



**Preferred Provider Organization (PPO)  
Dental Expense Insurance Plan**

**Schedule of benefits**

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group this may not apply. Please contact the policyholder for additional information.

**Prepared exclusively for:**

<b>Policyholder:</b>	California Institute of Technology
<b>Policyholder number:</b>	869105
	Schedule of Benefits 1A
<b>Group policy effective date:</b>	January 1, 2020
<b>Insurance plan effective date:</b>	January 1, 2020
<b>Insurance plan issue date:</b>	December 10, 2019

**Underwritten by Aetna Life Insurance Company in the state of California.**

## Schedule of benefits

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This schedule of benefits lists the **eligible dental services, deductibles, coinsurance**, maximums, and other limits that apply to the services you get under this plan.

### How to read your schedule of benefits

- When we say:
  - “In-network coverage” we mean that you get care from **in-network providers**.
  - “Out-of-network coverage” we mean that you can get care from **out-of-network providers**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year** or **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.

#### Important note:

All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

### How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at [www.aetna.com](http://www.aetna.com).
- Call Member Services at 1-877-238-6200.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

## General coverage provisions

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This section explains the:

- **Deductibles**
- **Coinsurance**
- **Maximums**

### Calendar Year deductible

**Eligible dental services** applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible dental services** applied to the **in-network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

#### Individual deductible

This is the amount you pay for in-network and out-of-network **eligible dental services** each **Calendar Year** before the plan begins to pay. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. Once you have reached the **Calendar Year deductible**, this plan will begin to pay for **eligible dental services** for the rest of the **Calendar Year**.

#### Family deductible

When you and each of your covered dependents incur **eligible dental services** that apply towards the individual **Calendar Year deductibles**, these expenses will also count toward a family **deductible**.

To satisfy this family **deductible** for the rest of the **Calendar Year**, the following must happen:

- The combined **eligible dental services** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** in a **Calendar Year**.

When this happens in a **Calendar Year**, the individual **Calendar Year deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

### Coinsurance

Once any applicable **deductibles** have been met, the specific **coinsurance** percentage the plan pays for **eligible dental services** is listed below.

### Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum** benefit.

The **Calendar Year maximum** benefit applies to in-network and out-of-network **eligible dental services** combined.

### Orthodontic lifetime maximum

The most the plan will pay for orthodontic expenses incurred by any one covered person during their lifetime is called the orthodontic **lifetime maximum**.

The orthodontic **lifetime maximum** applies to covered in-network and out-of-network **eligible orthodontic treatment** combined.

<b>Your financial responsibility and determination of benefits provisions</b>
Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one <b>Calendar Year</b> . Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

## Plan features

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### Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

	In-network coverage	Out-of-network coverage
<b>Calendar Year deductible</b>	Individual \$50 Family \$150	Individual \$50 Family \$150

### Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

	In-network coverage	Out-of-network coverage
<b>Type A expenses</b>	80% of the <b>negotiated charge</b>	80% of the <b>recognized charge</b>
<b>Type B expenses</b>	60% of the <b>negotiated charge</b>	60% of the <b>recognized charge</b>
<b>Type C expenses</b>	50% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>

### Orthodontic treatment coinsurance

	In-network coverage	Out-of-network coverage
<b>Orthodontic treatment coinsurance</b>	50% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>

### Calendar Year maximum

	In-network coverage	Out-of-network coverage
<b>Calendar Year maximum</b>	\$1,000	\$1,000

### Orthodontic lifetime maximum

	In-network coverage	Out-of-network coverage
<b>Orthodontic lifetime maximum</b>	\$1,000	\$1,000

## Eligible dental services

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### Type A expenses: Diagnostic & preventive care

#### Visits and exams

- Office visit during regular office hours for oral examination, (2 visits per year or 2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 application per year)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)

**Space maintainers** - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

#### Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

### Type B expenses: Basic restorative care

#### Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit

#### Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

**Restorative** - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (excluding temporary crowns)
- Recementation

## Oral surgery

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth - Soft tissue
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula

## Periodontics

- Periodontal maintenance (following active therapy, 2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)

## Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy

- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation

## **Type C expenses: Major restorative care**

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic **injury**, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 years. (See the Replacement rule.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown
- Core Build Up

## **Endodontics**

- Root canal therapy and retreatment
  - Molar

## **Periodontics**

- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Clinical Crown Lengthening – Hard Tissue
- Full Mouth Debridement, once per lifetime

**Prosthodontics** - The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible).
  - Complete upper and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)



- Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Adjustment to denture more than 6 months after installation
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

### **Oral surgery**

- Removal of impacted tooth
  - Partially bony
  - Completely bony
- Coronectomy

### **General anesthesia and intravenous sedation**

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

### **Type: Orthodontics care expenses**

- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**
- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Appliance therapy to control harmful habits
- Orthodontic retention
- Repair of orthodontic appliance

## Additional eligible dental services

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We will provide additional **eligible dental services** if you and your covered dependent have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

### **Additional eligible dental services:**

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant (one additional per **Calendar Year**)
- Scaling and root planing (limited to 1-3 teeth), per quadrant (one additional per **Calendar Year**)
- Full mouth debridement (one additional per **Calendar Year**)
- Periodontal maintenance (one additional per **Calendar Year**)

### **Payment of benefits**

We will waive the **Calendar Year deductible** for the additional **eligible dental services** above. The **coinsurance** applied to the additional **eligible dental services** will be 100% for in-network coverage and 100% for out-of-network coverage. These additional benefits will not be subject to any frequency limits except as shown above, or to any Calendar Year maximum.