Nevada 2-50 Standard and Voluntary Dental Plans

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan, program benefits, and limitations and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Plan Name	NV 1.1A DMO Copay 76	NV 1.2A PPO 1000 80th	NV 1.3A PPO 1000 80th	NV 2A Active PPO 80th		NV 4A Low PPO 1500 90th	NV 5A High PPO 1500 90th
	DMO 76	PPO 100/50/50	PPO 100/80/50	Preferred 100/80/50	Non-preferred 80/60/50	PPO 100/50/50	PPO 100/90/60
Office Visit Copay	$5	N/A	N/A	N/A	N/A	N/A	N/A
Annual Deductible per Member - does not apply to Diagnostic & Preventive Services	None	$50; 3X Family	$50; 3X Family	$50; 3X Family		$50; 3X Family	$50; 3X Family
Annual Maximum Benefit	None	$1,000	$1,000	$1,500	$1,000	$1,500	$1,500
Diagnostic Services							
Oral Exams							
Periodic oral exam	No charge	100%	100%	100%	80%	100%	100%
Comprehensive oral exam	No charge	100%	100%	100%	80%	100%	100%
Problem-focused oral exam	No charge	100%	100%	100%	80%	100%	100%
X-rays							
Bitewing - single film	No charge	100%	100%	100%	80%	100%	100%
Complete series	No charge	100%	100%	100%	80%	100%	100%
Preventive Services							
Cleaning	No charge	100%	100%	100%	80%	100%	100%
Fluoride application - child only	No charge	100%	100%	100%	80%	100%	100%
Sealants - per tooth	No charge	100%	100%	100%	80%	100%	100%
Space maintainers	No charge	100%	100%	100%	80%	100%	100%
Basic Services							
Amalgam filling - 2 surfaces	No charge	50%	80%	80%	60%	50%	90%
Resin filling - 2 surfaces, anterior	No charge	50%	80%	80%	60%	50%	90%
Endodontic Services							
Bicuspid root canal therapy	No charge	50%	80%	80%	60%	50%	90%
Periodontic Services							
Scaling & root planing - per quadrant	$37	50%	80%	80%	60%	50%	90%
Oral Surgery							
Extraction - exposed root or erupted tooth	No charge	50%	80%	80%	60%	50%	90%
Extraction of impacted tooth - soft tissue	No charge	50%	80%	80%	60%	50%	90%
***Major Services *Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major and Ortho Service.**							
Complete upper denture	$231	50%	50%	50%	50%	50%	60%
Partial upper denture (resin base)	$231	50%	50%	50%	50%	50%	60%
Crown - Porcelain with noble metal	$207	50%	50%	50%	50%	50%	60%
Pontic - Porcelain with noble metal	$207	50%	50%	50%	50%	50%	60%
Oral Surgery							
Removal of impacted tooth - partially bony	$55	50%	50%	80%	60%	50%	90%
Endodontic Services							
Molar root canal therapy	$161	50%	50%	80%	60%	50%	90%
Periodontic Services							
Osseous surgery - per quadrant	$147	50%	50%	80%	60%	50%	90%
***Orthodontic Services**	**$2,300 copay**	**50%**	**50%**	**50%**		**50%**	**50%**
Orthodontic Lifetime Maximum	Does not apply	$1,000	$1,000	$1,000		$1,000	$1,000

***Does not apply to Standard plans with 10+ eligibles.**
Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna)

3231340-01-01 (03/24)

Nevada 2-50 Standard and Voluntary Dental Plans

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan, program benefits, and limitations and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Plan Name	NV 6.1A PPO 2000 80th	NV 6A PPO 2000 Low 90th	NV 7A PPO 2000 High 90th	NV 8A PPO 2500 80th	NV 9A PPO 3000 90th
	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A	N/A
Annual Deductible per Member - does not apply to Diagnostic & Preventive Services	$50; 3X Family	$50; 3X Family	$50; 3X Family	$50; 3X Family	$50; 3X Family
Annual Maximum Benefit	$2,000	$2,000	$2,000	$2,500	$3,000
Diagnostic Services					
Oral Exams					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
X-rays					
Bitewing - single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
Preventive Services					
Cleaning	100%	100%	100%	100%	100%
Fluoride application - child only	100%	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
Basic Services					
Amalgam filling - 2 surfaces	80%	80%	80%	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%	80%	80%	80%
Endodontic Services					
Bicuspid root canal therapy	50%	80%	80%	50%	80%
Periodontic Services					
Scaling & root planing - per quadrant	50%	80%	80%	50%	80%
Oral Surgery					
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	80%
***Major Services *Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major and Ortho Service.**					
Complete upper denture	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	50%
Oral Surgery					
Removal of impacted tooth - partially bony	50%	50%	80%	50%	50%
Endodontic Services					
Molar root canal therapy	50%	50%	80%	50%	50%
Periodontic Services					
Osseous surgery - per quadrant	50%	50%	80%	50%	50%
***Orthodontic Services**	**50%**	**50%**	**50%**	**50%**	**50%**
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,000	$2,000

***Does not apply to Standard plans with 10+ eligibles.**

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

3231340-01-01 (03/24)

Limitations & Exclusions

Additional items not covered by a health plan

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Any dental examinations:
-required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
-required by any law of a government, securing insurance or school admissions, or professional or other licenses;
-required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
-any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:
-Cancelled or missed appointment charges or charges to complete claim forms;
-Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
-Care in charitable institutions;
-Care for conditions related to current or previous military service; or
-Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Limitations & Exclusions

Exclusions That Apply to Basic Comprehensive Dental Insurance

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services. These dental exclusions are in addition to the exclusions listed under your medical coverage.

Apicoectomy, (dental root resection), root canal treatment.
Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the What the Plan Covers section. Facings on molar crowns and pontics will always be considered cosmetic. This exclusion does not apply to external bleaching.

Crown, inlays and onlays, and veneers unless:
-It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
-The tooth is an abutment to a covered partial denture or fixed bridge.
Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.
Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider, provided in connection with treatment or care that is not covered under the plan.
Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Dental services and supplies that are covered in whole or in part:
-Under any other part of this plan; or
-Under any other plan of group benefits provided by the policyholder.
Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

Any instruction for diet, plaque control and oral hygiene.
General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
Except as covered in the What the Plan Covers section, non-surgical and surgical treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

Limitations & Exclusions

Orthodontic treatment except as covered in the What the Plan Covers section.
Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) except as covered in the What the Plan Covers section.
Prescribed drugs, pre-medication or analgesia.
Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
Replacement of teeth beyond the normal complement of 32.
Removal of soft bony impactions.
Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
Topical application of fluoride.
Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
-Scaling of teeth;
-Cleaning of teeth; and
-Topical application of fluoride.
Treatment of alveolectomy.
Treatment of periodontal disease.

Waiting periods, limitations and exclusions may not apply to all plans or all states.
Dental insurance plans are offered and/or underwritten by Aetna Dental Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Notes

*Coverage Waiting Period applies: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major and Orthodontic Services. Does not apply to DMO and 10+ Standard (non-voluntary) plans.

Copay amounts including the office visit and ortho copays on DMO Plan 1.1A are member responsibility.

All Endodontic and Periodontic services are covered as Major Services on Plans 1.2A, 6.1A and 8A. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on Plans 2A, 5A, & 7A.

Out-of-Network plan payments are limited by geographic area on PPO Plans 1.2A, 1.3A, 2A 6.1A & 8A to the prevailing fees at the 80th percentile and 4A, 5A, 6A, 7A & 9A at the 90th percentile.

Orthodontic coverage is available for Dependent Children Only.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change. Refer to Aetna.com for more information about Aetna® Dental plans.

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

3231340-01-01 (03/24)