The Catholic University of America

Aetna Dental Preferred Provider Organization (PPO) Coverage

2012-2013

The Aetna Dental PPO insurance plan is underwritten and/or administered by Aetna Life Insurance Company (Aetna).
Summary of Benefits

This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna) for some of the more frequently performed dental procedures. In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

To save more, visit a network dentist. You will typically pay more if you visit a dentist outside the network.

Payment made to a PPO provider is based on a negotiated fee, which is usually significantly less than the providers’ standard billed charges. PPO providers can not bill beyond the negotiated rate for covered services.

Nonparticipating benefits are also subject to reasonable charge limits.

<table>
<thead>
<tr>
<th>Annual Deductible*</th>
<th>Active participating / non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$50 / $50</td>
</tr>
<tr>
<td>Family</td>
<td>$150 / $150</td>
</tr>
<tr>
<td>Preventive Service Covered Percent</td>
<td>100% / 100%</td>
</tr>
<tr>
<td>Basic Service Covered Percent</td>
<td>80% / 60%</td>
</tr>
<tr>
<td>Major Service Covered Percent</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>Annual Benefit Maximum</td>
<td>$750 / $750</td>
</tr>
<tr>
<td>Office Visit Copay</td>
<td>N/A</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orthodontic Deductible</td>
<td>N/A</td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>N/A</td>
</tr>
<tr>
<td>*The deductible applies to: Basic and Major services only</td>
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</tbody>
</table>

List of Covered Services

Preventive

VISITS AND X-RAYS
Office visit during regular office hours; for oral examination (limited to 2 visits every year)
Prophylaxis (cleaning) (limited to 2 treatments per year)
   Adult
   Child
Topical application of fluoride; (limited to 1 course of treatment per year and to children under age 16)

Basic

VISITS AND X-RAYS
- Professional visit after hours (payment will be made on the basis of services rendered or visit; whichever is greater)
- Emergency palliative treatment; per visit
X-RAY AND PATHOLOGY
- Periapical x-rays (single films up to 13)
- Intra-oral; occlusal view; maxillary or mandibular
- Upper or lower jaw; extra-oral
- Biopsy and histopathologic examination of oral tissue

ORAL SURGERY
- Extractions
- Exposed root or erupted tooth
- Surgical removal of erupted tooth
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty; in conjunction with extractions - per quadrant
  - Alveoplasty; not in conjunction with extraction - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury

PERIODONTICS
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planning and scaling: per quadrant (limited to 4 separate quadrants every 2 years)
- Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Gingivectomy: per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy: 1 to 3 teeth per quadrant; limited to 1 per site every 3 years
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Periodontal maintenance procedures following active therapy (limited to 2 per year)
- Localized delivery of chemotherapeutic agents

ENDODONTICS
- Pulp cap
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy including necessary X-rays
  - Anterior
  - Bicuspids

RESTORATIVE DENTISTRY Excludes inlays; crowns (other than prefabricated stainless steel or resin) and bridges.
(Multiple restorations in 1 surface will be considered as a single restoration.) Amalgam restorations:Resin-based composite restorations (other than for molars)
- Pins
- Pin retention—per tooth; in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
- Prefabricated stainless steel
- Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge

## Major

### ORAL SURGERY

**Impacted Teeth**
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)

### PERIODONTICS
- Osseous surgery (including flap and closure); 1 to 3 teeth per quadrant; limited to 1 per quadrant; every 3 years
- Osseous surgery (including flap and closure); per quadrant; limited to 1 per site; every 3 years
- Soft tissue graft procedures

### RESTORATIVE

- Inlays; onlays; labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 8 years- see Replacement Rule)
- Inlays/Onlays-Metallic or Porcelain/Ceramic
  - Inlay; 1 or more surfaces
  - Onlay; 2 or more surfaces
- Inlays/Onlays-Resin-based composite
  - Inlay; 1 or more surfaces
  - Onlay; 2 or more surfaces
- Labial Veneers
  - Laminate-chairside
  - Resin laminate – laboratory
  - Porcelain laminate – laboratory
- Crowns
- Resin
  - Resin with noble metal
  - Resin with base metal
- Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- Metallic (3/4 cast)
- Post and core

### PROSTHODONTICS

- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 10 years old. (See Tooth Missing But Not Replaced Rule.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See Replacement Rule.)
- Bridge Abutments (See Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Base metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
Resin with base meta
- Removable Bridge (unilateral)
- One piece casting; chrome cobalt alloy clasp attachment (all types) per unit; including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines; rebases; and adjustments; within 6 months after installation.
- Fees for relines and rebases include adjustments within 6 months after installation.
  - Complete upper denture
  - Complete lower denture
  - Partial upper or lower; resin base (including any conventional clasps; rests and teeth)
  - Partial upper or lower; cast metal base with resin saddles (including any conventional clasps; rests and teeth)
- Stress breakers
- Interim partial denture (stayplate); anterior only
- Office reline
  - Laboratory reline
  - Special tissue conditioning; per denture
  - Rebase; per denture
  - Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
- Broken dentures; no teeth involved
- Repair cast framework
- Replacing missing or broken teeth; each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only); limited to 1 every 3 years

**SPACE MAINTAINERS** Only when needed to preserve space resulting from premature loss of deciduous teeth.
(Includes all adjustments within 6 months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

**GENERAL ANESTHESIA AND INTRAVENOUS SEDATION** (only when provided in conjunction with a covered surgical procedure)

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.*

**Emergency Dental Care**

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. When emergency services are provided by a participating PPO dentist, your coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist’s usual charge. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

*Covered emergency services may vary, based on state law.*
Premium

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring</th>
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<tbody>
<tr>
<td></td>
<td>8/14/12-8/13/13</td>
<td>1/1/13-8/13/13</td>
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<tr>
<td>Student</td>
<td>$321</td>
<td>$199</td>
</tr>
</tbody>
</table>

Definitions

1. **Accident:** an occurrence which (a) is unforeseen; (b) is not due to or contributed to by sickness or disease of any kind; and (c) causes injury.

2. **Actual Charge:** the charge made for a covered service by the provider who furnishes it.

3. **Copay:** this is a fee charged to a person for Covered Dental Expenses.

4. **Coinsurance:** both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that the covered person pays. The percentage that the plan pays is called “plan coinsurance” or the “payment percentage,” and varies by the type of expense. Please refer to the Schedule of Dental Expense Benefits for specific information on coinsurance amounts.

5. **Covered Dental Expenses:** those charges for any treatment; service; or supplies; covered by this Policy which are: not in excess of the reasonable and customary charges; or not in excess of the charges that would have been made in the absence of this coverage; and incurred while this Policy is in force as to the covered person.

6. **Covered dependent:** a covered student’s dependent who is insured under this Policy.

7. **Deductible:** the amount of Covered Dental Expenses that are paid by each covered person during the policy year before benefits are paid.

8. **Dental consultant:** a dentist who has agreed to provide consulting services in connection with the Dental Expense Benefit.

9. **Dental Emergency:** any dental condition that: occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and is characterized by symptoms such as severe pain and bleeding.

10. **Dental provider:** this is any dentist; group; organization; dental facility; or other institution; or person legally qualified to furnish dental services or supplies.

11. **Dentist:** a legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

12. **Dependent:** (a) the covered student’s spouse residing with the covered student; or (b) the person identified as a domestic partner in the “Declaration of Domestic Partnership” which is completed and signed by the covered student; and (c) the covered student’s unmarried child under the age of 19 years (or 23 if a student). The child must reside with, and be fully supported by, the covered student.

   The term “child” includes a covered student’s step-child; adopted child; and a child for whom a petition for adoption is pending; and who is residing with the covered student; and who is chiefly dependent on the covered student for his or her full support.

   The term dependent does not include a person who is: (a) an eligible student; or (b) a member of the armed forces.
13. **Jaw Joint Disorder**: a Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or a Myofacial Pain Dysfunction (MPD); or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

14. **Medically Necessary, Medical Necessity**: health care; or dental services and supplies; or prescription drugs that a physician; other health care provider or dental provider; exercising prudent clinical judgment; would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness; injury; disease; or its symptoms; and that provision of the service; supply; or prescription drug is:

   - in accordance with generally accepted standards of medical; or dental practice;
   - clinically appropriate; in terms of type; frequency; extent; site; and duration; and considered effective for the patient’s illness; injury; or disease; and

   not primarily for the convenience of the patient. physician; other health care; or dental provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results; as to the diagnosis or treatment of that patient’s illness; injury; or disease.

   For these purposes “generally accepted standards of medical or dental practice” means: standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

15. **Orthodontic treatment**: any medical service or supply; or dental service or supply; furnished to prevent or to diagnose or to correct a misalignment: of the teeth; or of the bite; or of the jaws or jaw joint relationship; whether or not for the purpose of relieving pain.

   Not included is: the installation of a space maintainer; or surgical procedure to correct malocclusion.

16. **Out-of-Area Emergency Dental Care**: medically necessary care or treatment for an emergency medical condition; that is rendered outside a 50 mile radius of the covered student’s member dental provider. Such care is subject to specific limitations set forth in this Policy.

17. **Policy Year**: the period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

18. **Reasonable Charge**: only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

   - The provider's usual charge for furnishing it; and
   - The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
   - The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

   In some circumstances; Aetna may have an agreement; either directly or indirectly through a third party; with a provider which sets the rate that Aetna will pay for a service or supply. In these instances; in spite of the methodology described above; the reasonable charge is the rate established in such agreement.

   In determining the reasonable charge for a service or supply that is:
   - Unusual; or
   - Not often provided in the area; or
   - Provided by only a small number of providers in the area.
Aetna may take into account factors, such as:
- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

19. **Service Area**: the geographic area; as determined by Aetna; in which network providers for this plan are located.

20. **Specialist Dentist**: any dentist who; by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

**Exclusions and Limitations - Coverage is not provided for the following:**

Not every dental care service or supply is covered by the plan, even if prescribed; recommended; or approved by the covered person’s physician; or dentist. The plan covers only those services and supplies that are included in the Dental Care Schedule. Charges made for the following are not covered. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered; or are subject to special limitations.

1. Apicoectomy (dental root resection); root canal treatment.
2. 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 Dental Care Schedule.
3. 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.
4. 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.
5. Services and supplies provided by an out-of-network provider.
6. Services and supplies provided for the covered person’s personal comfort or convenience, or the convenience of any other person, including a provider.
7. Services and supplies provided in connection with treatment or care that is not covered under the plan.
8. Space maintainers; except when needed to preserve space resulting from the premature loss of deciduous teeth.
9. 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.
10. 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.
11. 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 covered person was not covered.
12. Any instruction for diet; plaque control; and oral hygiene.
13. General anesthesia and intravenous sedation; unless specifically covered and only when done in connection with another medically necessary covered service or supply.
14. Except as covered in the Dental Care Schedule section, non-surgical 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.
15. Orthodontic treatment, except as covered in the Dental Care Schedule.
16. Pontics; crowns; cast or processed restorations; made with high noble metals (gold or titanium).
17. Prescribed drugs; pre-medication; or analgesia.
18. 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.
20. Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
21. Topical application of fluoride.
22. 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; and
   • Cleaning of teeth.
23. Treatment of alveolecctomy.
24. Treatment of periodontal disease.
25. Expense incurred for services normally provided without charge by the Policyholder's Health Service; Infirmary or Hospital; or by health care providers employed by the Policyholder.
26. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot” means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.
27. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
28. Expense incurred for injury or sickness resulting from declared or undeclared war or any act thereof.
29. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
30. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.
31. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
32. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
33. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
34. Expense incurred as a result of preventive medicines; serums;
35. Expense incurred as a result of commission of a felony.
36. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.
37. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
38. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.
39. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports; including collegiate or intercollegiate club sports and intramurals.
40. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).
41. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
42. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person's home country; if the covered person’s home country has a socialized medicine program.
43. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.
44. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
45. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.
46. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.
47. Expense for charges that are not recognized charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the recognized charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.
48. Expenses arising from a pre-existing condition.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

**Your Dental Care Plan Coverage Is Subject to the Following Rules:**

**Replacement Rule**
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

**Tooth Missing But Not Replaced Rule**
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

**Alternate Treatment Rule**
If more than one service can be used to treat a covered person’s dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) The service must be listed on the Dental Care Schedule;
(b) The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved; the specific copayment for such service will consist of:

(a) The copayment for the approved less costly service; plus
(b) The difference in cost between the approved less costly service and the more costly covered service.
Finding Participating Providers

Consult Aetna Dental online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna. The availability of any particular provider cannot be guaranteed. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna dental does not provide health care services and, therefore, can not guarantee any results or outcomes.
Aetna considers nonpublic personal member information confidential and has policies and procedures in place to
protect the information against unlawful use and disclosure. When necessary for your care or treatment, the
operation of your health Plan, or other related activities, we use personal information internally, share it with our
affiliates, and disclose it to health care providers (doctors, Pharmacies, hospitals, and other caregivers), vendors,
consultants, government authorities, and their respective agents. These parties are required to keep personal
information confidential as provided by applicable law. Participating Providers are also required to give you access
to your medical records within a reasonable amount of time after you make a request. By enrolling in the plan, you
permit us to use and disclose this information as described above on behalf of yourself and your dependents. To
obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and
disclosure of personal information, please call the toll-free Member Service number on your Dental ID card or visit

This material is for information only. Dental insurance plans contain exclusions, limitations and benefit maximums.
Not all dental services are covered. Plan features and availability may vary by location and/or group size and are
subject to change. Dental providers are independent contractors and are neither employees nor agents of Aetna Life
Insurance Company or their affiliates. 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.

Policy forms issued in OK include: GR-96134.