



Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Aetna Life Insurance Company

Policy Type: PPO

Effective Date: 01/01/2026-12/31/2026

Plan Name: Aetna Dental® PPO

Insurer Phone #: 1-877-238-6200

Insurer Website: [Aetna.com](https://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 INSURER WEBSITE AT [Aetna.com](https://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	\$100 per individual combined with Out-of-Network	\$100 per individual combined with In-Network
Orthodontia	None	None

- The **deductible** applies to the following services: Basic & Major.
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer 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 insurer for alternative rate of payment for 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 insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	\$3,000 per individual combined with Out-of-Network	\$3,000 per individual combined with In-Network
Lifetime or Annual Maximum for Orthodontia	\$750 per individual per lifetime combined with Out-of-Network	\$750 per individual per lifetime combined with In-Network

- **Annual maximum** is the maximum dollar amount your policy 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 policy 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
<i>Oral Exam</i>	Preventive & Diagnostic	No charge	20%	Two routine & two problem-focused exams per year. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, see your policy documents.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	No charge	20%	Two sets per year.
<i>Cleaning</i>	Preventive & Diagnostic	No charge	20%	Two per year.
<i>Filling</i>	Basic	20% for anterior resin composite	40% for anterior resin composite	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	20%	40%	
<i>Root Canal</i>	Basic	20% for molar	40% for molar	
<i>Scaling and Root Planing</i>	Basic	20%	40%	Four separate quadrants per 2 rolling years.
<i>Ceramic Crown</i>	Major	50%	50%	Replacement of existing crown limited to once every 3 years.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Removable Partial Denture</i>	Major	50%	50%	Replacement of existing denture limited to once every 3 years.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	20%	40%	
<i>Orthodontia</i>	Orthodontia	50%	50%	

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: \$100 Out-of-network: \$100	Deductible	In-network: \$100 Out-of-network: \$100
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: \$3,000 Out-of-network: \$3,000	Annual Maximum (Plan Will Pay)	In-network: \$3,000 Out-of-network: \$3,000
Patient Cost (copayment or coinsurance)	In-network: \$0 Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 40%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%

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: \$110	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$110 Out-of-network: \$140	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$700 Out-of-network: \$925
Summary of what is not covered or subject to a limitation:	Oral Exam: Two routine exams per year. X-rays (FMX): One set per 3 rolling years. Cleaning: Two per year. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, see your policy documents.	Summary of what is not covered or subject to a limitation:	Annual maximum applies. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, see your policy documents.	Summary of what is not covered or subject to a limitation:	Annual maximum applies. Replacement once every 3 years. For more information about dental limitations & exceptions, including balance billing by out-of-network dentists, see your policy documents.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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).

Dental policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna). Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

TTY: 711

English -	To access language services at no cost to you, call 1-877-238-6200.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-238-6200 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-238-6200.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-238-6200 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-238-6200.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-238-6200.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-877-238-6200.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-238-6200.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-238-6200.
French Creole (Haitian)-	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 -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની વહીવટ માટે, કોલ કરો 1-877-238-6200.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 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.
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 -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-238-6200 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-238-6200 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-877-238-6200.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-238-6200 ។

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