GA 2-9 (non-voluntary) and voluntary 3-9

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Plan name	Option 2 Freedom-of-Choice - Monthly selection between DMO and PPO Max		Option 4 PPO Max	Option 13 PPO 1000 90th	Voluntary Option 2 Freedom-of-Choice - Monthly selection between the DMO and PPO Max		Voluntary Option 4 PPO Max	Voluntary Option 13 PPO 1000 90th
	DMO member 0/10/40	PPO Max 100/70/40	PPO Max 100/80/50	PPO 100/80/50	DMO member 0/10/40	PPO Max 100/70/40	PPO Max 100/80/50	PPO 100/80/50
Office visit copay	$5	N/A	N/A	N/A	$10	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	None	$75; 3X Family Maximum	$75; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	Unlimited	$1,000	$1,500	$1,000	Unlimited	$1,000	$1,500	$1,000
Diagnostic services								
Oral Exams								
Periodic oral exam	0%	100%	100%	100%	0%	100%	100%	100%
Comprehensive oral exam	0%	100%	100%	100%	0%	100%	100%	100%
Problem-focused oral exam	0%	100%	100%	100%	0%	100%	100%	100%
X-rays								
Bitewing - single film	0%	100%	100%	100%	0%	100%	100%	100%
Complete series	0%	100%	100%	100%	0%	100%	100%	100%
Preventive Services								
Cleaning	0%	100%	100%	100%	0%	100%	100%	100%
Sealants - per tooth	0%	100%	100%	100%	0%	100%	100%	100%
Fluoride application - child	0%	100%	100%	100%	0%	100%	100%	100%
Space maintainers	0%	100%	100%	100%	0%	100%	100%	100%
Basic Services								
Amalgam filling - 2 surfaces	10%	70%	80%	80%	10%	70%	80%	80%
Resin filling - 2 surfaces, anterior	10%	70%	80%	80%	10%	70%	80%	80%
Oral Surgery								
Extraction - exposed root or erupted tooth	10%	70%	80%	80%	10%	70%	80%	80%
Extraction of impacted tooth - soft tissue	10%	70%	80%	80%	10%	70%	80%	80%
***Major services (Coverage Waiting Period applies to PPO & PPO Max plans: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service.)**								
Complete upper denture	40%	40%	50%	50%	40%	40%	50%	50%
Partial upper denture (resin base)	40%	40%	50%	50%	40%	40%	50%	50%
Crown - Porcelain with noble metal	40%	40%	50%	50%	40%	40%	50%	50%
Pontic - Porcelain with noble metal	40%	40%	50%	50%	40%	40%	50%	50%
Oral Surgery								
Removal of impacted tooth - partially bony	40%	40%	50%	50%	40%	40%	50%	50%
Endodontic Services								
Bicuspid root canal therapy	10%	40%	50%	50%	10%	40%	50%	50%
Molar root canal therapy	40%	40%	50%	50%	40%	40%	50%	50%
Periodontic Services								
Scaling & root planing - per quadrant	10%	40%	50%	50%	10%	40%	50%	50%
Osseous surgery - per quadrant	40%	40%	50%	50%	40%	40%	50%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not Covered	Not covered	Not covered	Not covered	Not covered

Dental insurance plans are offered and/or underwritten Aetna Life Insurance Company (Aetna).

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GA non-voluntary and voluntary dental (10+)

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Plan name	Option 2A FOC PPO Max Freedom-of-Choice - Monthly selection between DMO and PPO Max		Option 6A PPO Max 1500	Option 10A PPO 1500 90th	Option 12A PPO 2000 90th
	DMO member 0/10/40	PPO Max 100/70/40	PPO Max 100/80/50	PPO 100/80/50	PPO 100/80/50
Office visit copay	$5	N/A	N/A	N/A	N/A
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
Annual maximum benefit	Unlimited	$1,000	$1,500	$1,500	$2,000
Diagnostic services					
Oral exams					
Periodic oral exam	0%	100%	100%	100%	100%
Comprehensive oral exam	0%	100%	100%	100%	100%
Problem-focused oral exam	0%	100%	100%	100%	100%
X-rays					
Bitewing - single film	0%	100%	100%	100%	100%
Complete series	0%	100%	100%	100%	100%
Preventive Services					
Cleaning	0%	100%	100%	100%	100%
Sealants - per tooth	0%	100%	100%	100%	100%
Fluoride application - child	0%	100%	100%	100%	100%
Space maintainers	0%	100%	100%	100%	100%
Basic services					
Amalgam filling - 2 surfaces	10%	70%	80%	80%	80%
Resin filling - 2 surfaces, anterior	10%	70%	80%	80%	80%
Endodontic Services					
Bicuspid root canal therapy	10%	70%	80%	80%	80%
Periodontic Services					
Scaling & root planing - per quadrant	10%	70%	80%	80%	80%
Oral Surgery					
Extraction - exposed root or erupted tooth	10%	70%	80%	80%	80%
Extraction of impacted tooth - soft tissue	10%	70%	80%	80%	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 & Ortho Service. N/A to DMO)					
Complete upper denture	40%	40%	50%	50%	50%
Partial upper denture (resin base)	40%	40%	50%	50%	50%
Crown - Porcelain with noble metal	40%	40%	50%	50%	50%
Pontic - Porcelain with noble metal	40%	40%	50%	50%	50%
Oral Surgery					
Removal of impacted tooth - partially bony	40%	40%	50%	50%	80%
Endodontic Services					
Molar root canal therapy	40%	40%	50%	50%	80%
Periodontic Services					
Osseous surgery - per quadrant	40%	40%	50%	50%	80%
***Orthodontic Services**	$2300 copay	50%	50%	50%	50%
Orthodontic Lifetime Maximum	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).

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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.

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-23-8 and/or GR-29N.

Notes

2-9 non-voluntary and 3-9 voluntary:

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service. Does not apply to DMO.

Office Visit copays on DMO are member responsibility.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO plans.

Out-of-Network plan payments are limited by geographic area on PPO Option 13 to the 90th percentile.

PPO Max Plans; Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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.

10+ Voluntary:

*Coverage Waiting Period applies: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major and Orthodontic Services. This does not apply to Voluntary DMO.

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.

10+ Contributory (non-voluntary) and Voluntary:

General anesthesia along with and all Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on PPO Option 12A.

Out-of-Network plan payments are limited by geographic area on PPO Options 10A & 12A to the prevailing fees at the 90th percentile.

PPO Max Options 2A & 6A; Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

DMO plan 2A; Office Visit and Ortho copays are member responsibility.

Orthodontic coverage is available as a slection for dependent children on all plans except, 12A. Orthodontic coverage is available for and adults and dependent children in Plan Option 12A.

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

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.

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