillings, anterior	$33	Not covered	60%	80%	60%	80%
Endodontic services						
Bicuspid root canal therapy	$140	Not covered	Not covered	Not covered	40%	50%
Periodontic services						
Scaling & root planing - per quadrant	$39	Not covered	Not covered	Not covered	40%	50%
Oral surgery						
Extraction - exposed root or erupted tooth	$19	Not covered	60%	80%	60%	80%
Extraction of impacted tooth - soft tissue	$51	Not covered	60%	80%	60%	80%
Major services (Coverage Waiting Period applies to Voluntary plans: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major and Orthodontic Service)						
Complete upper denture	$220	Not covered	Not covered	Not covered	40%	50%
Partial upper denture (resin base)	$180	Not covered	Not covered	Not covered	40%	50%
Crown - Porcelain with noble metal	$180	Not covered	Not covered	Not covered	40%	50%
Pontic - Porcelain with noble metal	$170	Not covered	Not covered	Not covered	40%	50%
Inlay - Metallic (3 or more surfaces)	$177	Not covered	Not covered	Not covered	40%	50%
Oral surgery						
Removal of impacted tooth - partially bony	$66	Not covered	Not covered	Not covered	40%	50%
Endodontic services						
Molar root canal therapy	$167	Not covered	Not covered	Not covered	40%	50%
Periodontic services						
Osseous surgery - per quadrant	$183	Not covered	Not covered	Not covered	40%	50%
Orthodontic services	50%	Not covered	50%	50%	50%	50%
Orthodontic lifetime maximum	$1,000	Does not apply	$1,000	$1,000	$1,000	$1,000

Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna). Policy forms include: GR-9N, GR-23 and/or GR-29N.

14.02.059.1-ID (4/15)

Voluntary and contributory dental (10-50)

Idaho 2016

Plan name	Option 7A Indemnity 1000B 80th	Option 8A Indemnity 1500S 80th	Option 9A Indemnity 1500B 80th	Option 10A Indemnity 2000 90th
	Indemnity 100/80/50	Indemnity 100/80/50	Indemnity 100/80/50	Indemnity 100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	$1,000	$1,500	$1,500	$2,000
Diagnostic services				
Oral exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing - single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%
Fluoride application - child	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic services				
Amalgam fillings	80%	80%	80%	80%
Resin fillings, anterior	80%	80%	80%	80%
Endodontic services				
Bicuspid root canal therapy	80%	80%	80%	80%
Periodontic services				
Scaling & root planing - per quadrant	80%	80%	80%	80%
Oral surgery				
Extraction - exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%
Major services (Coverage Waiting Period applies to Voluntary plans: Must be an enrolled member of the Plan for 12 mo				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral surgery				
Removal of impacted tooth - partially bony	80%	50%	80%	80%
Endodontic services				
Molar root canal therapy	80%	50%	80%	80%
Periodontic services				
Osseous surgery - per quadrant	80%	50%	80%	80%
Orthodontic services	50%	50%	50%	50%
Orthodontic lifetime maximum	$1,000	$1,000	$1,000	$1,000

Notes

Voluntary Plans:
If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

Contributory and Voluntary plans:
All dollar amounts and percentages indicate what the plan will pay. Actual plan payments are limited by geographic area on options 3A - 5A to the prevailing fees at the 70th percentile, the 80th percentile the on options 1A, 6A - 9A and the 90th percentile on option 10A.

All Endodontic and Periodontic are covered as Major Services in options 5A & 6A. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in options 7A, 9A & 10A.

Orthodontic coverage is available as a selection to dependent children only.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. 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.

14.02.059.1-ID (4/15)

Limitations & Exclusions

Additional items not covered by a health plan

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Any dental examinations:

- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
- Care in charitable institutions;
- Care for conditions related to current or previous military service; or
- Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Exclusions That Apply to Basic Comprehensive Dental Insurance

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services. These dental exclusions are in addition to the exclusions listed under your medical coverage.

Apicoectomy, (dental root resection), root canal treatment.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered cosmetic. This exclusion does not apply to external bleaching.

Limitations & Exclusions

Crown, inlays and onlays, and veneers unless:
- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.
Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider, provided in connection with treatment or care that is not covered under the plan.
Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Dental services and supplies that are covered in whole or in part:
- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

Any instruction for diet, plaque control and oral hygiene.
General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
Except as covered in the *What the Plan Covers* section, non-surgical and surgical treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

Orthodontic treatment except as covered in the *What the Plan Covers* section.
Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) except as covered in the *What the Plan Covers* section.
Prescribed drugs, pre-medication or analgesia.
Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
Replacement of teeth beyond the normal complement of 32.
Removal of soft bony impactions.
Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
Topical application of fluoride.
Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Treatment of alveolectomy.
Treatment of periodontal disease.

Waiting periods, limitations and exclusions may not apply to all plans or all states.

Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna). Policy forms include: GR-9N, GR-23 and/or GR-29N.
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