



Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Aetna Dental of CA Inc.

Type of Product Line: DMO

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

Name of Product: Aetna Dental® DMO®

Plan Phone #: 1-877-238-6200

Plan Website: [Aetna.com](https://www.aetna.com)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT [Aetna.com](https://www.aetna.com) OR CALL 1-877-238-6200.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not covered
Orthodontia	None	Not covered

- There is no deductible.
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not covered
Lifetime or Annual Maximum for Orthodontia	None	Not covered

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Does not apply.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only.

For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Oral Exam</i>	Preventive & Diagnostic	No charge	Not covered	For more information about dental limitations & exceptions, see your policy documents.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	No charge	Not covered	
<i>Cleaning</i>	Preventive & Diagnostic	No charge	Not covered	
<i>Filling</i>	Basic	No charge for anterior resin composite	Not covered	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	No charge	Not covered	
<i>Root Canal</i>	Major	40% for molar	Not covered	
<i>Scaling and Root Planing</i>	Basic	No charge	Not covered	Four separate quadrants per 12 months.
<i>Ceramic Crown</i>	Major	40%	Not covered	Replacement of existing crown limited to once every 5 years.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Removable Partial Denture</i>	Major	40%	Not covered	Replacement of existing denture limited to once every 5 years.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	No charge	Not covered	
<i>Orthodontia</i>	Orthodontia	50%	Not covered	

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (full-mouth x-ray) and cleaning	Resin-based composite - one surface, posterior	Crown - porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: \$400 Out-of-network: \$550	Total Cost of Care	In-network: \$150 Out-of-network: \$200	Total Cost of Care	In-network: \$1,300 Out-of-network: \$1,750
Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: \$0 Out-of-network: 100%	Patient Cost (copayment or coinsurance)	In-network: \$0 Out-of-network: 100%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 100%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$0 Out-of-network: \$550	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$0 Out-of-network: \$200	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$520 Out-of-network: \$1,750
Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered. For more information about dental limitations & exceptions, see your policy documents.	Summary of what is not covered or subject to a limitation:	Out-of-Network: Not covered. Replacement once every 5 years. For more information about dental limitations & exceptions, see your policy documents.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705
CRCoordinator@aetna.com

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

DMO plans are insured by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products.

TTY: 711

English -	To access language services at no cost to you, call 1-877-238-6200.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-238-6200 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-238-6200.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-238-6200 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-238-6200.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-238-6200.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-877-238-6200.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-238-6200.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-238-6200.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-877-238-6200.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-238-6200 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-238-6200.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની વહીવટ માટે, કોલ કરો 1-877-238-6200.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-877-238-6200 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-238-6200.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-238-6200.
Japanese -	言語サービスを無料でご利用いただくには、1-877-238-6200 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-238-6200 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-238-6200 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-877-238-6200.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-238-6200 ។

Navajo -	T'áá ni nizaad k'éhjí bee níká a'doowoł doo báqáh ílínígóó koji' hólne' 1-877-238-6200.
Pennsylvania Dutch -	Um Schprooch Services zu grieghe mitaus Koscht, ruff 1-877-238-6200.
Persian-Farsi -	. برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-238-6200 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-238-6200.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-238-6200.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-238-6200 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-238-6200.
Samoan -	Mo le mauaina o auauina tau gagana e aunoa ma se totogi, vala’au le 1-877-238-6200.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-877-238-6200.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-877-238-6200.
Syriac-Assyrian -	:ܡܝܢܐ ܕܥܠܡܐ ܕܟܪܬܐ ܕܚܘܒܐ ܕܗܘܐ ܕܩܪܝܢܐ ܕܨܝܕܐ ܕܓܠܝܠܝܬܐ ܕܦܛܪܝܩܐ ܕܣܝܪܝܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ 1-877-238-6200.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-238-6200.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-238-6200.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-238-6200.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-238-6200.