2024 Dental Medicare Advantage

Quick reference guide

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Dental Medicare Advantage

Quick reference guide

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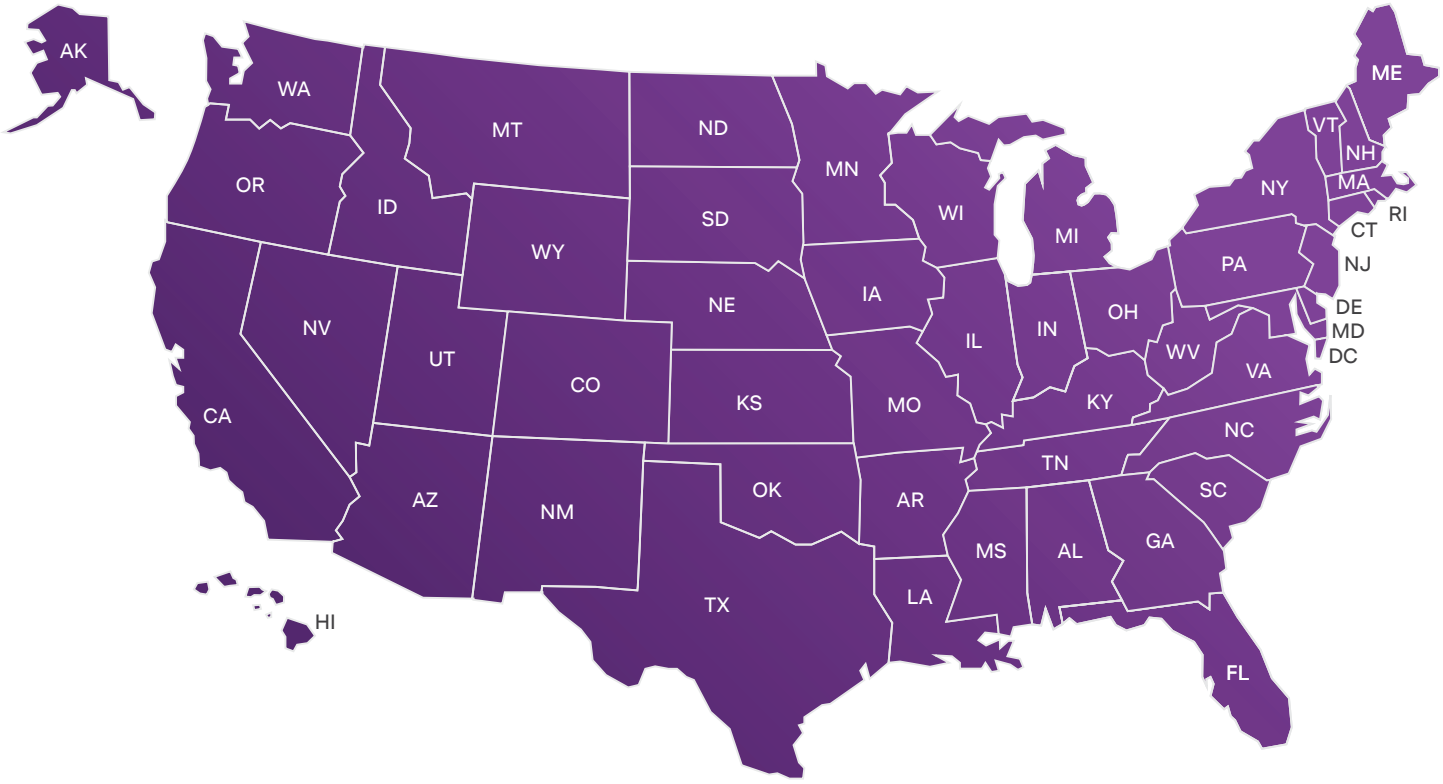
Plan name links



Important contact information

www.AetnaDental.com

Medicare Provider Services 1-800-624-0756 (TTY: 711)
We're here for you. You can call to confirm member eligibility and benefits, check claims status and more.

Send claims to:

Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

EDI Payer ID#60054

Liberty Dental Plan Partnership

Liberty Dental Plan will continue to service certain plans in CA, FL and NV in 2024.

Most comprehensive services require preauthorization. Please visit **https://www.libertydentalplan.com** for more information.

Liberty CA Claims address
ATTN: CLAIMS DEPARTMENT
LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110

Liberty CA Payor ID number
CX083

Liberty Provider Service Line
CA Provider Number: 1-800-268-9012

Liberty NV Claims address
ATTN: CLAIMS DEPARTMENT
LIBERTY Dental Plan
PO Box 401086
Las Vegas, NV 89140

Liberty NV Payor ID number
CX083

Liberty Provider Service Line
NV Provider Number: 1-888-700-0634

Liberty FL Claims address
ATTN: CLAIMS DEPARTMENT
LIBERTY Dental Plan
PO Box 15149
Tampa, FL 33684-5149

Liberty FL Payor ID number
CX063

Liberty Provider Service Line
FL Provider Number: 1-833-276-0851

2024 Member ID Card Samples

Refer to the contract number and PBP to review the Member plan details

- If you are directly contracted with Aetna, you'll be able to see all Aetna Dental Medicare Advantage Members.
- Don’t panic if a member references having an HMO, DSNP, HMO-POS plan, this refers to their Medical plan.
- You'll be reimbursed according to the PPO fee schedule you have with us.*

*The PPO fee schedule does not apply to Direct Member Reimbursement Plans.

Aetna Medicare package names by state

Alabama

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
AL	H3239	002	Broad Coverage EPO Mandatory	$3,000	No
AL	H3239	003	Broad Coverage EPO Mandatory	$4,000	No
AL	H3239	010	Broad Coverage EPO Mandatory	$2,700	No
AL	H3239	018	Broad Coverage EPO Mandatory	$4,000	No
AL	H3239	019	Broad Coverage EPO Mandatory	$2,950	No
AL	H3239	020	Broad Coverage EPO Mandatory	$2,250	No
AL	H5521	091	Total PPO Passive	$1,150	Yes
AL	H5521	116	Total PPO Passive	$1,200	Yes
AL	H5521	171	Total PPO Passive	$1,200	Yes
AL	H5521	216	Total PPO Passive	$2,200	Yes
AL	H5521	222	Total PPO Passive	$2,200	Yes
AL	H5521	224	Total PPO Passive	$2,200	Yes
AL	H5521	227	Total PPO Passive	$1,500	Yes
AL	H5521	229	Total PPO Passive	$3,500	Yes
AL	H5521	462	Total PPO Passive	$3,000	Yes
AL	H5521	463	Total PPO Passive	$2,500	Yes
AL	H5521	467	Total PPO Passive	$2,500	Yes
AL	H5521	475	Total PPO Passive	$1,150	Yes

Alaska

No Aetna dental plans are offered in Alaska.

Arizona

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
AZ	H3931	092	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
AZ	H3931	129	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
AZ	H3931	145	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
AZ	H3931	146	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
AZ	H3931	147	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
AZ	H3931	148	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
AZ	H3931	156	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
AZ	H3931	166	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
AZ	H3931	167	Total EPO POS 20% Coins OON Hybrid	$3,500	Yes
AZ	H3931	168	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
AZ	H3931	169	Total EPO POS 20% Coins OON Hybrid	$3,500	Yes
AZ	H4835	001	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes

Aetna Medicare package names by state

Arizona (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
AZ	H4835	002	Total EPO POS 20% Coins OON Hybrid	$500	Yes
AZ	H4835	003	Total EPO POS 20% Coins OON Hybrid	$750	Yes
AZ	H4835	004	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
AZ	H4835	005	Total EPO POS 20% Coins OON Hybrid	$750	Yes
AZ	H4835	006	Total EPO POS 20% Coins OON Hybrid	$750	Yes
AZ	H5521	100	Total PPO 20% Coins OON Hybrid	$2,000	Yes
AZ	H5521	184	Total PPO 20% Coins OON Hybrid	$1,000	Yes
AZ	H5521	290	Total PPO 20% Coins OON Hybrid	$2,500	Yes
AZ	H5521	329	Total PPO 20% Coins OON Hybrid	$3,000	Yes
AZ	H5521	331	Total PPO 20% Coins OON Hybrid	$1,500	Yes
AZ	H5521	363	Total PPO 20% Coins OON Hybrid	$2,000	Yes
AZ	H5521	424	Total PPO 20% Coins OON Hybrid	$3,500	Yes

Arkansas

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
AR	H1608	021	Total PPO Passive	$3,500	Yes
AR	H1608	054	Total PPO Passive	$2,150	Yes
AR	H1608	073	Total PPO Passive	$2,500	Yes
AR	H1608	074	Total PPO Passive	$2,500	Yes
AR	H1608	075	Total PPO Passive	$2,500	Yes
AR	H1608	076	Total PPO Passive	$3,000	Yes
AR	H1608	078	Total PPO Passive	$3,000	Yes
AR	H1608	079	Total PPO Passive	$1,000	Yes
AR	H2663	029	Total EPO POS Mandatory	$3,500	Yes
AR	H2663	039	Broad Coverage EPO Mandatory	$3,250	No
AR	H2663	067	Broad Coverage EPO Mandatory	$3,000	No
AR	H5325	007	Broad Coverage EPO Mandatory	$4,000	No
AR	H5325	010	Broad Coverage EPO Mandatory	$4,000	No
AR	H5325	011	Broad Coverage EPO Mandatory	$3,000	No

Aetna Medicare package names by state

California

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
CA	H0523	022	Direct Member Reimbursement	$750	Yes – Not a network-based benefit
CA	H0523	052	Direct Member Reimbursement	$600	Yes – Not a network-based benefit
CA	H0523	065	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
CA	H0523	067	Direct Member Reimbursement	$1,200	Yes – Not a network-based benefit
CA	H0523	068	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
CA	H0523	069	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
CA	H0523	070	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
CA	H0523	071	Direct Member Reimbursement	$1,150	Yes – Not a network-based benefit
CA	H0523	072	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
CA	H0523	073	Direct Member Reimbursement	$3,000	Yes – Not a network-based benefit
CA	H0523	074	Total EPO POS Mandatory	$2,000	Yes
CA	H0523	075	Direct Member Reimbursement	$2,750	Yes – Not a network-based benefit
CA	H0523	076	Total EPO POS Mandatory	$2,500	Yes
CA	H0523	077	Total EPO POS Mandatory	$1,500	Yes
CA	H0523	078	Total EPO POS Mandatory	$2,500	Yes
CA	H0523	079	Total EPO POS Mandatory	$3,500	Yes
CA	H0523	080	Total EPO POS Mandatory	$3,000	Yes
CA	H4982	001	Direct Member Reimbursement	$2,250	Yes – Not a network-based benefit
CA	H4982	002	Direct Member Reimbursement	$2,750	Yes – Not a network-based benefit
CA	H4982	003	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
CA	H4982	004	Direct Member Reimbursement	$1,750	Yes – Not a network-based benefit
CA	H4982	005	Direct Member Reimbursement	$1,200	Yes – Not a network-based benefit
CA	H4982	006	Direct Member Reimbursement	$700	Yes – Not a network-based benefit
CA	H4982	007	Direct Member Reimbursement	$1,100	Yes – Not a network-based benefit
CA	H4982	008	Liberty Wrap, contact Liberty Dental 1-800-268-9012	N/A	Must use Liberty Dental Network
CA	H4982	009	Liberty Wrap, contact Liberty Dental 1-800-268-9012	N/A	Must use Liberty Dental Network
CA	H4982	010	Direct Member Reimbursement	$1,300	Yes – Not a network-based benefit
CA	H4982	011	Direct Member Reimbursement	$850	Yes – Not a network-based benefit
CA	H4982	012	Direct Member Reimbursement	$825	Yes – Not a network-based benefit
CA	H4982	013	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
CA	H4982	016	Liberty Wrap, contact Liberty Dental 1-800-268-9012	N/A	Must use Liberty Dental Network
CA	H4982	017	Total EPO POS Mandatory	$3,000	Yes
CA	H4982	018	Total EPO POS Mandatory	$3,000	Yes
CA	H5309	001	Total PPO Passive	$750	Yes
CA	H5309	002	Total PPO Passive	$750	Yes
CA	H5309	003	Total PPO Passive	$750	Yes
CA	H5309	004	Total PPO 20% Coins OON Hybrid	$3,000	Yes
CA	H5521	053	Total PPO 20% Coins OON Hybrid	$1,500	Yes
CA	H5521	056	Total PPO 20% Coins OON Hybrid	$1,500	Yes

Aetna Medicare package names by state

California (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
CA	H5521	125	Total PPO 20% Coins OON Hybrid	$1,500	Yes
CA	H5521	292	Total PPO 20% Coins OON Hybrid	$1,250	Yes
CA	H5521	293	Total PPO Passive	$1,000	Yes
CA	H5521	332	Total PPO Passive	$1,200	Yes
CA	H5521	333	Total PPO 20% Coins OON Hybrid	$1,500	Yes
CA	H5521	369	Total PPO 20% Coins OON Hybrid	$3,000	Yes
CA	H5521	370	Total PPO Passive	$1,500	Yes
CA	H5521	371	Total PPO Passive	$1,500	Yes
CA	H5521	372	Total PPO Passive	$1,500	Yes
CA	H5521	419	Total PPO 20% Coins OON Hybrid	$1,000	Yes
CA	H5521	420	Total PPO 20% Coins OON Hybrid	$1,000	Yes
CA	H5521	421	Total PPO 20% Coins OON Hybrid	$1,000	Yes
CA	H5521	422	Total PPO 20% Coins OON Hybrid	$1,050	Yes
CA	H5521	425	Total PPO Passive	$1,500	Yes

Colorado

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
CO	H3931	153	Total EPO POS Mandatory	$2,250	Yes
CO	H3931	154	Total EPO POS Mandatory	$2,200	Yes
CO	H4711	006	Total EPO POS Mandatory	$1,600	Yes
CO	H4711	007	Total EPO POS Mandatory	$1,600	Yes
CO	H4711	008	Total EPO POS Mandatory	$1,400	Yes
CO	H4711	009	Total EPO POS Mandatory	$1,200	Yes
CO	H4711	010	Total EPO POS Mandatory	$2,000	Yes
CO	H4711	012	Broad Coverage EPO Mandatory	$3,000	No
CO	H5521	207	Total PPO Passive	$1,600	Yes
CO	H5521	250	Total PPO Passive	$1,650	Yes
CO	H5521	378	Total PPO Passive	$3,000	Yes
CO	H5521	443	Total PPO 50% Coins OON Hybrid	$2,000	Yes

Aetna Medicare package names by state

Connecticut

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
CT	H5521	013	Preventive Only PPO Mandatory	N/A	Yes
CT	H5521	157	Total PPO Passive	$500	Yes
CT	H5521	350	Total PPO Passive	$2,000	Yes
CT	H5521	352	Total PPO Passive	$1,000	Yes
CT	H5521	446	Total PPO Passive	$1,000	Yes
CT	H5793	001	Total EPO POS Mandatory	$1,500	Yes
CT	H5793	010	Preventive Only 0% OON EPO POS Mandatory	N/A	Yes
CT	H5793	017	Total EPO POS Mandatory	$2,500	Yes
CT	H5793	020	Total EPO POS Mandatory	$2,000	Yes

Delaware

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
DE	H3931	102	Total EPO POS Mandatory	$3,000	Yes
DE	H3959	055	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
DE	H3959	056	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
DE	H3959	063	Broad Coverage EPO Mandatory	$4,000	No
DE	H3959	068	Preventive Only 0% OON EPO POS Mandatory	N/A	Yes
DE	H5521	095	Total PPO 50% Coins OON Hybrid	$3,000	Yes
DE	H5521	262	Total PPO 50% Coins OON Hybrid	$1,500	Yes
DE	H5521	397	Total PPO 50% Coins OON Hybrid	$3,000	Yes

Florida

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
FL	H1609	016	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	017	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	018	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	019	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	020	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	021	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	022	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	025	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	026	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	027	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	028	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network

Aetna Medicare package names by state

Florida (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
FL	H1609	034	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	035	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	038	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	041	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	042	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	043	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	044	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	045	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	046	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	047	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	048	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	049	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	052	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	053	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	055	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	056	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	059	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	060	Liberty Den 100, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	061	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	062	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	063	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	064	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	065	Liberty Den 300, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	066	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H1609	067	Liberty Den 200, contact Liberty Dental 1-833-276-0851	N/A	Must use Liberty Dental Network
FL	H5521	033	Direct Member Reimbursement	$750	Yes – Not a network-based benefit
FL	H5521	268	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
FL	H5521	269	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit
FL	H5521	270	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit
FL	H5521	271	Direct Member Reimbursement	$1,650	Yes – Not a network-based benefit
FL	H5521	272	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	273	Direct Member Reimbursement	$1,450	Yes – Not a network-based benefit
FL	H5521	305	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
FL	H5521	306	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	308	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	347	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	377	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
FL	H5521	432	Direct Member Reimbursement	$1,550	Yes – Not a network-based benefit
FL	H5521	433	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit

Aetna Medicare package names by state

Florida (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
FL	H5521	434	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	435	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
FL	H5521	436	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit
FL	H5521	437	Direct Member Reimbursement	$2,100	Yes – Not a network-based benefit
FL	H5521	438	Direct Member Reimbursement	$2,100	Yes – Not a network-based benefit
FL	H5521	439	Direct Member Reimbursement	$1,750	Yes – Not a network-based benefit
FL	H5521	440	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit

Georgia

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
GA	H1109	005	Broad Coverage EPO Mandatory	$1,200	No
GA	H1608	028	Total PPO Passive	$1,100	Yes
GA	H2293	001	Total PPO Passive	$2,250	Yes
GA	H2293	002	Total PPO Passive	$3,500	Yes
GA	H2293	003	Total PPO Passive	$3,000	Yes
GA	H2293	004	Total PPO Passive	$2,500	Yes
GA	H2293	005	Total PPO Passive	$3,500	Yes
GA	H2293	006	Total PPO Passive	$2,250	Yes
GA	H2293	007	Total PPO Passive	$1,700	Yes
GA	H2293	008	Total PPO Passive	$1,700	Yes
GA	H2293	009	Total PPO Passive	$2,000	Yes
GA	H2293	010	Total PPO Passive	$1,250	Yes
GA	H2293	011	Total PPO Passive	$2,250	Yes
GA	H2293	021	Total PPO Passive	$3,500	Yes
GA	H2293	022	Total PPO Passive	$2,500	Yes
GA	H2293	023	Total PPO Passive	$2,250	Yes
GA	H3288	027	Total PPO Passive	$2,000	Yes
GA	H3288	031	Total PPO Passive	$2,000	Yes
GA	H3288	034	Total PPO Passive	$2,000	Yes
GA	H3288	042	Total PPO Passive	$1,650	Yes
GA	H3288	045	Total PPO Passive	$850	Yes
GA	H5302	012	Broad Coverage EPO Mandatory	$3,500	No
GA	H5302	013	Broad Coverage EPO Mandatory	$3,500	No
GA	H5302	014	Broad Coverage EPO Mandatory	$3,500	No
GA	H5302	019	Broad Coverage EPO Mandatory	$2,350	No
GA	H5302	020	Broad Coverage EPO Mandatory	$3,000	No
GA	H5521	328	Total PPO Passive	$2,150	Yes

Aetna Medicare package names by state

Georgia (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
GA	H5521	091	Total PPO Passive	$1,150	Yes
GA	H5521	360	Total PPO Passive	$2,200	Yes
GA	H5521	364	Total PPO Passive	$2,250	Yes

Hawaii

No Aetna dental plans are offered in Hawaii.

Idaho

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
ID	H2056	001	Total EPO POS 20% Coins OON Hybrid	$2,100	Yes
ID	H2056	002	Total EPO POS 20% Coins OON Hybrid	$1,200	Yes
ID	H2056	013	Total EPO POS 20% Coins OON Hybrid	$1,800	Yes
ID	H9431	002	Total PPO 20% Coins OON Hybrid	$1,600	Yes
ID	H9431	006	Total PPO 20% Coins OON Hybrid	$1,000	Yes
ID	H9431	016	Total PPO 20% Coins OON Hybrid	$1,250	Yes
ID	H9431	019	Total PPO 20% Coins OON Hybrid	$1,750	Yes

Illinois

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
IL	H1608	013	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
IL	H1608	050	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H1608	051	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H1608	067	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H2663	002	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H2663	005	Direct Member Reimbursement	$3,250	Yes – Not a network-based benefit
IL	H2663	006	Direct Member Reimbursement	$1,400	Yes – Not a network-based benefit
IL	H2663	017	Direct Member Reimbursement	$2,700	Yes – Not a network-based benefit
IL	H3192	001	Total EPO POS 20% Coins OON Hybrid	$3,750	Yes
IL	H3192	013	Total EPO POS 20% Coins OON Hybrid	$2,200	Yes
IL	H5521	016	Total PPO 20% Coins OON Hybrid	$2,000	Yes
IL	H5521	086	Total PPO 20% Coins OON Hybrid	$1,500	Yes
IL	H5521	286	Total PPO Passive	$3,500	Yes
IL	H5521	314	Total PPO 20% Coins OON Hybrid	$3,250	Yes

Aetna Medicare package names by state

Illinois (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
IL	H7301	002	Total PPO Passive	$2,500	Yes
IL	H7301	006	Total PPO Passive	$1,950	Yes
IL	H7301	007	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H7301	009	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H7301	013	Total PPO 20% Coins OON Hybrid	$3,750	Yes
IL	H7301	014	Total PPO 20% Coins OON Hybrid	$3,500	Yes
IL	H7301	015	Total PPO 20% Coins OON Hybrid	$1,500	Yes
IL	H7301	016	Preventive Only PPO Mandatory	N/A	Yes
IL	H7301	017	Direct Member Reimbursement	$1,850	Yes – Not a network-based benefit
IL	H7301	021	Total PPO 20% Coins OON Hybrid	$3,000	Yes

Indiana

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
IN	H3192	004	Total EPO POS 20% Coins OON Hybrid	$2,800	Yes
IN	H3192	005	Total EPO POS 20% Coins OON Hybrid	$2,900	Yes
IN	H3192	006	Total EPO POS 20% Coins OON Hybrid	$2,800	Yes
IN	H3192	008	Broad Coverage EPO Mandatory	$3,000	No
IN	H3192	009	Broad Coverage EPO Mandatory	$3,000	No
IN	H3192	012	Total EPO POS 20% Coins OON Hybrid	$1,850	Yes
IN	H3192	020	Total EPO POS 20% Coins OON Hybrid	$2,300	Yes
IN	H5521	099	Total PPO 20% Coins OON Hybrid	$1,450	Yes
IN	H5521	190	Total PPO 20% Coins OON Hybrid	$1,500	Yes
IN	H5521	211	Total PPO Passive	$900	Yes
IN	H5521	223	Total PPO 20% Coins OON Hybrid	$1,300	Yes
IN	H5521	226	Total PPO 20% Coins OON Hybrid	$2,000	Yes
IN	H5521	231	Total PPO 20% Coins OON Hybrid	$1,800	Yes
IN	H5521	302	Total PPO 20% Coins OON Hybrid	$2,750	Yes
IN	H5521	405	Total PPO 20% Coins OON Hybrid	$2,300	Yes
IN	H5521	406	Total PPO 20% Coins OON Hybrid	$2,350	Yes
IN	H5521	408	Total PPO 20% Coins OON Hybrid	$2,000	Yes
IN	H5521	409	Total PPO 20% Coins OON Hybrid	$2,550	Yes
IN	H5521	286	Total PPO Passive	$3,500	Yes

Aetna Medicare package names by state

Iowa

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
IA	H1608	001	Total PPO Passive	$1,200	Yes
IA	H1608	037	Total PPO Passive	$1,150	Yes
IA	H1608	048	Total PPO Passive	$1,150	Yes
IA	H1608	065	Total PPO Passive	$1,600	Yes
IA	H1609	001	Total EPO POS Mandatory	$1,650	Yes
IA	H1609	058	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
IA	H1609	068	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
IA	H1609	069	Total EPO POS Mandatory	$1,850	Yes
IA	H5593	001	Broad Coverage EPO Mandatory	$3,500	No

Kansas

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
KS	H1608	016	Total PPO 20% Coins OON Hybrid	$2,000	Yes
KS	H1608	017	Deluxe PPO Mandatory	$4,000	Yes
KS	H1608	018	Total PPO 20% Coins OON Hybrid	$2,000	Yes
KS	H1608	024	Total PPO 20% Coins OON Hybrid	$2,000	Yes
KS	H1608	052	Total PPO 20% Coins OON Hybrid	$1,000	Yes
KS	H1608	068	Total PPO 20% Coins OON Hybrid	$3,000	Yes
KS	H1608	070	Total PPO 20% Coins OON Hybrid	$3,000	Yes
KS	H1608	071	Total PPO 20% Coins OON Hybrid	$2,500	Yes
KS	H1608	072	Total PPO 20% Coins OON Hybrid	$1,500	Yes
KS	H2663	025	Total EPO POS Mandatory	$2,000	Yes
KS	H2663	026	Total EPO POS Mandatory	$2,500	Yes
KS	H2663	028	Total EPO POS Mandatory	$2,500	Yes
KS	H2663	038	Deluxe EPO Mandatory	$3,000	No
KS	H2663	040	Deluxe EPO Mandatory	$3,000	No
KS	H2663	042	Deluxe EPO Mandatory	$3,000	No
KS	H2663	043	Total EPO POS Mandatory	$3,000	Yes
KS	H2663	052	Broad Coverage EPO Mandatory	$3,500	No
KS	H2663	053	Broad Coverage EPO Mandatory	$3,500	No
KS	H2663	054	Broad Coverage EPO Mandatory	$2,500	No
KS	H2663	055	Broad Coverage EPO Mandatory	$2,000	No
KS	H2663	056	Broad Coverage EPO Mandatory	$1,500	No
KS	H2663	061	Total EPO POS Mandatory	$3,500	Yes
KS	H2663	062	Total EPO POS Mandatory	$3,500	Yes
KS	H2663	063	Total EPO POS Mandatory	$3,500	Yes
KS	H2663	064	Broad Coverage EPO Mandatory	$4,000	No

Aetna Medicare package names by state

Kansas (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
KS	H2663	065	Preventive Only EPO Mandatory	N/A	No
KS	H5325	001	Broad Coverage EPO Mandatory	$4,000	No
KS	H5325	002	Broad Coverage EPO Mandatory	$4,500	No
KS	H5325	009	Broad Coverage EPO Mandatory	$3,000	No

Kentucky

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
KY	H0628	006	Total EPO POS 50% Coins OON Hybrid	$2,100	Yes
KY	H0628	007	Total EPO POS 50% Coins OON Hybrid	$1,600	Yes
KY	H0628	008	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
KY	H0628	009	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
KY	H0628	010	Total EPO POS 50% Coins OON Hybrid	$2,500	Yes
KY	H0628	011	Deluxe EPO Mandatory	$2,000	No
KY	H0628	012	Broad Coverage EPO Mandatory	$6,000	No
KY	H0628	014	Deluxe EPO Mandatory	$2,000	No
KY	H5521	020	Total PPO 50% Coins OON Hybrid	$2,000	Yes
KY	H5521	085	Basic PPO Mandatory	$2,000	Yes
KY	H5521	156	Total PPO 50% Coins OON Hybrid	$2,000	Yes
KY	H5521	259	Total PPO 50% Coins OON Hybrid	$1,000	Yes
KY	H5521	260	Total PPO 50% Coins OON Hybrid	$2,100	Yes
KY	H5521	266	Total PPO 50% Coins OON Hybrid	$2,100	Yes
KY	H5521	442	Total PPO 50% Coins OON Hybrid	$2,000	Yes

Louisiana

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
LA	H3239	001	Broad Coverage EPO Mandatory	$4,500	No
LA	H3239	006	Broad Coverage EPO Mandatory	$3,500	No
LA	H3239	007	Broad Coverage EPO Mandatory	$3,750	No
LA	H3239	011	Broad Coverage EPO Mandatory	$3,000	No
LA	H3239	013	Broad Coverage EPO Mandatory	$5,000	No
LA	H3928	001	Broad Coverage EPO Mandatory	$2,650	No
LA	H5521	178	Total PPO Passive	$1,300	Yes
LA	H5521	230	Total PPO Passive	$2,800	Yes
LA	H5521	232	Total PPO Passive	$2,000	Yes

Aetna Medicare package names by state

Louisiana (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
LA	H5521	233	Total PPO Passive	$1,300	Yes
LA	H5521	234	Total PPO Passive	$2,000	Yes
LA	H5521	235	Total PPO Passive	$2,000	Yes
LA	H5521	326	Total PPO Passive	$2,500	Yes
LA	H5521	365	Total PPO Passive	$2,200	Yes
LA	H5521	366	Total PPO Passive	$2,200	Yes
LA	H5521	468	Total PPO Passive	$3,000	Yes
LA	H5521	469	Total PPO Passive	$3,500	Yes
LA	H5521	472	Total PPO Passive	$3,500	Yes
LA	H5521	473	Total PPO Passive	$3,000	Yes
LA	H5521	474	Total PPO Passive	$2,500	Yes
LA	H5521	476	Total PPO Passive	$1,000	Yes

Maine

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
ME	H3597	001	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
ME	H3597	007	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
ME	H3597	009	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
ME	H3597	011	Total EPO POS Mandatory	$2,200	Yes
ME	H3597	012	Total EPO POS Mandatory	$2,200	Yes
ME	H3597	014	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
ME	H5521	144	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
ME	H5521	349	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit

Maryland

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MD	H3931	097	Total EPO POS 50% Coins OON Hybrid	$1,000	Yes
MD	H3931	159	Broad Coverage EPO Mandatory	$2,000	No
MD	H3931	161	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes

Aetna Medicare package names by state

Massachusetts

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MA	H5521	159	Total PPO Passive	$1,000	Yes
MA	H5521	160	Total PPO Passive	$1,000	Yes
MA	H5521	296	Total PPO Passive	$2,000	Yes
MA	H5521	447	Total PPO Passive	$2,000	Yes
MA	H5521	448	Total PPO Passive	$2,500	Yes
MA	H5521	450	Total PPO Passive	$2,000	Yes
MA	H5521	451	Total PPO Passive	$1,500	Yes
MA	H5793	014	Total EPO POS Mandatory	$1,000	Yes
MA	H5793	018	Total EPO POS Mandatory	$1,000	Yes

Michigan

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MI	H3192	002	Total EPO POS 20% Coins OON Hybrid	$1,900	Yes
MI	H3192	003	Total EPO POS 20% Coins OON Hybrid	$2,800	Yes
MI	H3192	007	Broad Coverage EPO Mandatory	$3,500	No
MI	H3192	010	Total EPO POS 20% Coins OON Hybrid	$1,800	Yes
MI	H3192	011	Total EPO POS 20% Coins OON Hybrid	$2,300	Yes
MI	H3192	017	Total EPO POS 20% Coins OON Hybrid	$2,350	Yes
MI	H5521	194	Total PPO 20% Coins OON Hybrid	$2,600	Yes
MI	H5521	214	Total PPO 20% Coins OON Hybrid	$2,200	Yes
MI	H5521	217	Total PPO 20% Coins OON Hybrid	$1,750	Yes
MI	H5521	219	Total PPO 20% Coins OON Hybrid	$2,250	Yes
MI	H5521	284	Total PPO Passive	$2,000	Yes
MI	H5521	285	Total PPO Passive	$1,450	Yes
MI	H5521	288	Total PPO Passive	$1,200	Yes
MI	H5521	311	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
MI	H5521	399	Total PPO 20% Coins OON Hybrid	$3,000	Yes
MI	H5521	404	Total PPO 20% Coins OON Hybrid	$2,900	Yes
MI	H5521	407	Total PPO 20% Coins OON Hybrid	$3,000	Yes
MI	H5521	286	Total PPO Passive	$3,500	Yes

Aetna Medicare package names by state

Minnesota — Allina Health

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MN	H3219	001	Total PPO Passive	$1,750	Yes
MN	H3219	002	Total PPO Passive	$1,250	Yes
MN	H3219	003	Total PPO Passive	$2,000	Yes
MN	H3219	004	Total PPO Passive	$2,250	Yes
MN	H3219	005	Total PPO Passive	$2,250	Yes
MN	H3219	007	Total PPO Passive	$1,450	Yes
MN	H3219	008	Total PPO 20% Coins OON Hybrid	$2,550	Yes

Mississippi

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MS	H3239	005	Broad Coverage EPO Mandatory	$4,000	No
MS	H3239	008	Broad Coverage EPO Mandatory	$4,000	No
MS	H3239	012	Broad Coverage EPO Mandatory	$2,600	No
MS	H3239	014	Broad Coverage EPO Mandatory	$2,550	No
MS	H3239	015	Broad Coverage EPO Mandatory	$4,500	No
MS	H3239	016	Broad Coverage EPO Mandatory	$2,800	No
MS	H3239	017	Broad Coverage EPO Mandatory	$2,000	No
MS	H5521	218	Total PPO Passive	$2,200	Yes
MS	H5521	220	Total PPO Passive	$2,250	Yes
MS	H5521	324	Total PPO Passive	$3,500	Yes
MS	H5521	464	Total PPO Passive	$3,000	Yes
MS	H5521	465	Total PPO Passive	$2,550	Yes
MS	H5521	470	Total PPO Passive	$2,650	Yes
MS	H5521	471	Total PPO Passive	$2,000	Yes
MS	H5521	477	Total PPO Passive	$1,000	Yes

Missouri

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MO	H1608	013	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
MO	H1608	016	Total PPO 20% Coins OON Hybrid	$2,000	Yes
MO	H1608	018	Total PPO 20% Coins OON Hybrid	$2,000	Yes
MO	H1608	050	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
MO	H1608	051	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
MO	H1608	052	Total PPO 20% Coins OON Hybrid	$1,000	Yes

Aetna Medicare package names by state

Missouri (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
MO	H1608	067	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
MO	H1608	068	Total PPO 20% Coins OON Hybrid	$3,000	Yes
MO	H1608	071	Total PPO 20% Coins OON Hybrid	$2,500	Yes
MO	H2663	002	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
MO	H2663	005	Direct Member Reimbursement	$3,250	Yes – Not a network-based benefit
MO	H2663	006	Direct Member Reimbursement	$1,400	Yes – Not a network-based benefit
MO	H2663	021	Total EPO POS Mandatory	$4,000	Yes
MO	H2663	022	Total EPO POS Mandatory	$2,000	Yes
MO	H2663	023	Total EPO POS Mandatory	$3,500	Yes
MO	H2663	025	Total EPO POS Mandatory	$2,000	Yes
MO	H2663	026	Total EPO POS Mandatory	$2,500	Yes
MO	H2663	041	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
MO	H2663	042	Deluxe EPO Mandatory	$3,000	No
MO	H2663	043	Total EPO POS Mandatory	$3,000	Yes
MO	H2663	052	Broad Coverage EPO Mandatory	$3,500	No
MO	H2663	056	Broad Coverage EPO Mandatory	$1,500	No
MO	H2663	057	Direct Member Reimbursement	$2,250	Yes – Not a network-based benefit
MO	H2663	059	Direct Member Reimbursement	$3,000	Yes – Not a network-based benefit
MO	H2663	061	Total EPO POS Mandatory	$3,500	Yes
MO	H2663	063	Total EPO POS Mandatory	$3,500	Yes
MO	H2663	064	Broad Coverage EPO Mandatory	$4,000	No
MO	H2663	065	Preventive Only EPO Mandatory	N/A	No
MO	H2663	066	Preventive Only EPO Mandatory	N/A	No
MO	H5325	003	Broad Coverage EPO Mandatory	$4,000	No
MO	H5325	004	Broad Coverage EPO Mandatory	$4,500	No
MO	H5325	005	Broad Coverage EPO Mandatory	$5,000	No
MO	H5325	006	Broad Coverage EPO Mandatory	$5,000	No

Montana

No Aetna dental plans are offered in Montana.

Aetna Medicare package names by state

Nebraska

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NE	H1608	012	Total PPO Passive	$1,150	Yes
NE	H1608	038	Total PPO Passive	$1,600	Yes
NE	H7149	001	Total EPO POS Mandatory	$2,200	Yes
NE	H7149	006	Broad Coverage EPO Mandatory	$4,000	No
NE	H7149	007	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
NE	H7149	008	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
NE	H7149	009	Total EPO POS Mandatory	$2,400	Yes

Nevada

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NV	H3931	094	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
NV	H3931	151	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
NV	H3931	152	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
NV	H3931	157	Total EPO POS 20% Coins OON Hybrid	$3,500	Yes
NV	H3931	160	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
NV	H4711	001	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
NV	H4711	002	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
NV	H4711	005	Total EPO POS 20% Coins OON Hybrid	$1,000	Yes
NV	H4711	011	Liberty Complete, contact Liberty Dental 1-888-700-0634	$4,000	Must use Liberty Dental Network
NV	H4711	013	Liberty Complete, contact Liberty Dental 1-888-700-0634	$4,000	Must use Liberty Dental Network
NV	H5521	022	Total PPO 20% Coins OON Hybrid	$2,500	Yes
NV	H5521	055	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NV	H5521	299	Total PPO 20% Coins OON Hybrid	$1,500	Yes
NV	H5521	301	Total PPO 20% Coins OON Hybrid	$1,200	Yes
NV	H5521	303	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NV	H5521	353	Total PPO 20% Coins OON Hybrid	$2,500	Yes

New Hampshire

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NH	H5521	349	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
NH	H5521	374	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
NH	H5521	376	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
NH	H5793	015	Direct Member Reimbursement	$500	Yes – Not a network-based benefit

Aetna Medicare package names by state

New Jersey

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NJ	H3152	022	Total EPO POS 20% Coins OON Hybrid	$1,000	Yes
NJ	H3152	045	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
NJ	H3152	048	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
NJ	H3152	080	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
NJ	H3152	082	Deluxe EPO Combo	$1,000	No
NJ	H3152	084	Deluxe EPO Combo	$1,000	No
NJ	H3152	088	Deluxe EPO Combo	$1,000	No
NJ	H5521	037	Total PPO 50% Coins OON Hybrid	$1,000	Yes
NJ	H5521	123	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	124	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	275	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
NJ	H5521	277	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	278	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	390	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	391	Deluxe PPO Combo	$1,000	Yes
NJ	H5521	392	Total PPO 20% Coins OON Hybrid	$1,500	Yes
NJ	H5521	455	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NJ	H5521	456	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NJ	R6694	006	Deluxe RPPO Combo	$1,000	Yes

New Mexico

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NM	H9431	001	Deluxe PPO Combo	$2,500	Yes
NM	H9431	017	Deluxe PPO Combo	$2,000	Yes

New York

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NY	H3312	002	Deluxe EPO Combo	$2,000	No
NY	H3312	018	Broad Coverage EPO Mandatory	$1,000	No
NY	H3312	048	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
NY	H3312	062	Total EPO POS Mandatory	$1,250	Yes
NY	H3312	064	Deluxe EPO Combo	$2,000	No
NY	H3312	065	Total EPO POS Mandatory	$2,000	Yes
NY	H3312	069	Broad Coverage EPO Mandatory	$2,000	No

Aetna Medicare package names by state

New York (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NY	H3312	070	Broad Coverage EPO Mandatory	$2,000	No
NY	H3312	072	Deluxe EPO Combo	$1,000	No
NY	H3312	074	Broad Coverage EPO Mandatory	$1,750	No
NY	H5521	040	Deluxe PPO Combo	$2,000	Yes
NY	H5521	076	Deluxe PPO Combo	$2,000	Yes
NY	H5521	077	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
NY	H5521	110	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
NY	H5521	117	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NY	H5521	118	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
NY	H5521	119	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NY	H5521	120	Deluxe PPO Combo	$2,000	Yes
NY	H5521	121	Deluxe PPO Combo	$2,000	Yes
NY	H5521	215	Total PPO Passive	$2,000	Yes
NY	H5521	310	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NY	H5521	312	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NY	H5521	313	Deluxe PPO Combo	$1,000	Yes
NY	H5521	318	Deluxe PPO Combo	$2,000	Yes
NY	H5521	320	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NY	H5521	323	Total PPO 20% Coins OON Hybrid	$2,000	Yes
NY	H5521	340	Total PPO Passive	$1,750	Yes
NY	H5521	341	Deluxe PPO Combo	$1,000	Yes
NY	H5521	381	Total PPO Passive	$2,000	Yes
NY	H5521	382	Total PPO Passive	$1,000	Yes
NY	H5521	383	Total PPO Passive	$1,000	Yes
NY	H5521	384	Total PPO 50% Coins OON Hybrid	$1,000	Yes
NY	H5521	457	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NY	H5521	458	Total PPO 50% Coins OON Hybrid	$1,000	Yes
NY	H5521	459	Total PPO 20% Coins OON Hybrid	$1,000	Yes
NY	H5521	460	Total PPO 20% Coins OON Hybrid	$1,000	Yes

Aetna Medicare package names by state

North Carolina

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NC	H3146	001	Total EPO POS 20% Coins OON Hybrid	$2,200	Yes
NC	H3146	002	Broad Coverage EPO Mandatory	$3,000	No
NC	H3146	003	Broad Coverage EPO Mandatory	$3,000	No
NC	H3146	004	Total EPO POS 20% Coins OON Hybrid	$2,200	Yes
NC	H3146	006	Broad Coverage EPO Mandatory	$2,500	No
NC	H3146	007	Total EPO POS 20% Coins OON Hybrid	$3,500	Yes
NC	H3146	008	Broad Coverage EPO Mandatory	$3,000	No
NC	H3146	009	Broad Coverage EPO Mandatory	$3,000	No
NC	H3146	015	Broad Coverage EPO Mandatory	$3,000	No
NC	H3146	018	Preventive Only EPO Mandatory	N/A	No
NC	H3146	020	Total EPO POS 20% Coins OON Hybrid	$1,750	Yes
NC	H5521	081	Total PPO 20% Coins OON Hybrid	$2,750	Yes
NC	H5521	139	Total PPO 20% Coins OON Hybrid	$1,500	Yes
NC	H5521	168	Total PPO 20% Coins OON Hybrid	$2,500	Yes
NC	H5521	169	Total PPO 20% Coins OON Hybrid	$3,000	Yes
NC	H5521	170	Total PPO 20% Coins OON Hybrid	$2,900	Yes
NC	H5521	236	Total PPO 20% Coins OON Hybrid	$1,600	Yes
NC	H5521	241	Total PPO Passive	$3,000	Yes
NC	H5521	243	Total PPO 20% Coins OON Hybrid	$2,900	Yes
NC	H5521	348	Total PPO 20% Coins OON Hybrid	$1,700	Yes

North Dakota

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
ND	H9431	013	Total PPO Passive	$650	Yes
ND	H9431	014	Total PPO Passive	$1,200	Yes
ND	H9431	018	Total PPO 50% Coins OON Hybrid	$1,500	Yes

Ohio

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
OH	H0628	001	Total EPO POS 50% Coins OON Hybrid	$1,200	Yes
OH	H0628	003	Total EPO POS 50% Coins OON Hybrid	$2,900	Yes
OH	H0628	005	Total EPO POS 50% Coins OON Hybrid	$2,900	Yes
OH	H0628	013	Broad Coverage EPO Mandatory	$6,000	No
OH	H0628	015	Deluxe EPO Mandatory	$2,000	No

Aetna Medicare package names by state

Ohio (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
OH	H0628	017	Total EPO POS 50% Coins OON Hybrid	$2,200	Yes
OH	H0628	018	Broad Coverage EPO Mandatory	$3,500	No
OH	H1608	029	Deluxe PPO Mandatory	$2,500	Yes
OH	H1608	077	Total PPO Passive	$2,250	Yes
OH	H3931	107	Total EPO POS 50% Coins OON Hybrid	$2,400	Yes
OH	H3931	108	Deluxe EPO Mandatory	$2,500	No
OH	H3931	109	Total EPO POS Mandatory	$2,100	Yes
OH	H5521	020	Total PPO 50% Coins OON Hybrid	$2,000	Yes
OH	H5521	087	Deluxe PPO Mandatory	$2,000	Yes
OH	H5521	088	Deluxe PPO Mandatory	$2,000	Yes
OH	H5521	089	Deluxe PPO Mandatory	$1,000	Yes
OH	H5521	090	Deluxe PPO Mandatory	$2,000	Yes
OH	H5521	134	Total PPO 50% Coins OON Hybrid	$2,500	Yes
OH	H5521	441	Deluxe PPO Mandatory	$2,000	Yes
OH	R6694	003	Total RPPO 50% Coins OON Hybrid	$1,500	Yes
OH	R6694	005	Total RPPO 50% Coins OON Hybrid	$1,000	Yes

Oklahoma

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
OK	H2663	034	Deluxe EPO Mandatory	$2,500	No
OK	H3288	017	Deluxe PPO Mandatory	$2,000	Yes
OK	H3288	019	Deluxe PPO Mandatory	$3,000	Yes
OK	H3288	020	Total PPO 50% Coins OON Hybrid	$3,000	Yes
OK	H3288	021	Deluxe PPO Mandatory	$3,500	Yes
OK	H3288	051	Deluxe PPO Mandatory	$3,000	Yes

Aetna Medicare package names by state

Oregon

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
OR	H2056	003	Total EPO POS 20% Coins OON Hybrid	$2,100	Yes
OR	H2056	004	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
OR	H2056	005	Total EPO POS 20% Coins OON Hybrid	$2,100	Yes
OR	H2056	010	Total EPO POS 20% Coins OON Hybrid	$1,800	Yes
OR	H2056	011	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
OR	H2056	012	Total EPO POS 20% Coins OON Hybrid	$1,800	Yes
OR	H9431	004	Total PPO 20% Coins OON Hybrid	$775	Yes
OR	H9431	005	Total PPO 20% Coins OON Hybrid	$1,500	Yes
OR	H9431	015	Total PPO 20% Coins OON Hybrid	$1,250	Yes

Pennsylvania

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
PA	H3931	004	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3931	064	Total EPO POS 50% Coins OON Hybrid	$3,500	Yes
PA	H3931	070	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
PA	H3931	091	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3931	105	Total EPO POS 50% Coins OON Hybrid	$1,000	Yes
PA	H3959	001	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	002	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	010	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
PA	H3959	011	Total EPO POS 20% Coins OON Hybrid	$2,500	Yes
PA	H3959	032	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
PA	H3959	033	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	035	Broad Coverage EPO Mandatory	$6,000	No
PA	H3959	036	Broad Coverage EPO Mandatory	$7,000	No
PA	H3959	037	Total EPO POS Mandatory	$3,250	Yes
PA	H3959	039	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	041	Total EPO POS Mandatory	$3,000	Yes
PA	H3959	045	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	046	Total EPO POS Mandatory	$3,000	Yes
PA	H3959	047	Total EPO POS Mandatory	$3,000	Yes
PA	H3959	049	Total EPO POS Mandatory	$3,000	Yes
PA	H3959	051	Total EPO POS Mandatory	$3,000	Yes
PA	H3959	052	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
PA	H3959	053	Total EPO POS 20% Coins OON Hybrid	$3,000	Yes
PA	H3959	057	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
PA	H3959	066	Broad Coverage EPO Mandatory	$3,500	No

Aetna Medicare package names by state

Pennsylvania (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
PA	H5521	122	Total PPO 50% Coins OON Hybrid	$1,000	Yes
PA	H5521	261	Total PPO 50% Coins OON Hybrid	$3,000	Yes
PA	H5521	263	Total PPO 20% Coins OON Hybrid	$1,000	Yes
PA	H5521	294	Total PPO 20% Coins OON Hybrid	$2,000	Yes
PA	H5522	001	Total PPO 50% Coins OON Hybrid	$3,500	Yes
PA	H5522	002	Total PPO Passive	$3,500	Yes
PA	H5522	004	Total PPO 50% Coins OON Hybrid	$2,000	Yes
PA	H5522	005	Total PPO 50% Coins OON Hybrid	$3,000	Yes
PA	H5522	013	Total PPO 50% Coins OON Hybrid	$3,000	Yes
PA	H5522	014	Total PPO 20% Coins OON Hybrid	$3,000	Yes
PA	H5522	017	Total PPO 50% Coins OON Hybrid	$1,000	Yes
PA	H5522	022	Total PPO 50% Coins OON Hybrid	$2,500	Yes
PA	H5522	023	Total PPO Passive	$2,500	Yes
PA	H5522	024	Total PPO Passive	$5,000	Yes
PA	H5522	025	Preventive Only PPO Mandatory	N/A	Yes
PA	H5522	026	Preventive Only PPO Mandatory	N/A	Yes
PA	H5522	027	Preventive Only PPO Mandatory	N/A	Yes
PA	H5522	028	Total PPO 50% Coins OON Hybrid	$3,000	Yes
PA	H5522	029	Total PPO 50% Coins OON Hybrid	$3,500	Yes

Rhode Island

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
RI	H5521	375	Total PPO Passive	$1,500	Yes
RI	H5521	449	Total PPO Passive	$2,000	Yes
RI	H5793	016	Total EPO POS Mandatory	$500	Yes
RI	H5793	019	Total EPO POS Mandatory	$1,500	Yes

South Carolina

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
SC	H3146	011	Broad Coverage EPO Mandatory	$2,000	No
SC	H3146	014	Total EPO POS 20% Coins OON Hybrid	$3,500	Yes
SC	H3146	016	Broad Coverage EPO Mandatory	$3,000	No
SC	H3146	017	Broad Coverage EPO Mandatory	$3,000	No
SC	H3146	019	Preventive Only EPO Mandatory	N/A	No
SC	H5521	140	Total PPO 20% Coins OON Hybrid	$1,900	Yes

Aetna Medicare package names by state

South Carolina (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
SC	H5521	245	Total PPO 20% Coins OON Hybrid	$3,000	Yes
SC	H5521	247	Total PPO 20% Coins OON Hybrid	$2,000	Yes
SC	H5521	249	Total PPO 20% Coins OON Hybrid	$2,100	Yes
SC	H5521	251	Total PPO 20% Coins OON Hybrid	$1,200	Yes
SC	H5521	279	Total PPO Passive	$2,500	Yes
SC	H5521	319	Total PPO 20% Coins OON Hybrid	$2,900	Yes
SC	H5521	373	Total PPO 20% Coins OON Hybrid	$1,500	Yes
SC	H5521	444	Total PPO 20% Coins OON Hybrid	$1,300	Yes

South Dakota

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
SD	H1608	001	Total PPO Passive	$1,200	Yes
SD	H1608	043	Total PPO Passive	$1,200	Yes
SD	H1608	061	Total PPO 50% Coins OON Hybrid	$2,000	Yes
SD	H1608	062	Total PPO Passive	$2,000	Yes
SD	H1608	064	Total PPO 50% Coins OON Hybrid	$1,500	Yes

Tennessee

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
TN	H3146	012	Broad Coverage EPO Mandatory	$2,500	No
TN	H3146	013	Broad Coverage EPO Mandatory	$2,000	No
TN	H5521	141	Total PPO 20% Coins OON Hybrid	$1,700	Yes
TN	H5521	154	Total PPO 20% Coins OON Hybrid	$2,300	Yes
TN	H5521	254	Total PPO 20% Coins OON Hybrid	$2,200	Yes
TN	H5521	280	Total PPO 20% Coins OON Hybrid	$2,600	Yes
TN	H5521	321	Total PPO 20% Coins OON Hybrid	$2,000	Yes
TN	H5521	355	Total PPO Passive	$2,500	Yes
TN	H5521	445	Total PPO 20% Coins OON Hybrid	$1,400	Yes

Aetna Medicare package names by state

Texas

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
TX	H2293	013	Deluxe PPO Mandatory	$2,500	Yes
TX	H2293	014	Deluxe PPO Mandatory	$2,500	Yes
TX	H2293	015	Deluxe PPO Mandatory	$3,000	Yes
TX	H2293	016	Deluxe PPO Mandatory	$2,500	Yes
TX	H2293	017	Deluxe PPO Mandatory	$2,500	Yes
TX	H2293	018	Deluxe PPO Mandatory	$2,500	Yes
TX	H2293	019	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	001	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	002	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	003	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	004	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	005	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	006	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	007	Deluxe PPO Mandatory	$4,000	Yes
TX	H3288	008	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	009	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	011	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	016	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	018	Deluxe PPO Mandatory	$3,000	Yes
TX	H3288	046	Deluxe PPO Mandatory	$3,500	Yes
TX	H3288	047	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	048	Deluxe PPO Mandatory	$2,500	Yes
TX	H3288	051	Deluxe PPO Mandatory	$3,000	Yes
TX	H4523	001	Deluxe EPO Mandatory	$3,500	No
TX	H4523	015	Deluxe EPO Mandatory	$2,500	No
TX	H4523	020	Deluxe EPO Mandatory	$3,500	No
TX	H4523	021	Deluxe EPO Mandatory	$2,500	No
TX	H4523	024	$0 INN Deluxe EPO Mandatory	$3,500	No
TX	H8332	001	Deluxe EPO Mandatory	$3,000	No
TX	H8332	002	Deluxe EPO Mandatory	$2,500	No
TX	H8332	003	Deluxe EPO Mandatory	$3,500	No
TX	H8332	004	Deluxe EPO Mandatory	$3,500	No
TX	H8332	005	Deluxe EPO Mandatory	$2,500	No
TX	H8597	001	Broad Coverage EPO Mandatory	$4,000	No
TX	H8597	002	Broad Coverage EPO Mandatory	$3,500	No
TX	H8597	003	Broad Coverage EPO Mandatory	$3,500	No

Aetna Medicare package names by state

Utah

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
UT	H5521	101	Total PPO 20% Coins OON Hybrid	$2,000	Yes
UT	H5521	197	Total PPO 20% Coins OON Hybrid	$2,000	Yes
UT	H5521	246	Total PPO 20% Coins OON Hybrid	$2,000	Yes
UT	H5521	351	Total PPO 20% Coins OON Hybrid	$2,000	Yes
UT	H5521	398	Total PPO Passive	$4,000	Yes
UT	H5521	414	Total PPO 20% Coins OON Hybrid	$3,500	Yes
UT	H8649	003	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
UT	H8649	008	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes
UT	H8649	010	Broad Coverage EPO Mandatory	$4,000	No

Vermont

No Aetna dental plans are offered in Vermont.

Virginia

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
VA	H3931	096	Total EPO POS 50% Coins OON Hybrid	$500	Yes
VA	H3931	098	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
VA	H3931	099	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
VA	H3931	100	Total EPO POS 50% Coins OON Hybrid	$2,500	Yes
VA	H3931	101	Total EPO POS 50% Coins OON Hybrid	$1,000	Yes
VA	H3931	124	Total EPO POS 50% Coins OON Hybrid	$1,500	Yes
VA	H3931	143	Total EPO POS 50% Coins OON Hybrid	$1,500	Yes
VA	H3931	158	Total EPO POS 50% Coins OON Hybrid	$2,900	Yes
VA	H3931	162	Total EPO POS 50% Coins OON Hybrid	$3,500	Yes
VA	H5521	027	Total PPO 50% Coins OON Hybrid	$2,000	Yes
VA	H5521	084	Total PPO 50% Coins OON Hybrid	$2,700	Yes
VA	H5521	322	Total PPO 50% Coins OON Hybrid	$3,000	Yes
VA	H5521	344	Total PPO 50% Coins OON Hybrid	$1,500	Yes
VA	H5521	345	Preventive Only PPO Mandatory	N/A	Yes
VA	H5521	395	Total PPO 50% Coins OON Hybrid	$1,500	Yes
VA	H5521	396	Total PPO 50% Coins OON Hybrid	$3,500	Yes

Aetna Medicare package names by state

Washington

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
WA	H3748	001	Total EPO POS 20% Coins OON Hybrid	$1,100	Yes
WA	H3748	003	Total EPO POS 20% Coins OON Hybrid	$875	Yes
WA	H3748	004	Total EPO POS 20% Coins OON Hybrid	$750	Yes
WA	H3748	006	Total EPO POS 20% Coins OON Hybrid	$2,100	Yes
WA	H3748	007	Total EPO POS 20% Coins OON Hybrid	$1,700	Yes
WA	H3748	008	Total EPO POS 20% Coins OON Hybrid	$1,700	Yes
WA	H3748	009	Total EPO POS 20% Coins OON Hybrid	$2,100	Yes
WA	H3748	010	Preventive Only 0% OON EPO POS Mandatory	N/A	Yes
WA	H3748	013	Total EPO POS 20% Coins OON Hybrid	$1,800	Yes
WA	H3931	126	Total EPO POS 20% Coins OON Hybrid	$900	Yes
WA	H3931	149	Total EPO POS 20% Coins OON Hybrid	$1,000	Yes
WA	H3931	165	Total EPO POS 20% Coins OON Hybrid	$2,000	Yes
WA	H5521	127	Total PPO 20% Coins OON Hybrid	$1,050	Yes
WA	H5521	128	Total PPO 20% Coins OON Hybrid	$1,050	Yes
WA	H5521	330	Total PPO 20% Coins OON Hybrid	$1,750	Yes
WA	H5521	379	Total PPO 20% Coins OON Hybrid	$1,000	Yes
WA	H5521	380	Total PPO 20% Coins OON Hybrid	$1,500	Yes
WA	H5521	393	Preventive Only PPO Mandatory	N/A	Yes
WA	H5521	423	Total PPO 20% Coins OON Hybrid	$1,500	Yes
WA	H5521	431	Total PPO 20% Coins OON Hybrid	$1,800	Yes

Washington DC

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
DC	H3931	095	Total EPO POS 50% Coins OON Hybrid	$1,500	Yes
DC	H3931	161	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
DC	H5521	015	Total PPO 50% Coins OON Hybrid	$1,000	Yes

West Virginia

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
WV	H1608	026	Total PPO Passive	$2,000	Yes
WV	H1608	027	Total PPO Passive	$3,000	Yes
WV	H1608	031	Total PPO 20% Coins OON Hybrid	$1,000	Yes
WV	H1608	040	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WV	H1608	041	Total PPO 50% Coins OON Hybrid	$1,125	Yes

Return to map

Aetna Medicare package names by state

West Virginia (continued)

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
WV	H1692	002	Total EPO POS 20% Coins OON Hybrid	$2,800	Yes
WV	H1692	003	Total EPO POS 50% Coins OON Hybrid	$2,000	Yes
WV	H1692	005	Broad Coverage EPO Mandatory	$5,000	No
WV	H1692	006	Total EPO POS 50% Coins OON Hybrid	$3,000	Yes
WV	H1692	007	Total EPO POS 20% Coins OON Hybrid	$1,000	Yes

Wisconsin

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
WI	H1206	001	Total EPO POS 20% Coins OON Hybrid	$2,300	Yes
WI	H1206	002	Total EPO POS 20% Coins OON Hybrid	$2,300	Yes
WI	H5521	150	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WI	H5521	195	Total PPO 20% Coins OON Hybrid	$1,800	Yes
WI	H5521	283	Total PPO Passive	$2,150	Yes
WI	H5521	286	Total PPO Passive	$3,500	Yes
WI	H5521	289	Total PPO 20% Coins OON Hybrid	$1,300	Yes
WI	H5521	386	Total PPO 20% Coins OON Hybrid	$1,500	Yes
WI	H5521	387	Total PPO 20% Coins OON Hybrid	$1,300	Yes
WI	H5521	388	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WI	H5521	389	Total PPO 20% Coins OON Hybrid	$1,650	Yes
WI	H5521	400	Total PPO 20% Coins OON Hybrid	$2,750	Yes
WI	H5521	403	Total PPO 20% Coins OON Hybrid	$2,600	Yes
WI	H5521	410	Total PPO Passive	$1,400	Yes
WI	H5521	411	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WI	H5521	412	Total PPO Passive	$1,150	Yes
WI	H5521	413	Total PPO Passive	$1,250	Yes

Wyoming

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
WY	H5521	197	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WY	H5521	351	Total PPO 20% Coins OON Hybrid	$2,000	Yes
WY	H8649	008	Total EPO POS 20% Coins OON Hybrid	$1,500	Yes

Return to map

Aetna Medicare

$0 INN Deluxe EPO Mandatory

This Aetna Dental Medicare plan offers in-network coverage for both preventive and comprehensive coverage.

For this plan:

- All services are covered at 100% in network
- Preventive services do not count towards the annual benefit maximum
- Annual benefit maximum of $3,500 only applies to comprehensive services
- This plan is only available to members in Plan H4523-024
- No out-of-network benefits

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and maximum remaining.

Plan coverage details — $0 INN Deluxe EPO Mandatory

Member Responsibility:		In Network	Out of Network
Preventive Services		**No Maximum**	
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	No Coverage
D0150	Comprehensive oral exam	$0	
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	No Coverage
D0180	Comprehensive Periodontal Exam	$0	
Cleanings - two procedures per calendar year			
D1110	Adult prophylaxis	$0	No Coverage
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	No Coverage
D0272	Two radiographic images	$0	
D0273	Three radiographic images	$0	
D0274	Four radiographic images	$0	
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	
Comprehensive Services		**Maximum $3,500**	
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	No Coverage
D0230	Periapical - each additional image	$0	
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	
Panoramic or Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	No Coverage
D0330	Panoramic image	$0	
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	

Plan coverage details — $0 INN Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite, once per tooth per calendar year			
D2140	Amalgam - one surface	$0	No Coverage
D2150	Amalgam - two surfaces	$0	
D2160	Amalgam - three surfaces	$0	
D2161	Amalgam - four or more surfaces	$0	
D2330	Resin-based composite - one surface, anterior	$0	
D2331	Resin-based composite - two surfaces, anterior	$0	
D2332	Resin-based composite - three surfaces, anterior	$0	
D2335	Resin-based composite - four or more surfaces, anterior	$0	
D2390	Resin-based composite crown, anterior	$0	
D2391	Resin-based composite - one surface, posterior	$0	
D2392	Resin-based composite - two surfaces, posterior	$0	
D2393	Resin-based composite - three surfaces, posterior	$0	
D2394	Resin-based composite - four or more surfaces, posterior	$0	
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	$0	No Coverage
D2915	Re-cement cast or prefabricated post and core	$0	
D2920	Re-cement crown	$0	
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	$0	No Coverage
D3320	Premolar, excluding final restoration	$0	
D3330	Molar, excluding final restoration	$0	
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	$0	No Coverage
D3347	Retreatment of root canal, premolar	$0	
D3348	Retreatment of root canal, molar	$0	
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$0	No Coverage
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$0	
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	$0	No Coverage
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	$0	No Coverage
D7210	Surgical removal of erupted tooth	$0	
D7220	Removal of impacted tooth - soft tissue	$0	
D7250	Surgical removal of residual tooth	$0	
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	$0	No Coverage

Plan coverage details — $0 INN Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Core Buildups/Posts and Cores - one per tooth every five years			
D2950	Core buildup, including any pins when required	$0	No Coverage
D2952	Post and core in addition to crown, indirectly fabricated	$0	
D2953	Each additional indirectly fabricated post - same tooth	$0	
D2954	Prefabricated post and core in addition to crown	$0	
D2957	Each additional prefabricated post - same tooth	$0	
Crown - one per tooth every five years			
D2720	Crown - resin with high noble metal	$0	No Coverage
D2740	Crown - porcelain/ceramic substrate	$0	
D2750	Crown - porcelain fused to high noble metal	$0	
D2751	Crown - porcelain fused to predominantly base metal	$0	
D2752	Crown - porcelain fused to noble metal	$0	
D2753	Crown - porcelain fused to titanium and titanium alloy	$0	
D2780	Crown - 3/4 cast high noble metal	$0	
D2781	Crown - 3/4 cast predominantly base metal	$0	
D2782	Crown - 3/4 cast noble metal	$0	
D2783	Crown - 3/4 cast porcelain/ceramic	$0	
D2790	Crown - full cast high noble metal	$0	
D2791	Crown - full cast predominantly metal	$0	
D2792	Crown - full cast noble metal	$0	
Crown Repair - one per tooth per year			
D2980	Crown repair necessitated by restorative material failure	$0	No Coverage
Debridement - one per lifetime			
D4355	Full mouth debridement	$0	No Coverage
Complete Dentures - one per arch every five years			
D5110	Complete denture, maxillary	$0	No Coverage
D5120	Complete denture, mandibular	$0	
D5130	Immediate Denture - Maxillary	$0	
D5140	Immediate Denture - Mandibular	$0	
Partial Dentures - one per arch every five years			
D5211	Maxillary partial denture - resin base	$0	No Coverage
D5212	Mandibular partial denture - resin base	$0	
D5213	Maxillary partial denture - cast base	$0	
D5214	Mandibular partial denture - cast base	$0	
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$0	
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$0	
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$0	
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$0	
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	$0	
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	$0	

Plan coverage details — $0 INN Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Denture Adjustment, Repair and Rebase - as needed			
D5410	Adjustments complete denture, maxillary	$0	No Coverage
D5411	Adjustments complete denture, mandibular	$0	
D5421	Adjustments partial denture, maxillary	$0	
D5422	Adjustments partial denture, mandibular	$0	
D5511	Repair broken complete denture base, mandibular	$0	
D5512	Repair broken complete denture base, maxillary	$0	
D5520	Replace missing or broken teeth, complete denture (each tooth)	$0	
D5611	Repair resin denture base, mandibular	$0	
D5612	Repair resin denture base, maxillary	$0	
D5621	Repair cast framework, mandibular	$0	
D5622	Repair cast framework, maxillary	$0	
D5630	Repair or replace broken clasp	$0	
D5640	Replace broken teeth, per tooth	$0	
D5650	Add tooth to existing partial denture	$0	
D5660	Add clasp to existing partial denture	$0	
D5670	Replace all teeth, upper partial	$0	
D5671	Replace all teeth, lower partial	$0	
D5710	Rebase complete maxillary denture	$0	
D5711	Rebase complete mandibular denture	$0	
D5720	Rebase partial maxillary denture	$0	
D5721	Rebase partial mandibular denture	$0	
D5730	Reline complete maxillary denture (direct)	$0	
D5731	Reline complete mandibular denture (direct)	$0	
D5740	Reline complete maxillary partial denture (direct)	$0	
D5741	Reline complete mandibular partial denture (direct)	$0	
D5750	Reline complete maxillary denture (indirect)	$0	
D5751	Reline complete mandibular denture (indirect)	$0	
D5760	Reline maxillary partial denture (indirect)	$0	
D5761	Reline mandibular partial denture (indirect)	$0	
D5876	Add metal substructure to acrylic full denture (per arch)	$0	

Plan coverage details — $0 INN Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Pontic - one per tooth every five years			
D6210	Pontic - cast high noble metal	$0	No Coverage
D6211	Pontic - cast predominantly base metal	$0	
D6212	Pontic - cast noble metal	$0	
D6240	Pontic - porcelain fused to high noble	$0	
D6241	Pontic - porcelain fused to base metal	$0	
D6242	Pontic - porcelain fused to noble metal	$0	
D6243	Pontic - porcelain fused to titanium and titanium alloys	$0	
D6245	Pontic - porcelain/ceramic	$0	
D6250	Pontic - resin with high noble metal	$0	
D6251	Pontic - resin with predominantly base metal	$0	
D6252	Pontic - resin with noble metal	$0	
Bridge Retainers - one per tooth every five years			
D6545	Retainer - cast metal for resin bonded	$0	No Coverage
D6548	Retainer - porcelain/ceramic resin bonded fixed prosthesis	$0	
D6720	Crown - resin with high noble metal	$0	
D6721	Crown - resin with predominantly base metal	$0	
D6722	Crown - resin with noble metal	$0	
D6740	Crown - porcelain/ceramic	$0	
D6750	Crown - porcelain fused to high noble metal	$0	
D6751	Crown - porcelain fused to predominantly base metal	$0	
D6752	Crown - porcelain fused to noble metal	$0	
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$0	
D6780	Crown - 3/4 cast high noble metal	$0	
D6781	Crown - 3/4 cast predominantly based metal	$0	
D6782	Crown - 3/4 cast noble metal	$0	
D6783	Crown - 3/4 porcelain/ceramic	$0	
D6784	Retainer crown - 3/4 titanium and titanium alloys	$0	
D6790	Crown - full cast high noble metal	$0	
D6791	Crown - full cast predominantly base metal	$0	
D6792	Crown - full cast noble metal	$0	
Fixed partial denture - as needed			
D6980	Fixed partial denture repair	$0	No Coverage
Oral Surgery - once per tooth per lifetime			
D7230	Removal of impacted tooth - part bony	$0	No Coverage
D7240	Removal of impacted tooth - full bony	$0	
D7241	Removal of impacted tooth - complication	$0	
Anesthesia - as needed/medical necessity			
D9219	Evaluation - deep sedation or general anesthesia	$0	No Coverage
D9222	General anesthesia - first 15 minutes	$0	
D9223	General anesthesia - 15-minute increments	$0	
D9239	Intravenous sedation/analgesia - first 15 minutes	$0	
D9243	Intravenous sedation/analgesia - 15-minute increments	$0	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	$0	

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Dental services received from a non-network dentist
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Basic PPO Mandatory

This Aetna Dental Medicare plan offers in- and out-of-network coverage for both preventive and basic comprehensive coverage.

For this plan:

- Preventive services are covered at 100% in network and 70% out of network
- Preventive services do not count towards the annual benefit maximum
- Member coinsurance applies to most comprehensive services
- $2,000 annual benefit maximum only applies to comprehensive services
- This plan is only available to members in Plan H5521-085
- Out-of-network rates are based on “usual and customary charges” at the time of service

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and maximum remaining.

Plan coverage details — Basic PPO Mandatory

Member Responsibility:		In Network	Out of Network
Preventive Services		**No Maximum**	
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	30%
D0150	Comprehensive oral exam	$0	30%
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	30%
D0180	Comprehensive periodontal exam	$0	30%
Cleanings - two per calendar year			
D1110	Adult prophylaxis	$0	30%
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	30%
D0272	Two radiographic images	$0	30%
D0273	Three radiographic images	$0	30%
D0274	Four radiographic images	$0	30%
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	30%
Comprehensive Services		**Maximum $2,000**	
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	30%
D0230	Periapical - each additional image	$0	30%
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	30%
Panoramic and Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	30%
D0330	Panoramic image	$0	30%
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	30%

Plan coverage details — Basic PPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite - once per tooth per calendar year			
D2140	Amalgam - one surface	50%	70%
D2150	Amalgam - two surfaces	50%	70%
D2160	Amalgam - three surfaces	50%	70%
D2161	Amalgam - four or more surfaces	50%	70%
D2330	Resin-based - one surface, anterior	50%	70%
D2331	Resin-based - two surfaces, anterior	50%	70%
D2332	Resin-based - three surfaces, anterior	50%	70%
D2335	Resin-based - four or more surfaces, anterior	50%	70%
D2390	Resin-based composite crown, anterior	50%	70%
D2391	Resin-based - one surface, posterior	50%	70%
D2392	Resin-based - two surfaces, posterior	50%	70%
D2393	Resin-based - three surfaces, posterior	50%	70%
D2394	Resin-based - four or more surfaces, posterior	50%	70%
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	50%	70%
D2915	Re-cement cast or prefabricated post and core	50%	70%
D2920	Re-cement crown	50%	70%
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	50%	70%
D3320	Premolar, excluding final restoration	50%	70%
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	50%	70%
D3347	Retreatment of root canal, premolar	50%	70%
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	50%	70%
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	50%	70%
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	50%	70%
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	50%	70%
D7210	Surgical removal of erupted tooth	50%	70%
D7220	Removal of impacted tooth - soft tissue	50%	70%
D7250	Surgical removal of residual tooth	50%	70%
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	50%	70%

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Out-of-Network Benefits

The member may receive covered services from providers who are not in our network. The cost for services from an out-of-network provider are described in the table above. Every dental service has a "usual and customary charge," which is the amount we will use for calculating benefits. The member is responsible for any copayments and coinsurance. You may call Provider Services to find out the usual and customary charge for a particular dental service.

If the amount charged for a covered service is equal to or less than the usual and customary charge, we will pay that amount less any cost sharing that the member owes. However, if the amount charged is greater than the usual and customary charge for that service, the member is responsible to pay the difference. As an example, assume the coinsurance is 20%, the out-of-network provider charge is $150, and the usual and customary charge is $100. In this example, we would pay $80, and the member would pay the coinsurance of $20 (20%) plus the $50 in actual charges that exceed the usual and customary charge. The member is responsible for amounts charged by the provider that exceed benefits. Billing arrangements are between the member and the provider.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Broad Coverage EPO Mandatory

This Aetna Dental® Medicare plan offers in network coverage for both preventive and comprehensive dental services that are recognized by the American Dental Association (ADA); excluding only cosmetic services, those considered medical in nature, and administrative changes.

For this plan:

- Preventive and Comprehensive services are covered at 100% in network
- All covered services count towards the annual benefit maximum
- Services include Exams, Cleanings, X-rays, Fillings, Extractions, Anesthesia, Periodontal Services, Root Canals, Crowns, Dentures, Bridges, Implants and more
- No frequency limitations
- No out-of-network benefits

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm the member's eligibility and maximum remaining.

Member Responsibility	In Network	Out of Network
Preventive and comprehensive services	$0	No Coverage
Annual maximum benefit	Varies per chart below	

Non-Covered Services

The plan does not cover the following:

- CDT codes listed in the table below
- Services or items listed in the Limitations & Exclusions section
- Services performed outside the United States of America
- Dental services received from a non-network dentist
- Medical in Nature Oral Surgery. Please see **AetnaDental.com** for more details.

Plan coverage details — Broad Coverage EPO Mandatory

CDT Code	Non-Covered Services Definition
D9961	Duplicate/copy of patient records
D9972	Bleaching external - per arch
D9973	Bleaching external - per tooth
D9974	Bleaching internal - per tooth
D9975	Bleaching external for home application, per arch
D9985	Sales tax
D9986	Missed appointments
D9987	Canceled appointments
D9991	Dental case management - Addressing appointment compliance barriers

Plan coverage details — Broad Coverage EPO Mandatory (continued)

These codes are not covered and unspecified by the American Dental Association.			
D0000	D3000	D5999	D8000
D0999	D3999	D6199	D8999
D1000	D4000	D6999	D9000
D1999	D4999	D7000	D9999
D2000	D5000	D7899	
D2999	D5899	D7999	

Limitations & Exclusions:

1. Services provided out of network.
2. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
3. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
4. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
5. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Deluxe EPO Combo

This Aetna Dental Medicare plan offers in-network preventive coverage and the option for the member to add in-network comprehensive coverage at an additional cost.

For this plan:

- Preventive services are covered at 100% in network
- Preventive services do not count towards the annual benefit maximum
- Comprehensive coverage must be elected by the member
- Member coinsurance applies to most comprehensive services
- Annual benefit maximum only applies to comprehensive services
- No out-of-network benefits

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm if the member elected the optional dental coverage.

Plan coverage details — Deluxe EPO Combo

Member Responsibility:		In Network	Out of Network
Preventive Services No Maximum			
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	No Coverage
D0150	Comprehensive oral exam	$0	
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	No Coverage
D0180	Comprehensive Periodontal Exam	$0	
Cleanings - two procedures per calendar year			
D1110	Adult prophylaxis	$0	No Coverage
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	No Coverage
D0272	Two radiographic images	$0	
D0273	Three radiographic images	$0	
D0274	Four radiographic images	$0	
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	
Optional Comprehensive Services Maximum Varies by Chart Below			
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	No Coverage
D0230	Periapical - each additional image	$0	
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	
Panoramic or Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	No Coverage
D0330	Panoramic image	$0	
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	

Plan coverage details — Deluxe EPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite, once per tooth per calendar year			
D2140	Amalgam - one surface	20%	No Coverage
D2150	Amalgam - two surfaces	20%	
D2160	Amalgam - three surfaces	20%	
D2161	Amalgam - four or more surfaces	20%	
D2330	Resin-based composite - one surface, anterior	20%	
D2331	Resin-based composite - two surfaces, anterior	20%	
D2332	Resin-based composite - three surfaces, anterior	20%	
D2335	Resin-based composite - four or more surfaces, anterior	20%	
D2390	Resin-based composite crown, anterior	20%	
D2391	Resin-based composite - one surface, posterior	20%	
D2392	Resin-based composite - two surfaces, posterior	20%	
D2393	Resin-based composite - three surfaces, posterior	20%	
D2394	Resin-based composite - four or more surfaces, posterior	20%	
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	20%	No Coverage
D2915	Re-cement cast or prefabricated post and core	20%	
D2920	Re-cement crown	20%	
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	20%	No Coverage
D3320	Premolar, excluding final restoration	20%	
D3330	Molar, excluding final restoration	20%	
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	20%	No Coverage
D3347	Retreatment of root canal, premolar	20%	
D3348	Retreatment of root canal, molar	20%	
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	No Coverage
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	20%	No Coverage
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	20%	No Coverage
D7210	Surgical removal of erupted tooth	20%	
D7220	Removal of impacted tooth - soft tissue	20%	
D7250	Surgical removal of residual tooth	20%	
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	20%	No Coverage
Core Buildups/Posts and Cores - one per tooth every five years			
D2950	Core buildup, including any pins when required	50%	No Coverage
D2952	Post and core in addition to crown, indirectly fabricated	50%	
D2953	Each additional indirectly fabricated post - same tooth	50%	
D2954	Prefabricated post and core in addition to crown	50%	
D2957	Each additional prefabricated post - same tooth	50%	

Plan coverage details — Deluxe EPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Crown - one per tooth every five years			
D2720	Crown - resin with high noble metal	50%	No Coverage
D2740	Crown - porcelain/ceramic substrate	50%	
D2750	Crown - porcelain fused to high noble metal	50%	
D2751	Crown - porcelain fused to predominantly base metal	50%	
D2752	Crown - porcelain fused to noble metal	50%	
D2753	Crown - porcelain fused to titanium and titanium alloy	50%	
D2780	Crown - 3/4 cast high noble metal	50%	
D2781	Crown - 3/4 cast predominantly base metal	50%	
D2782	Crown - 3/4 cast noble metal	50%	
D2783	Crown - 3/4 cast porcelain/ceramic	50%	
D2790	Crown - full cast high noble metal	50%	
D2791	Crown - full cast predominantly metal	50%	
D2792	Crown - full cast noble metal	50%	
Crown Repair - one per tooth per year			
D2980	Crown repair necessitated by restorative material failure	50%	No Coverage
Debridement - one per lifetime			
D4355	Full mouth debridement	50%	No Coverage
Complete Dentures - one per arch every five years			
D5110	Complete denture, maxillary	50%	No Coverage
D5120	Complete denture, mandibular	50%	
D5130	Immediate Denture - Maxillary	50%	
D5140	Immediate Denture - Mandibular	50%	
Partial Dentures - one per arch every five years			
D5211	Maxillary partial denture - resin base	50%	No Coverage
D5212	Mandibular partial denture - resin base	50%	
D5213	Maxillary partial denture - cast base	50%	
D5214	Mandibular partial denture - cast base	50%	
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	50%	
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	50%	
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	50%	
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	50%	

Plan coverage details — Deluxe EPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Denture Adjustment, Repair and Rebase - as needed			
D5410	Adjustments complete denture, maxillary	50%	No Coverage
D5411	Adjustments complete denture, mandibular	50%	
D5421	Adjustments partial denture, maxillary	50%	
D5422	Adjustments partial denture, mandibular	50%	
D5511	Repair broken complete denture base, mandibular	50%	
D5512	Repair broken complete denture base, maxillary	50%	
D5520	Replace missing or broken teeth, complete denture (each tooth)	50%	
D5611	Repair resin denture base, mandibular	50%	
D5612	Repair resin denture base, maxillary	50%	
D5621	Repair cast framework, mandibular	50%	
D5622	Repair cast framework, maxillary	50%	
D5630	Repair or replace broken clasp	50%	
D5640	Replace broken teeth, per tooth	50%	
D5650	Add tooth to existing partial denture	50%	
D5660	Add clasp to existing partial denture	50%	
D5670	Replace all teeth, upper partial	50%	
D5671	Replace all teeth, lower partial	50%	
D5710	Rebase complete maxillary denture	50%	
D5711	Rebase complete mandibular denture	50%	
D5720	Rebase partial maxillary denture	50%	
D5721	Rebase partial mandibular denture	50%	
D5730	Reline complete maxillary denture (direct)	50%	
D5731	Reline complete mandibular denture (direct)	50%	
D5740	Reline complete maxillary partial denture (direct)	50%	
D5741	Reline complete mandibular partial denture (direct)	50%	
D5750	Reline complete maxillary denture (indirect)	50%	
D5751	Reline complete mandibular denture (indirect)	50%	
D5760	Reline maxillary partial denture (indirect)	50%	
D5761	Reline mandibular partial denture (indirect)	50%	
D5876	Add metal substructure to acrylic full denture (per arch)	50%	
Pontic - one per tooth every five years			
D6210	Pontic - cast high noble metal	50%	No Coverage
D6211	Pontic - cast predominantly base metal	50%	
D6212	Pontic - cast noble metal	50%	
D6240	Pontic - porcelain fused to high noble	50%	
D6241	Pontic - porcelain fused to base metal	50%	
D6242	Pontic - porcelain fused to noble metal	50%	
D6243	Pontic - porcelain fused to titanium and titanium alloys	50%	
D6245	Pontic - porcelain/ceramic	50%	
D6250	Pontic - resin with high noble metal	50%	
D6251	Pontic - resin with predominantly base metal	50%	
D6252	Pontic - resin with noble metal	50%	

Plan coverage details — Deluxe EPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Bridge Retainers - one per tooth every five years			
D6545	Retainer - cast metal for resin bonded	50%	No Coverage
D6548	Retainer - porcelain/ceramic resin bonded fixed prosthesis	50%	
D6720	Crown - resin with high noble metal	50%	
D6721	Crown - resin with predominantly base metal	50%	
D6722	Crown - resin with noble metal	50%	
D6740	Crown - porcelain/ceramic	50%	
D6750	Crown - porcelain fused to high noble metal	50%	
D6751	Crown - porcelain fused to predominantly base metal	50%	
D6752	Crown - porcelain fused to noble metal	50%	
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	50%	
D6780	Crown - 3/4 cast high noble metal	50%	
D6781	Crown - 3/4 cast predominantly based metal	50%	
D6782	Crown - 3/4 cast noble metal	50%	
D6783	Crown - 3/4 porcelain/ceramic	50%	
D6784	Retainer crown - 3/4 titanium and titanium alloys	50%	
D6790	Crown - full cast high noble metal	50%	
D6791	Crown - full cast predominantly base metal	50%	
D6792	Crown - full cast noble metal	50%	
Fixed partial denture - as needed			
D6980	Fixed partial denture repair	50%	No Coverage
Oral Surgery - once per tooth per lifetime			
D7230	Removal of impacted tooth - part bony	50%	No Coverage
D7240	Removal of impacted tooth - full bony	50%	
D7241	Removal of impacted tooth - complication	50%	
Anesthesia - as needed/medical necessity			
D9219	Evaluation - deep sedation or general anesthesia	50%	No Coverage
D9222	General anesthesia - first 15 minutes	50%	
D9223	General anesthesia - 15-minute increments	50%	
D9239	Intravenous sedation/analgesia - first 15 minutes	50%	
D9243	Intravenous sedation/analgesia - 15-minute increments	50%	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	50%	

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Dental services received from a non-network dentist
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Deluxe EPO Mandatory

This Aetna Dental Medicare plan offers in network coverage for both preventive and comprehensive coverage.

For this plan:

- Preventive services are covered at 100% in network
- Preventive services do not count towards the annual benefit maximum
- Annual benefit maximum only applies to comprehensive services
- No out-of-network benefits

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and maximum remaining.

Plan coverage details — Deluxe EPO Mandatory

Member Responsibility:		In Network	Out of Network
Preventive Services No Maximum			
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	No Coverage
D0150	Comprehensive oral exam	$0	
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	No Coverage
D0180	Comprehensive Periodontal Exam	$0	
Cleanings - two procedures per calendar year			
D1110	Adult prophylaxis	$0	No Coverage
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	No Coverage
D0272	Two radiographic images	$0	
D0273	Three radiographic images	$0	
D0274	Four radiographic images	$0	
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	
Optional Comprehensive Services Maximum Varies by Chart Below			
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	No Coverage
D0230	Periapical - each additional image	$0	
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	
Panoramic or Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	No Coverage
D0330	Panoramic image	$0	
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	

Plan coverage details — Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite, once per tooth per calendar year			
D2140	Amalgam - one surface	20%	No Coverage
D2150	Amalgam - two surfaces	20%	
D2160	Amalgam - three surfaces	20%	
D2161	Amalgam - four or more surfaces	20%	
D2330	Resin-based composite - one surface, anterior	20%	
D2331	Resin-based composite - two surfaces, anterior	20%	
D2332	Resin-based composite - three surfaces, anterior	20%	
D2335	Resin-based composite - four or more surfaces, anterior	20%	
D2390	Resin-based composite crown, anterior	20%	
D2391	Resin-based composite - one surface, posterior	20%	
D2392	Resin-based composite - two surfaces, posterior	20%	
D2393	Resin-based composite - three surfaces, posterior	20%	
D2394	Resin-based composite - four or more surfaces, posterior	20%	
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	20%	No Coverage
D2915	Re-cement cast or prefabricated post and core	20%	
D2920	Re-cement crown	20%	
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	20%	No Coverage
D3320	Premolar, excluding final restoration	20%	
D3330	Molar, excluding final restoration	20%	
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	20%	No Coverage
D3347	Retreatment of root canal, premolar	20%	
D3348	Retreatment of root canal, molar	20%	
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	No Coverage
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	20%	No Coverage
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	20%	No Coverage
D7210	Surgical removal of erupted tooth	20%	
D7220	Removal of impacted tooth - soft tissue	20%	
D7250	Surgical removal of residual tooth	20%	
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	20%	No Coverage
Core Buildups/Posts and Cores - one per tooth every five years			
D2950	Core buildup, including any pins when required	50%	No Coverage
D2952	Post and core in addition to crown, indirectly fabricated	50%	
D2953	Each additional indirectly fabricated post - same tooth	50%	
D2954	Prefabricated post and core in addition to crown	50%	
D2957	Each additional prefabricated post - same tooth	50%	

Plan coverage details — Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Crown - one per tooth every five years			
D2720	Crown - resin with high noble metal	50%	No Coverage
D2740	Crown - porcelain/ceramic substrate	50%	
D2750	Crown - porcelain fused to high noble metal	50%	
D2751	Crown - porcelain fused to predominantly base metal	50%	
D2752	Crown - porcelain fused to noble metal	50%	
D2753	Crown - porcelain fused to titanium and titanium alloy	50%	
D2780	Crown - 3/4 cast high noble metal	50%	
D2781	Crown - 3/4 cast predominantly base metal	50%	
D2782	Crown - 3/4 cast noble metal	50%	
D2783	Crown - 3/4 cast porcelain/ceramic	50%	
D2790	Crown - full cast high noble metal	50%	
D2791	Crown - full cast predominantly metal	50%	
D2792	Crown - full cast noble metal	50%	
Crown Repair - one per tooth per year			
D2980	Crown repair necessitated by restorative material failure	50%	No Coverage
Debridement - one per lifetime			
D4355	Full mouth debridement	50%	No Coverage
Complete Dentures - one per arch every five years			
D5110	Complete denture, maxillary	50%	No Coverage
D5120	Complete denture, mandibular	50%	
D5130	Immediate Denture - Maxillary	50%	
D5140	Immediate Denture - Mandibular	50%	
Partial Dentures - one per arch every five years			
D5211	Maxillary partial denture - resin base	50%	No Coverage
D5212	Mandibular partial denture - resin base	50%	
D5213	Maxillary partial denture - cast base	50%	
D5214	Mandibular partial denture - cast base	50%	
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	50%	
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	50%	
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	50%	
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	50%	

Plan coverage details — Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Denture Adjustment, Repair and Rebase - as needed			
D5410	Adjustments complete denture, maxillary	50%	No Coverage
D5411	Adjustments complete denture, mandibular	50%	
D5421	Adjustments partial denture, maxillary	50%	
D5422	Adjustments partial denture, mandibular	50%	
D5511	Repair broken complete denture base, mandibular	50%	
D5512	Repair broken complete denture base, maxillary	50%	
D5520	Replace missing or broken teeth, complete denture (each tooth)	50%	
D5611	Repair resin denture base, mandibular	50%	
D5612	Repair resin denture base, maxillary	50%	
D5621	Repair cast framework, mandibular	50%	
D5622	Repair cast framework, maxillary	50%	
D5630	Repair or replace broken clasp	50%	
D5640	Replace broken teeth, per tooth	50%	
D5650	Add tooth to existing partial denture	50%	
D5660	Add clasp to existing partial denture	50%	
D5670	Replace all teeth, upper partial	50%	
D5671	Replace all teeth, lower partial	50%	
D5710	Rebase complete maxillary denture	50%	
D5711	Rebase complete mandibular denture	50%	
D5720	Rebase partial maxillary denture	50%	
D5721	Rebase partial mandibular denture	50%	
D5730	Reline complete maxillary denture (direct)	50%	
D5731	Reline complete mandibular denture (direct)	50%	
D5740	Reline complete maxillary partial denture (direct)	50%	
D5741	Reline complete mandibular partial denture (direct)	50%	
D5750	Reline complete maxillary denture (indirect)	50%	
D5751	Reline complete mandibular denture (indirect)	50%	
D5760	Reline maxillary partial denture (indirect)	50%	
D5761	Reline mandibular partial denture (indirect)	50%	
D5876	Add metal substructure to acrylic full denture (per arch)	50%	
Pontic - one per tooth every five years			
D6210	Pontic - cast high noble metal	50%	No Coverage
D6211	Pontic - cast predominantly base metal	50%	
D6212	Pontic - cast noble metal	50%	
D6240	Pontic - porcelain fused to high noble	50%	
D6241	Pontic - porcelain fused to base metal	50%	
D6242	Pontic - porcelain fused to noble metal	50%	
D6243	Pontic - porcelain fused to titanium and titanium alloys	50%	
D6245	Pontic - porcelain/ceramic	50%	
D6250	Pontic - resin with high noble metal	50%	
D6251	Pontic - resin with predominantly base metal	50%	
D6252	Pontic - resin with noble metal	50%	

Plan coverage details — Deluxe EPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Bridge Retainers - one per tooth every five years			
D6545	Retainer - cast metal for resin bonded	50%	No Coverage
D6548	Retainer - porcelain/ceramic resin bonded fixed prosthesis	50%	
D6720	Crown - resin with high noble metal	50%	
D6721	Crown - resin with predominantly base metal	50%	
D6722	Crown - resin with noble metal	50%	
D6740	Crown - porcelain/ceramic	50%	
D6750	Crown - porcelain fused to high noble metal	50%	
D6751	Crown - porcelain fused to predominantly base metal	50%	
D6752	Crown - porcelain fused to noble metal	50%	
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	50%	
D6780	Crown - 3/4 cast high noble metal	50%	
D6781	Crown - 3/4 cast predominantly based metal	50%	
D6782	Crown - 3/4 cast noble metal	50%	
D6783	Crown - 3/4 porcelain/ceramic	50%	
D6784	Retainer crown - 3/4 titanium and titanium alloys	50%	
D6790	Crown - full cast high noble metal	50%	
D6791	Crown - full cast predominantly base metal	50%	
D6792	Crown - full cast noble metal	50%	
Fixed partial denture - as needed			
D6980	Fixed partial denture repair	50%	No Coverage
Oral Surgery - once per tooth per lifetime			
D7230	Removal of impacted tooth - part bony	50%	No Coverage
D7240	Removal of impacted tooth - full bony	50%	
D7241	Removal of impacted tooth - complication	50%	
Anesthesia - as needed/medical necessity			
D9219	Evaluation - deep sedation or general anesthesia	50%	No Coverage
D9222	General anesthesia - first 15 minutes	50%	
D9223	General anesthesia - 15-minute increments	50%	
D9239	Intravenous sedation/analgesia - first 15 minutes	50%	
D9243	Intravenous sedation/analgesia - 15-minute increments	50%	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	50%	

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Dental services received from a non-network dentist
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Deluxe PPO Mandatory

This Aetna Dental Medicare plan offers both preventive and comprehensive coverage.

For this plan:

- Preventive services are covered at 100% in network and 70% out of network
- Preventive services do not count towards the annual benefit maximum in or out of network
- Member coinsurance applies to most comprehensive services
- Annual benefit maximum only applies to comprehensive services
- Out of network rates are based on "usual and customary charges" at the time of service

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and maximum remaining.

Plan coverage details — Deluxe PPO Mandatory

Member Responsibility:		In Network	Out of Network
Preventive Services No Maximum			
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	30%
D0150	Comprehensive oral exam	$0	30%
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	30%
D0180	Comprehensive Periodontal Exam	$0	30%
Cleanings - two procedures per calendar year			
D1110	Adult prophylaxis	$0	30%
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	30%
D0272	Two radiographic images	$0	30%
D0273	Three radiographic images	$0	30%
D0274	Four radiographic images	$0	30%
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	30%
Optional Comprehensive Services Maximum Varies by Chart Below			
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	30%
D0230	Periapical - each additional image	$0	30%
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	30%
Panoramic or Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	30%
D0330	Panoramic image	$0	30%
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	30%

Plan coverage details — Deluxe PPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite, once per tooth per calendar year			
D2140	Amalgam - one surface	20%	50%
D2150	Amalgam - two surfaces	20%	50%
D2160	Amalgam - three surfaces	20%	50%
D2161	Amalgam - four or more surfaces	20%	50%
D2330	Resin-based composite - one surface, anterior	20%	50%
D2331	Resin-based composite - two surfaces, anterior	20%	50%
D2332	Resin-based composite - three surfaces, anterior	20%	50%
D2335	Resin-based composite - four or more surfaces, anterior	20%	50%
D2390	Resin-based composite crown, anterior	20%	50%
D2391	Resin-based composite - one surface, posterior	20%	50%
D2392	Resin-based composite - two surfaces, posterior	20%	50%
D2393	Resin-based composite - three surfaces, posterior	20%	50%
D2394	Resin-based composite - four or more surfaces, posterior	20%	50%
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	20%	50%
D2915	Re-cement cast or prefabricated post and core	20%	50%
D2920	Re-cement crown	20%	50%
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	20%	50%
D3320	Premolar, excluding final restoration	20%	50%
D3330	Molar, excluding final restoration	20%	50%
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	20%	50%
D3347	Retreatment of root canal, premolar	20%	50%
D3348	Retreatment of root canal, molar	20%	50%
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	50%
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	50%
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	20%	50%
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	20%	50%
D7210	Surgical removal of erupted tooth	20%	50%
D7220	Removal of impacted tooth - soft tissue	20%	50%
D7250	Surgical removal of residual tooth	20%	50%
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	20%	50%
Core Buildups/Posts and Cores - one per tooth every five years			
D2950	Core buildup, including any pins when required	50%	70%
D2952	Post and core in addition to crown, indirectly fabricated	50%	70%
D2953	Each additional indirectly fabricated post - same tooth	50%	70%
D2954	Prefabricated post and core in addition to crown	50%	70%
D2957	Each additional prefabricated post - same tooth	50%	70%

Plan coverage details — Deluxe PPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Crown - one per tooth every five years			
D2720	Crown - resin with high noble metal	50%	70%
D2740	Crown - porcelain/ceramic substrate	50%	70%
D2750	Crown - porcelain fused to high noble metal	50%	70%
D2751	Crown - porcelain fused to predominantly base metal	50%	70%
D2752	Crown - porcelain fused to noble metal	50%	70%
D2753	Crown - porcelain fused to titanium and titanium alloy	50%	70%
D2780	Crown - 3/4 cast high noble metal	50%	70%
D2781	Crown - 3/4 cast predominantly base metal	50%	70%
D2782	Crown - 3/4 cast noble metal	50%	70%
D2783	Crown - 3/4 cast porcelain/ceramic	50%	70%
D2790	Crown - full cast high noble metal	50%	70%
D2791	Crown - full cast predominantly metal	50%	70%
D2792	Crown - full cast noble metal	50%	70%
Crown Repair - one per tooth per year			
D2980	Crown repair necessitated by restorative material failure	50%	70%
Debridement - one per lifetime			
D4355	Full mouth debridement	50%	70%
Complete Dentures - one per arch every five years			
D5110	Complete denture, maxillary	50%	70%
D5120	Complete denture, mandibular	50%	70%
D5130	Immediate Denture - Maxillary	50%	70%
D5140	Immediate Denture - Mandibular	50%	70%
Partial Dentures - one per arch every five years			
D5211	Maxillary partial denture - resin base	50%	70%
D5212	Mandibular partial denture - resin base	50%	70%
D5213	Maxillary partial denture - cast base	50%	70%
D5214	Mandibular partial denture - cast base	50%	70%
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	70%
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	70%
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	50%	70%
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	50%	70%
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	50%	70%
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	50%	70%
Denture Adjustment, Repair and Rebase - as needed			
D5410	Adjustments complete denture, maxillary	50%	70%
D5411	Adjustments complete denture, mandibular	50%	70%
D5421	Adjustments partial denture, maxillary	50%	70%
D5422	Adjustments partial denture, mandibular	50%	70%
D5511	Repair broken complete denture base, mandibular	50%	70%

Plan coverage details — Deluxe PPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
D5512	Repair broken complete denture base, maxillary	50%	70%
D5520	Replace missing or broken teeth, complete denture (each tooth)	50%	70%
D5611	Repair resin denture base, mandibular	50%	70%
D5612	Repair resin denture base, maxillary	50%	70%
D5621	Repair cast framework, mandibular	50%	70%
D5622	Repair cast framework, maxillary	50%	70%
D5630	Repair or replace broken clasp	50%	70%
D5640	Replace broken teeth, per tooth	50%	70%
D5650	Add tooth to existing partial denture	50%	70%
D5660	Add clasp to existing partial denture	50%	70%
D5670	Replace all teeth, upper partial	50%	70%
D5671	Replace all teeth, lower partial	50%	70%
D5710	Rebase complete maxillary denture	50%	70%
D5711	Rebase complete mandibular denture	50%	70%
D5720	Rebase partial maxillary denture	50%	70%
D5721	Rebase partial mandibular denture	50%	70%
D5730	Reline complete maxillary denture (direct)	50%	70%
D5731	Reline complete mandibular denture (direct)	50%	70%
D5740	Reline complete maxillary partial denture (direct)	50%	70%
D5741	Reline complete mandibular partial denture (direct)	50%	70%
D5750	Reline complete maxillary denture (indirect)	50%	70%
D5751	Reline complete mandibular denture (indirect)	50%	70%
D5760	Reline maxillary partial denture (indirect)	50%	70%
D5761	Reline mandibular partial denture (indirect)	50%	70%
D5876	Add metal substructure to acrylic full denture (per arch)	50%	70%
Pontic - one per tooth every five years			
D6210	Pontic - cast high noble metal	50%	70%
D6211	Pontic - cast predominantly base metal	50%	70%
D6212	Pontic - cast noble metal	50%	70%
D6240	Pontic - porcelain fused to high noble	50%	70%
D6241	Pontic - porcelain fused to base metal	50%	70%
D6242	Pontic - porcelain fused to noble metal	50%	70%
D6243	Pontic - porcelain fused to titanium and titanium alloys	50%	70%
D6245	Pontic - porcelain/ceramic	50%	70%
D6250	Pontic - resin with high noble metal	50%	70%
D6251	Pontic - resin with predominantly base metal	50%	70%
D6252	Pontic - resin with noble metal	50%	70%

Plan coverage details — Deluxe PPO Mandatory (continued)

Member Responsibility:		In Network	Out of Network
Bridge Retainers - one per tooth every five years			
D6545	Retainer - cast metal for resin bonded	50%	70%
D6548	Retainer - porcelain/ceramic resin bonded fixed prosthesis	50%	70%
D6720	Crown - resin with high noble metal	50%	70%
D6721	Crown - resin with predominantly base metal	50%	70%
D6722	Crown - resin with noble metal	50%	70%
D6740	Crown - porcelain/ceramic	50%	70%
D6750	Crown - porcelain fused to high noble metal	50%	70%
D6751	Crown - porcelain fused to predominantly base metal	50%	70%
D6752	Crown - porcelain fused to noble metal	50%	70%
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	50%	70%
D6780	Crown - 3/4 cast high noble metal	50%	70%
D6781	Crown - 3/4 cast predominantly based metal	50%	70%
D6782	Crown - 3/4 cast noble metal	50%	70%
D6783	Crown - 3/4 porcelain/ceramic	50%	70%
D6784	Retainer crown - 3/4 titanium and titanium alloys	50%	70%
D6790	Crown - full cast high noble metal	50%	70%
D6791	Crown - full cast predominantly base metal	50%	70%
D6792	Crown - full cast noble metal	50%	70%
D6980	Fixed partial denture repair	50%	70%
Fixed partial denture - as needed			
D6980	Fixed partial denture repair	50%	70%
Oral Surgery - once per tooth per lifetime			
D7230	Removal of impacted tooth - part bony	50%	70%
D7240	Removal of impacted tooth - full bony	50%	70%
D7241	Removal of impacted tooth - complication	50%	70%
Anesthesia - as needed/medical necessity			
D9219	Evaluation - deep sedation or general anesthesia	50%	70%
D9222	General anesthesia - first 15 minutes	50%	70%
D9223	General anesthesia - 15-minute increments	50%	70%
D9239	Intravenous sedation/analgesia - first 15 minutes	50%	70%
D9243	Intravenous sedation/analgesia - 15-minute increments	50%	70%
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	50%	70%

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Out-of-Network Benefits

The member may receive covered services from providers who are not in our network. The cost for services from an out-of-network provider are described in the table above. Every dental service has a "usual and customary charge," which is the amount we will use for calculating benefits. The member is responsible for any copayments and coinsurance. You may call Provider Services to find out the usual and customary charge for a particular dental service.

If the amount charged for a covered service is equal to or less than the usual and customary charge, we will pay that amount less any cost sharing that the member owes. However, if the amount charged is greater than the usual and customary charge for that service, the member is responsible to pay the difference. As an example, assume the coinsurance is 20%, the out-of-network provider charge is $150, and the usual and customary charge is $100. In this example, we would pay $80, and the member would pay the coinsurance of $20 (20%) plus the $50 in actual charges that exceed the usual and customary charge. The member is responsible for amounts charged by the provider that exceed benefits. Billing arrangements are between the member and the provider.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Deluxe PPO/RPPO Combo

This Aetna Dental Medicare plan offers preventive coverage and the option for the member to add comprehensive coverage at an additional cost.

For this plan:

- Preventive services are covered at 100% in network and 70% out of network
- Preventive services do not count towards the annual benefit maximum in or out of network
- Comprehensive coverage must be elected by the member
- Member coinsurance applies to most comprehensive services
- Annual benefit maximum only applies to comprehensive services
- Out-of-network rates are based on "usual and customary charges" at the time of service

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm if the member elected the optional dental coverage.

Plan coverage details — Deluxe PPO/RPPO Combo

Member Responsibility:		In Network	Out of Network
Preventive Services No Maximum			
Exams - two procedures per calendar year			
D0120	Periodic oral exam	$0	30%
D0150	Comprehensive oral exam	$0	30%
Exams - two procedures per calendar year			
D0140	Limited oral evaluation - problem focused	$0	30%
D0180	Comprehensive Periodontal Exam	$0	30%
Cleanings - two procedures per calendar year			
D1110	Adult prophylaxis	$0	30%
Bitewing X-ray - one procedure per calendar year			
D0270	Single radiographic image	$0	30%
D0272	Two radiographic images	$0	30%
D0273	Three radiographic images	$0	30%
D0274	Four radiographic images	$0	30%
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0	30%
Optional Comprehensive Services Maximum Varies by Chart Below			
Periapical X-ray - as needed			
D0220	Periapical - first image	$0	30%
D0230	Periapical - each additional image	$0	30%
D0374	Intraoral tomosynthesis - periapical radiographic image	$0	30%
Panoramic or Full Mouth Series - one procedure every three years			
D0210	Full mouth series	$0	30%
D0330	Panoramic image	$0	30%
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0	30%

Plan coverage details — Deluxe PPO/RPPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Restorative (Fillings) - Amalgam and Composite, once per tooth per calendar year			
D2140	Amalgam - one surface	20%	50%
D2150	Amalgam - two surfaces	20%	50%
D2160	Amalgam - three surfaces	20%	50%
D2161	Amalgam - four or more surfaces	20%	50%
D2330	Resin-based composite - one surface, anterior	20%	50%
D2331	Resin-based composite - two surfaces, anterior	20%	50%
D2332	Resin-based composite - three surfaces, anterior	20%	50%
D2335	Resin-based composite - four or more surfaces, anterior	20%	50%
D2390	Resin-based composite crown, anterior	20%	50%
D2391	Resin-based composite - one surface, posterior	20%	50%
D2392	Resin-based composite - two surfaces, posterior	20%	50%
D2393	Resin-based composite - three surfaces, posterior	20%	50%
D2394	Resin-based composite - four or more surfaces, posterior	20%	50%
Re-cementation - one per tooth per year			
D2910	Re-cement inlay, onlay, or veneer	20%	50%
D2915	Re-cement cast or prefabricated post and core	20%	50%
D2920	Re-cement crown	20%	50%
Root Canal - one per tooth per lifetime			
D3310	Anterior, excluding final restoration	20%	50%
D3320	Premolar, excluding final restoration	20%	50%
D3330	Molar, excluding final restoration	20%	50%
Retreatment of Root Canal - one per tooth per lifetime			
D3346	Retreatment of root canal, anterior	20%	50%
D3347	Retreatment of root canal, premolar	20%	50%
D3348	Retreatment of root canal, molar	20%	50%
Scaling and Root Planing - each quadrant every two years			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	50%
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	50%
Periodontal Maintenance - two per calendar year			
D4910	Periodontal maintenance - procedures	20%	50%
Extractions - one per tooth per lifetime			
D7140	Extraction - erupted tooth or exposed	20%	50%
D7210	Surgical removal of erupted tooth	20%	50%
D7220	Removal of impacted tooth - soft tissue	20%	50%
D7250	Surgical removal of residual tooth	20%	50%
Pain Treatment - as medically necessary			
D9110	Palliative treatment of dental pain, minor	20%	50%
Core Buildups/Posts and Cores - one per tooth every five years			
D2950	Core buildup, including any pins when required	50%	70%
D2952	Post and core in addition to crown, indirectly fabricated	50%	70%
D2953	Each additional indirectly fabricated post - same tooth	50%	70%
D2954	Prefabricated post and core in addition to crown	50%	70%
D2957	Each additional prefabricated post - same tooth	50%	70%

Plan coverage details — Deluxe PPO/RPPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Crown - one per tooth every five years			
D2720	Crown - resin with high noble metal	50%	70%
D2740	Crown - porcelain/ceramic substrate	50%	70%
D2750	Crown - porcelain fused to high noble metal	50%	70%
D2751	Crown - porcelain fused to predominantly base metal	50%	70%
D2752	Crown - porcelain fused to noble metal	50%	70%
D2753	Crown - porcelain fused to titanium and titanium alloy	50%	70%
D2780	Crown - 3/4 cast high noble metal	50%	70%
D2781	Crown - 3/4 cast predominantly base metal	50%	70%
D2782	Crown - 3/4 cast noble metal	50%	70%
D2783	Crown - 3/4 cast porcelain/ceramic	50%	70%
D2790	Crown - full cast high noble metal	50%	70%
D2791	Crown - full cast predominantly metal	50%	70%
D2792	Crown - full cast noble metal	50%	70%
Crown Repair - one per tooth per year			
D2980	Crown repair necessitated by restorative material failure	50%	70%
Debridement - one per lifetime			
D4355	Full mouth debridement	50%	70%
Complete Dentures - one per arch every five years			
D5110	Complete denture, maxillary	50%	70%
D5120	Complete denture, mandibular	50%	70%
D5130	Immediate Denture - Maxillary	50%	70%
D5140	Immediate Denture - Mandibular	50%	70%
Partial Dentures - one per arch every five years			
D5211	Maxillary partial denture - resin base	50%	70%
D5212	Mandibular partial denture - resin base	50%	70%
D5213	Maxillary partial denture - cast base	50%	70%
D5214	Mandibular partial denture - cast base	50%	70%
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	70%
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	50%	70%
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	50%	70%
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	50%	70%
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	50%	70%
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	50%	70%

Plan coverage details — Deluxe PPO/RPPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Denture Adjustment, Repair and Rebase - as needed			
D5410	Adjustments complete denture, maxillary	50%	70%
D5411	Adjustments complete denture, mandibular	50%	70%
D5421	Adjustments partial denture, maxillary	50%	70%
D5422	Adjustments partial denture, mandibular	50%	70%
D5511	Repair broken complete denture base, mandibular	50%	70%
D5512	Repair broken complete denture base, maxillary	50%	70%
D5520	Replace missing or broken teeth, complete denture (each tooth)	50%	70%
D5611	Repair resin denture base, mandibular	50%	70%
D5612	Repair resin denture base, maxillary	50%	70%
D5621	Repair cast framework, mandibular	50%	70%
D5622	Repair cast framework, maxillary	50%	70%
D5630	Repair or replace broken clasp	50%	70%
D5640	Replace broken teeth, per tooth	50%	70%
D5650	Add tooth to existing partial denture	50%	70%
D5660	Add clasp to existing partial denture	50%	70%
D5670	Replace all teeth, upper partial	50%	70%
D5671	Replace all teeth, lower partial	50%	70%
D5710	Rebase complete maxillary denture	50%	70%
D5711	Rebase complete mandibular denture	50%	70%
D5720	Rebase partial maxillary denture	50%	70%
D5721	Rebase partial mandibular denture	50%	70%
D5730	Reline complete maxillary denture (direct)	50%	70%
D5731	Reline complete mandibular denture (direct)	50%	70%
D5740	Reline complete maxillary partial denture (direct)	50%	70%
D5741	Reline complete mandibular partial denture (direct)	50%	70%
D5750	Reline complete maxillary denture (indirect)	50%	70%
D5751	Reline complete mandibular denture (indirect)	50%	70%
D5760	Reline maxillary partial denture (indirect)	50%	70%
D5761	Reline mandibular partial denture (indirect)	50%	70%
D5876	Add metal substructure to acrylic full denture (per arch)	50%	70%
Pontic - one per tooth every five years			
D6210	Pontic - cast high noble metal	50%	70%
D6211	Pontic - cast predominantly base metal	50%	70%
D6212	Pontic - cast noble metal	50%	70%
D6240	Pontic - porcelain fused to high noble	50%	70%
D6241	Pontic - porcelain fused to base metal	50%	70%
D6242	Pontic - porcelain fused to noble metal	50%	70%
D6243	Pontic - porcelain fused to titanium and titanium alloys	50%	70%
D6245	Pontic - porcelain/ceramic	50%	70%
D6250	Pontic - resin with high noble metal	50%	70%
D6251	Pontic - resin with predominantly base metal	50%	70%
D6252	Pontic - resin with noble metal	50%	70%

Plan coverage details — Deluxe PPO/RPPO Combo (continued)

Member Responsibility:		In Network	Out of Network
Bridge Retainers - one per tooth every five years			
D6545	Retainer - cast metal for resin bonded	50%	70%
D6548	Retainer - porcelain/ceramic resin bonded fixed prosthesis	50%	70%
D6720	Crown - resin with high noble metal	50%	70%
D6721	Crown - resin with predominantly base metal	50%	70%
D6722	Crown - resin with noble metal	50%	70%
D6740	Crown - porcelain/ceramic	50%	70%
D6750	Crown - porcelain fused to high noble metal	50%	70%
D6751	Crown - porcelain fused to predominantly base metal	50%	70%
D6752	Crown - porcelain fused to noble metal	50%	70%
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	50%	70%
D6780	Crown - 3/4 cast high noble metal	50%	70%
D6781	Crown - 3/4 cast predominantly based metal	50%	70%
D6782	Crown - 3/4 cast noble metal	50%	70%
D6783	Crown - 3/4 porcelain/ceramic	50%	70%
D6784	Retainer crown - 3/4 titanium and titanium alloys	50%	70%
D6790	Crown - full cast high noble metal	50%	70%
D6791	Crown - full cast predominantly base metal	50%	70%
D6792	Crown - full cast noble metal	50%	70%
D6980	Fixed partial denture repair	50%	70%
Oral Surgery - once per tooth per lifetime			
D7230	Removal of impacted tooth - part bony	50%	70%
D7240	Removal of impacted tooth - full bony	50%	70%
D7241	Removal of impacted tooth - complication	50%	70%
Anesthesia - as needed/medical necessity			
D9219	Evaluation - deep sedation or general anesthesia	50%	70%
D9222	General anesthesia - first 15 minutes	50%	70%
D9223	General anesthesia - 15-minute increments	50%	70%
D9239	Intravenous sedation/analgesia - first 15 minutes	50%	70%
D9243	Intravenous sedation/analgesia - 15-minute increments	50%	70%
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	50%	70%

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Out-of-Network Benefits

The member may receive covered services from providers who are not in our network. The cost for services from an out of network provider are described in the table above. Every dental service has a "usual and customary charge," which is the amount we will use for calculating benefits. The member is responsible for any copayments and coinsurance. You may call Provider Services to find out the usual and customary charge for a particular dental service.

If the amount charged for a covered service is equal to or less than the usual and customary charge, we will pay that amount less any cost sharing that the member owes. However, if the amount charged is greater than the usual and customary charge for that service, the member is responsible to pay the difference. As an example, assume the coinsurance is 20%, the out-of-network provider charge is $150, and the usual and customary charge is $100. In this example, we would pay $80, and the member would pay the coinsurance of $20 (20%) plus the $50 in actual charges that exceed the usual and customary charge. The member is responsible for amounts charged by the provider that exceed benefits. Billing arrangements are between the member and the provider.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Direct Member Reimbursement Mandatory

This Aetna Dental® Medicare plan offers coverage for both preventive and comprehensive dental services that are recognized by the American Dental Association (ADA); excluding only cosmetic services, those considered medical in nature, and administrative changes. This plan is not network based.

For this plan:

- Preventive and Comprehensive services are covered at 100%
- All covered services count towards the annual benefit maximum
- Services include Exams, Cleanings, X-rays, Fillings, Extractions, Anesthesia, Periodontal Services, Root Canals, Crowns, Dentures, Bridges, Implants and more
- No frequency limitations
- Not network based

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm the member's eligibility and maximum remaining.

Member Responsibility	
Preventive and comprehensive services	$0
Annual maximum benefit	Varies per chart below

Non-Covered Services

The plan does not cover the following:

- CDT codes listed in the table below
- Services or items listed in the Limitations & Exclusions section
- Services performed outside the United States of America
- Dental services received from a non-network dentist
- Medical in Nature Oral Surgery. Please see **AetnaDental.com** for more details.

CDT Code	Non-Covered Services Definition
D9961	Duplicate/copy of patient records
D9972	Bleaching external - per arch
D9973	Bleaching external - per tooth
D9974	Bleaching internal - per tooth
D9975	Bleaching external for home application, per arch
D9985	Sales tax
D9986	Missed appointments
D9987	Canceled appointments
D9991	Dental case management - Addressing appointment compliance barriers

These codes are not covered and unspecified by the American Dental Association.			
D0000	D3000	D5999	D8000
D0999	D3999	D6199	D8999
D1000	D4000	D6999	D9000
D1999	D4999	D7000	D9999
D2000	D5000	D7899	
D2999	D5899	D7999	

Limitations & Exclusions:

1. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
2. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
3. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
4. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
CA	H0523	022	Direct Member Reimbursement	$750	Yes – Not a network-based benefit
CA	H0523	052	Direct Member Reimbursement	$600	Yes – Not a network-based benefit
CA	H0523	065	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
CA	H0523	067	Direct Member Reimbursement	$1,200	Yes – Not a network-based benefit
CA	H0523	068	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
CA	H0523	069	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
CA	H0523	070	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
CA	H0523	071	Direct Member Reimbursement	$1,150	Yes – Not a network-based benefit
CA	H0523	072	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
CA	H0523	073	Direct Member Reimbursement	$3,000	Yes – Not a network-based benefit
CA	H0523	075	Direct Member Reimbursement	$2,750	Yes – Not a network-based benefit
IL	H1608	013	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
IL	H1608	050	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H1608	051	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H1608	067	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H2663	002	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H2663	005	Direct Member Reimbursement	$3,250	Yes – Not a network-based benefit
IL	H2663	006	Direct Member Reimbursement	$1,400	Yes – Not a network-based benefit
IL	H2663	017	Direct Member Reimbursement	$2,700	Yes – Not a network-based benefit
MO	H2663	041	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
MO	H2663	057	Direct Member Reimbursement	$2,250	Yes – Not a network-based benefit
MO	H2663	059	Direct Member Reimbursement	$3,000	Yes – Not a network-based benefit
NJ	H3152	045	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
NY	H3312	048	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
ME	H3597	001	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
ME	H3597	007	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
ME	H3597	009	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
ME	H3597	014	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
CA	H4982	001	Direct Member Reimbursement	$2,250	Yes – Not a network-based benefit
CA	H4982	002	Direct Member Reimbursement	$2,750	Yes – Not a network-based benefit
CA	H4982	003	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
CA	H4982	004	Direct Member Reimbursement	$1,750	Yes – Not a network-based benefit
CA	H4982	005	Direct Member Reimbursement	$1,200	Yes – Not a network-based benefit
CA	H4982	006	Direct Member Reimbursement	$700	Yes – Not a network-based benefit
CA	H4982	007	Direct Member Reimbursement	$1,100	Yes – Not a network-based benefit
CA	H4982	010	Direct Member Reimbursement	$1,300	Yes – Not a network-based benefit
CA	H4982	011	Direct Member Reimbursement	$850	Yes – Not a network-based benefit
CA	H4982	012	Direct Member Reimbursement	$825	Yes – Not a network-based benefit
CA	H4982	013	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
FL	H5521	033	Direct Member Reimbursement	$750	Yes – Not a network-based benefit
NY	H5521	077	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
NY	H5521	110	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
NY	H5521	118	Direct Member Reimbursement	$1,250	Yes – Not a network-based benefit
ME	H5521	144	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
FL	H5521	268	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
FL	H5521	269	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit
FL	H5521	270	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit
FL	H5521	271	Direct Member Reimbursement	$1,650	Yes – Not a network-based benefit
FL	H5521	272	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	273	Direct Member Reimbursement	$1,450	Yes – Not a network-based benefit
NJ	H5521	275	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
FL	H5521	305	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
FL	H5521	306	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	308	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
MI	H5521	311	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
FL	H5521	347	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
ME	H5521	349	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
NH	H5521	374	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
NH	H5521	376	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
FL	H5521	377	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
FL	H5521	432	Direct Member Reimbursement	$1,550	Yes – Not a network-based benefit
FL	H5521	433	Direct Member Reimbursement	$1,600	Yes – Not a network-based benefit
FL	H5521	434	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
FL	H5521	435	Direct Member Reimbursement	$1,700	Yes – Not a network-based benefit
FL	H5521	436	Direct Member Reimbursement	$1,900	Yes – Not a network-based benefit

State	Contract	PBP	Dental Plan Name	Maximum	Out of Network Coverage Included?
FL	H5521	437	Direct Member Reimbursement	$2,100	Yes – Not a network-based benefit
FL	H5521	438	Direct Member Reimbursement	$2,100	Yes – Not a network-based benefit
FL	H5521	439	Direct Member Reimbursement	$1,750	Yes – Not a network-based benefit
FL	H5521	440	Direct Member Reimbursement	$2,000	Yes – Not a network-based benefit
NH	H5793	015	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
IL	H7301	007	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
IL	H7301	009	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
IL	H7301	017	Direct Member Reimbursement	$1,850	Yes – Not a network-based benefit
NH	H5521	349	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
MO	H1608	013	Direct Member Reimbursement	$500	Yes – Not a network-based benefit
MO	H1608	050	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
MO	H1608	051	Direct Member Reimbursement	$1,000	Yes – Not a network-based benefit
MO	H1608	067	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
MO	H2663	002	Direct Member Reimbursement	$1,500	Yes – Not a network-based benefit
MO	H2663	005	Direct Member Reimbursement	$3,250	Yes – Not a network-based benefit
MO	H2663	006	Direct Member Reimbursement	$1,400	Yes – Not a network-based benefit

Aetna Medicare

Preventive Only 0% OON EPO/POS Mandatory

This Aetna Dental® Medicare plan offers both in- and out-of-network preventive only coverage.

For this plan:

- Preventive services are covered at 100% in network and out of network
- No annual maximum
- Out-of-network rates are based usual and customary charges at the time of service

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and services remaining.

Member Responsibility:	In Network	Out of Network
Exams - two procedures per calendar year		
D0120 – Periodic oral exam	$0	0%
D0150 – Comprehensive oral exam	$0	0%
Exams - two procedures per calendar year		
D0140 – Limited oral evaluation – Problem focused	$0	0%
D0180 – Comprehensive periodontal exam	$0	0%
Cleanings - two procedures per calendar year		
D1110 – Adult prophylaxis	$0	0%
Bitewing X-ray - one procedure per calendar year		
D0270 – Single radiographic image	$0	0%
D0272 – Two radiographic images	$0	0%
D0273 – Three radiographic images	$0	0%
D0274 – Four radiographic images	$0	0%
D0373 – Intraoral tomosynthesis – Bitewing radiographic image	$0	0%

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Out-of-Network Benefits

The member may receive covered services from providers who are not in our network. The cost for services from an out of network provider are described in the table above. Every dental service has a "usual and customary charge," which is the amount we will use for calculating benefits. The member is responsible for any copayments and coinsurance. You may call Provider Services to find out the usual and customary charge for a particular dental service.

If the amount charged for a covered service is equal to or less than the usual and customary charge, we will pay that amount less any cost sharing that the member owes. However, if the amount charged is greater than the usual and customary charge for that service, the member is responsible to pay the difference. As an example, assume the coinsurance is 20%, the out-of-network provider charge is $150, and the usual and customary charge is $100. In this example, we would pay $80, and the member would pay the coinsurance of $20 (20%) plus the $50 in actual charges that exceed the usual and customary charge. The member is responsible for amounts charged by the provider that exceed benefits. Billing arrangements are between the member and the provider.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Preventive Only EPO Mandatory

This Aetna Dental® Medicare plan offers in-network preventive only coverage.

For this plan:

- Preventive services are covered at 100% in network
- No annual maximum
- No out-of-network coverage

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and services remaining.

Member Responsibility:	In Network	Out of Network
Exams - two procedures per calendar year		
D0120 – Periodic oral exam	$0	No Coverage
D0150 – Comprehensive oral exam	$0	
Exams - two procedures per calendar year		
D0140 – Limited oral evaluation – Problem focused	$0	No Coverage
D0180 – Comprehensive periodontal exam	$0	
Cleanings - two procedures per calendar year		
D1110 – Adult prophylaxis	$0	No Coverage
Bitewing X-ray - one procedure per calendar year		
D0270 – Single radiographic image	$0	No Coverage
D0272 – Two radiographic images	$0	
D0273 – Three radiographic images	$0	
D0274 – Four radiographic images	$0	
D0373 – Intraoral tomosynthesis – Bitewing radiographic image	$0	

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Dental services received from a non-network dentist
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Preventive Only PPO Mandatory

This Aetna Dental® Medicare plan offers both in- and out-of-network preventive only coverage.

For this plan:

- Preventive services are covered at 100% in network
- Preventive services are covered at 70% out of network
- No annual maximum
- Out of network rates are based on "usual and customary charges" at the time of service

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm member eligibility and services remaining.

Member Responsibility:	In Network	Out of Network
Exams – Two procedures per calendar year		
D0120 – Periodic oral exam	$0	30%
D0150 – Comprehensive oral exam	$0	30%
Exams – Two procedures per calendar year		
D0140 – Limited oral evaluation – Problem focused	$0	30%
D0180 – Comprehensive periodontal exam	$0	30%
Cleanings – Two procedures per calendar year		
D1110 – Adult prophylaxis	$0	30%
Bitewing X-ray – One procedure per calendar year		
D0270 – Single radiographic image	$0	30%
D0272 – Two radiographic images	$0	30%
D0273 – Three radiographic images	$0	30%
D0274 – Four radiographic images	$0	30%
D0373 – Intraoral tomosynthesis – Bitewing radiographic image	$0	30%

Non-Covered Services

The plan does not cover the following:

- Dental services not listed in the table above
- Services or items listed in the Limitations & Exclusions section or dental services that exceed frequency limitations
- Services performed outside the United States of America

The member is responsible for all charges related to any excluded services and must pay the costs of any services received greater than the limits specified.

Out-of-Network Benefits

The member may receive covered services from providers who are not in our network. The cost for services from an out of network provider are described in the table above. Every dental service has a "usual and customary charge," which is the amount we will use for calculating benefits. The member is responsible for any copayments and coinsurance. You may call Provider Services to find out the usual and customary charge for a particular dental service.

If the amount charged for a covered service is equal to or less than the usual and customary charge, we will pay that amount less any cost sharing that the member owes. However, if the amount charged is greater than the usual and customary charge for that service, the member is responsible to pay the difference. As an example, assume the coinsurance is 20%, the out-of-network provider charge is $150, and the usual and customary charge is $100. In this example, we would pay $80, and the member would pay the coinsurance of $20 (20%) plus the $50 in actual charges that exceed the usual and customary charge. The member is responsible for amounts charged by the provider that exceed benefits. Billing arrangements are between the member and the provider.

Limitations & Exclusions

1. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered.
2. Any services related to implants including implant removal, repair, restoration or placement are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Total PPO 20% Coins OON Hybrid/ Total EPO POS 20% Coins OON Hybrid

This Aetna Dental® Medicare plan offers both in- and out-of-network coverage for both preventive and comprehensive dental services that are recognized by the American Dental Association (ADA); excluding only cosmetic services, those considered medical in nature, and administrative changes.

For this plan:

- Preventive and Comprehensive services are covered at 100% in network
- Preventive and Comprehensive services are covered at 80% out of network
- All covered services count towards the annual benefit maximum
- Services include Exams, Cleanings, X-rays, Fillings, Extractions, Anesthesia, Periodontal Services, Root Canals, Crowns, Dentures, Bridges, Implants and more
- No frequency limitations

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm the member's eligibility and maximum remaining.

Member Responsibility	In Network	Out of Network
Preventive and comprehensive services	$0	20%
Annual maximum benefit	Varies per chart below	

Non-Covered Services

The plan does not cover the following:

- CDT codes listed in the table below
- Services or items listed in the Limitations & Exclusions section
- Services performed outside the United States of America
- Medical in Nature Oral Surgery. Please see **AetnaDental.com** for more details.

CDT Code	Non-Covered Services
D9961	Duplicate/copy of patient records
D9972	Bleaching external - per arch
D9973	Bleaching external - per tooth
D9974	Bleaching internal - per tooth
D9975	Bleaching external for home application, per arch
D9985	Sales tax
D9986	Missed appointments
D9987	Canceled appointments
D9991	Dental case management - Addressing appointment compliance barriers

These codes are not covered and unspecified by the American Dental Association.			
D0000	D3000	D5999	D8000
D0999	D3999	D6199	D8999
D1000	D4000	D6999	D9000
D1999	D4999	D7000	D9999
D2000	D5000	D7899	
D2999	D5899	D7999	

Limitations & Exclusions:

1. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
2. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
3. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
4. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Total Choice 50% OON PPO Hybrid/ Total EPO POS 50% Coins OON Hybrid/ Total RPPO 50% Coins OON Hybrid

This Aetna Dental® Medicare plan offers both in- and out-of-network coverage for both preventive and comprehensive dental services that are recognized by the American Dental Association (ADA); excluding only cosmetic services, those considered medical in nature, and administrative changes.

For this plan:

- Preventive and Comprehensive services are covered at 100% in network
- Preventive and Comprehensive services are covered at 50% out of network
- All covered services count towards the annual benefit maximum
- Services include Exams, Cleanings, X-rays, Fillings, Extractions, Anesthesia, Periodontal Services, Root Canals, Crowns, Dentures, Bridges, Implants and more
- No frequency limitations

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm the member's eligibility and maximum remaining.

Member Responsibility	In Network	Out of Network
Preventive and comprehensive services	$0	50%
Annual maximum benefit	Varies per chart below	

Non-Covered Services

The plan does not cover the following:

- CDT codes listed in the table below
- Services or items listed in the Limitations & Exclusions section
- Services performed outside the United States of America
- Medical in Nature Oral Surgery. Please see **AetnaDental.com** for more details.

CDT Code	Non-Covered Services
D9961	Duplicate/copy of patient records
D9972	Bleaching external - per arch
D9973	Bleaching external - per tooth
D9974	Bleaching internal - per tooth
D9975	Bleaching external for home application, per arch
D9985	Sales tax
D9986	Missed appointments
D9987	Canceled appointments
D9991	Dental case management - Addressing appointment compliance barriers

These codes are not covered and unspecified by the American Dental Association.			
D0000	D3000	D5999	D8000
D0999	D3999	D6199	D8999
D1000	D4000	D6999	D9000
D1999	D4999	D7000	D9999
D2000	D5000	D7899	
D2999	D5899	D7999	

Limitations & Exclusions:

1. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
2. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
3. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
4. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

Aetna Medicare

Total Choice Passive /Total Choice EPO POS

This Aetna Dental® Medicare plan offers both in- and out-of-network coverage for both preventive and comprehensive dental services that are recognized by the American Dental Association (ADA); excluding only cosmetic services, those considered medical in nature, and administrative changes.

For this plan:

- Preventive and Comprehensive services are covered at 100% in network and out of network
- All covered services count towards the annual benefit maximum
- Services include Exams, Cleanings, X-rays, Fillings, Extractions, Anesthesia, Periodontal Services, Root Canals, Crowns, Dentures, Bridges, Implants and more
- No frequency limitations

Note: Please call the National Dental Provider services team at **1-800-624-0756** to confirm the member's eligibility and maximum remaining.

Member Responsibility	In Network	Out of Network
Preventive and comprehensive services	$0	$0
Annual maximum benefit	Varies per chart below	

Non-Covered Services

The plan does not cover the following:

- CDT codes listed in the table below
- Services or items listed in the Limitations & Exclusions section
- Services performed outside the United States of America
- Medical in Nature Oral Surgery. Please see **AetnaDental.com** for more details.

CDT Code	Non-Covered Services
D9961	Duplicate/copy of patient records
D9972	Bleaching external - per arch
D9973	Bleaching external - per tooth
D9974	Bleaching internal - per tooth
D9975	Bleaching external for home application, per arch
D9985	Sales tax
D9986	Missed appointments
D9987	Canceled appointments
D9991	Dental case management - Addressing appointment compliance barriers

These codes are not covered and unspecified by the American Dental Association.			
D0000	D3000	D5999	D8000
D0999	D3999	D6199	D8999
D1000	D4000	D6999	D9000
D1999	D4999	D7000	D9999
D2000	D5000	D7899	
D2999	D5899	D7999	

Limitations & Exclusions:

1. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
2. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the member by any municipality, county or other political subdivision is not covered.
3. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
4. Any treatment covered under an individual or group medical plan, auto insurance, no-fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

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