

SERFF Tracking Number:	AENX-126102146	State:	Arkansas
Filing Company:	Aetna Life Insurance Company	State Tracking Number:	42053
Company Tracking Number:	GH AR0143601F01		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	2009 Dental		
Project Name/Number:	2009 Dental/GH AR0143601F01		

## Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2009 Dental

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: AENX-126102146 State: ArkansasLH

SERFF Status: Closed State Tr Num: 42053

Co Tr Num: GH AR0143601F01 State Status: Approved-Closed

Co Status: Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 04/08/2009

Date Submitted: 04/06/2009 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: 2009 Dental

Project Number: GH AR0143601F01

Requested Filing Mode: File & Use

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/08/2009

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 04/08/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

The purpose of this filing is to support the following options for our dental products:

1. A new Lifetime Individual Deductible option for our traditional expense incurred dental and preferred provider dental plans.

2. Addition of full mouth debridement, adjunctive pre-diagnostic tests, brush biopsy, and bone grafts services for our traditional expense incurred dental, preferred provider dental; and gatekeeper dental plans.

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3. Addition of clinical crown lengthening and localized delivery of antimicrobial agents for our gatekeeper dental plans only.

## Company and Contact

### Filing Contact Information

John Ciesielski, Product and Regulatory Affairs CiesielskiJW@Aetna.com  
 Manager  
 151 Farmington Avenue (860) 279-1282 [Phone]  
 Hartford, CT 06156 (860) 952-2069[FAX]

### Filing Company Information

Aetna Life Insurance Company CoCode: 60054 State of Domicile: Connecticut  
 151 Farmington Avenue Group Code: 1 Company Type:  
 Hartford, CT 06156 Group Name: Aetna State ID Number:  
 (860) 273-7546 ext. [Phone] FEIN Number: 06-6033492  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	04/06/2009	26966198

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/08/2009	04/08/2009

*SERFF Tracking Number:*      *AENX-126102146*                      *State:*                      *Arkansas*  
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*TOI:*                      *H10G Group Health - Dental*                      *Sub-TOI:*                      *H10G.000 Health - Dental*  
*Product Name:*              *2009 Dental*  
*Project Name/Number:*      *2009 Dental/GH AR0143601F01*

## **Disposition**

Disposition Date: 04/08/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-126102146 State: Arkansas  
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Transmittal Document	Approved-Closed	Yes
Form	Dental Care Schedule	Approved-Closed	Yes
Form	Network Benefits	Approved-Closed	Yes
Form	Out-of-Network Benefits	Approved-Closed	Yes
Form	[Limited][Comprehensive] Dental Expense Insurance	Approved-Closed	Yes
Form	Comprehensive Dental Expense Insurance (PPO)	Approved-Closed	Yes
Form	[Schedule of Benefits]	Approved-Closed	Yes
Form	[Schedule of Benefits]	Approved-Closed	Yes
Form	[Schedule of Benefits]	Approved-Closed	Yes
Form	Comprehensive Dental Expense Insurance [Schedule of Benefits]	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-9N 18-010 04	Certificate Amendmen	Dental Care Schedule	Initial		0	GR-9N 18-010 04.PDF
		t, Insert					
		Page,					
		Endorseme					
		nt or Rider					
Approved-Closed	GR-9N 19-010 03	Certificate Amendmen	Network Benefits	Initial		0	GR-9N 19-010 03.PDF
		t, Insert					
		Page,					
		Endorseme					
		nt or Rider					
Approved-Closed	GR-9N 19-015 03	Certificate Amendmen	Out-of-Network Benefits	Initial		0	GR-9N 19-015 03.PDF
		t, Insert					
		Page,					
		Endorseme					
		nt or Rider					
Approved-Closed	GR-9N S-20-005 04	Certificate Amendmen	[Limited][Comprehen sive] Dental Expense	Initial		0	GR-9N S-20-005 04.PDF
		t, Insert	Insurance				
		Page,					
		Endorseme					
		nt or Rider					
Approved-Closed	GR-9N S-21-005 04	Certificate Amendmen	Comprehensive Dental Expense	Initial		0	GR-9N S-21-005 04.PDF
		t, Insert	Insurance (PPO)				
		Page,					
		Endorseme					
		nt or Rider					
Approved-Closed	GR-9N S-22-010 04	Certificate Amendmen	[Schedule of Benefits]	Initial		0	GR-9N S-22-010 04.PDF

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Approved- Closed	GR-9N S- 22-020 03	Schedule Pages	[Schedule of Benefits]	Initial	0	GR-9N S-22- 020 03.PDF
Approved- Closed	GR-9N S- 23-010 02	Schedule Pages	[Schedule of Benefits]	Initial	0	GR-9N S-23- 010 02.PDF
Approved- Closed	GR-9N S- 30-010 04	Schedule Pages	Comprehensive Dental Expense Insurance [Schedule of Benefits]	Initial	0	GR-9N S-30- 010 04.PDF



### **Important Reminder**

The [copays, deductible,] coinsurance and maximums that apply to each type of dental care are shown in the [Schedule of Benefits].

[You may receive services and supplies from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the network level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the **out-of-network** level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.]

### **[Type A Expenses: Diagnostic and Preventive Care]**

#### **[VISITS AND X-RAYS**

Office visit during regular office hours, for oral examination (limited to 2-6 visits every year)

Prophylaxis (cleaning) (limited to 2-6 treatments per year)

Adult

Child

Topical application of fluoride, (limited to 1-4 courses of treatment per year and to covered persons under age 14-30)

Sealants, per tooth (limited to 1-2 application every 1-5 years for permanent bicuspids and molars only, and to covered persons under age 14-30)

Bitewing x-rays (limited to 1-4 set per year)

Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every 1-5 years)

Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)]

### **[Type B Expenses: Basic Restorative Care**

#### **[VISITS AND X-RAYS**

Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

Emergency palliative treatment, per visit]

#### **[X-RAY AND PATHOLOGY**

Periapical x-rays (single films up to 13-25)

Intra-oral, occlusal view, maxillary or mandibular

Upper or lower jaw, extra-oral

Biopsy and histopathologic examination of oral tissue]

## **[ORAL SURGERY**

Extractions

Exposed root or erupted tooth

Surgical removal of erupted tooth

Impacted Teeth

Removal of tooth (soft tissue)

Odontogenic Cysts and Neoplasms

Incision and drainage of abscess

Removal of odontogenic cyst or tumor

Other Surgical Procedures

Alveoplasty, in conjunction with extractions - per quadrant

Alveoplasty, not in conjunction with extraction - per quadrant

Sialolithotomy: removal of salivary calculus

Closure of salivary fistula

Excision of hyperplastic tissue

Removal of exostosis

Transplantation of tooth or tooth bud

Closure of oral fistula of maxillary sinus

Sequestrectomy

Crown exposure to aid eruption

Removal of foreign body from soft tissue

Frenectomy

Suture of soft tissue injury]

## **[PERIODONTICS**

Occlusal adjustment (other than with an appliance or by restoration)

Root planing and scaling, per quadrant (limited to 1-4 separate quadrants every 1-2 years)

Root planing and scaling – 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)

Gingivectomy, per quadrant (limited to 1-2 per quadrant every 1-3 years)

Gingivectomy, 1 to 3 teeth per quadrant, (limited to 1-2 per site every 1-3 years)

Gingival flap procedure - per quadrant (limited to 1-2 per quadrant every 1-3 years)

Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1-2 per site every 1-3 years)

Periodontal maintenance procedures following active therapy (limited to 1-2 per year)

Localized delivery of chemotherapeutic agents]

## **[ENDODONTICS**

Pulp cap

Pulpotomy

Apexification/recalcification

Apicoectomy

Root canal therapy, including necessary x-rays

Anterior

Bicuspid]

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**[RESTORATIVE DENTISTRY** Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)

Amalgam restorations

Resin-based composite restorations (other than for molars)

Pins

Pin retention—per tooth, in addition to amalgam or resin restoration

Crowns (when tooth cannot be restored with a filling material)

Prefabricated stainless steel

Prefabricated resin crown (excluding temporary crowns)

Recementation

Inlay

Crown

Bridge]

**[Type C Expenses: Major Restorative Care]**

**[ORAL SURGERY**

Impacted Teeth

Removal of tooth (partially bony)

Removal of tooth (completely bony)

Brush biopsy]

**[PERIODONTICS**

Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant (limited to 1-4 per quadrant, every 1-5 years)

Osseous surgery (including flap and closure), per quadrant (limited to 1-4 per site, every 1-5 years)

Soft tissue graft procedures

Clinical Crown Lengthening - Hard Tissue

Full mouth debridement (limited to 1-4 per lifetime)

Bone grafts – first site in quadrant (limited to 1-4 per lifetime)

Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)]

**[ENDODONTICS**

Root canal therapy, including necessary x-rays

Molar]

**[RESTORATIVE.** Inlays, onlays, labial veneers and 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 (limited to 1-2 per tooth every 1-10 years- see *Replacement Rule*).

Inlays/Onlays-Metallic or Porcelain/Ceramic

Inlay, 1 or more surfaces

Onlay, 2 or more surfaces

Inlays/Onlays-Resin-based composite

Inlay, 1 or more surfaces

Onlay, 2 or more surfaces

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Labial Veneers

- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns

Resin

- Resin with noble metal
- Resin with base metal

Porcelain

- Porcelain with noble metal
- Porcelain with base metal

Base metal (full cast)

Noble metal (full cast)

Metallic (3/4 cast)

Post and core

Core Build-Up]

**[PROSTHODONTICS-** 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 1-10 years old. (See *Tooth Missing But Not Replaced Rule.*) Replacement of existing bridges or dentures is limited to 1 every 1-10 years. (See *Replacement Rule.*)

Bridge Abutments (See Inlays and Crowns)

Pontics

- Base metal (full cast)
- Noble metal (full cast)
- Base metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Removable Bridge (unilateral)

One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including 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 denture

Complete lower denture

Partial upper or lower, resin base (including any conventional clasps, rests and teeth)

Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)

Stress breakers  
Interim partial denture (stayplate), anterior only  
Office reline  
    Laboratory reline  
    Special tissue conditioning, per denture  
    Rebase, per denture  
    Adjustment to denture more than 6 months after installation  
Full and partial denture repairs  
Broken dentures, no teeth involved  
Repair cast framework  
Replacing missing or broken teeth, each tooth  
Adding teeth to existing partial denture  
    Each tooth  
    Each clasp  
Repairs: crowns and bridges  
Occlusal guard (for bruxism only)(limited to 1-4 every 1-5 years)]

**[IMPLANTS]**

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

Fixed (unilateral or bilateral)  
Removable (unilateral or bilateral)  
Removable inhibiting appliance to correct thumbsucking  
Fixed or cemented inhibiting appliance to correct thumb sucking]

**[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION** (only when medically necessary and provided in conjunction with a covered surgical procedure)]

**[ORTHODONTICS**

Interceptive orthodontic treatment  
Limited orthodontic treatment  
Comprehensive orthodontic treatment of adolescent dentition  
Comprehensive orthodontic treatment of adult dentition  
Post treatment stabilization]

**[VISITS AND EXAMS**

Adjunctive pre-diagnostic tests (limited to 2-6 visits every year)]

## [Network] Benefits

This Dental Care Schedule applies to covered services and supplies provided by **Primary Care Dentists (PCD)** and other **[network] providers** upon referral from your **PCD**. The plan covers only the services and supplies in the list below.

### PRIMARY DENTAL SERVICES

#### [TYPE A EXPENSES]

#### [VISITS AND EXAMS]

- Office visit for oral exam (limited to 2-6 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2-6 treatments per year)
- Topical application of fluoride (limited to 1-4 treatments per year and to covered persons under age 14-30)
- Oral hygiene instruction
- Sealants, per tooth (limited to 1-2 applications every 1-5 years for permanent molars only, and to covered persons under age 14-30)
- Pulp vitality test
- Diagnostic casts]

#### [X-RAYS AND PATHOLOGY]

- Bitewing X-rays (limited to 1-4 set per year)
- Entire dental series, including bitewings, or panoramic film (limited to 1-8 sets every 1-5 years)
- Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue]

#### [SPACE MAINTAINERS (Includes all adjustments within 6 months after installation.)]

- Fixed, band type
- Removable acrylic with round wire clasp]

#### [TYPE B EXPENSES]

#### [ENDODONTICS]

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid]

#### [RESTORATION AND REPAIR]

- Amalgam restoration
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Resin restoration (other than for molars)

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- 1 surface
- 2 surfaces
- 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures]

**[PERIODONTICS**

- Scaling and root planing (limited to 1-4 separate quadrants, every 1-2 years)
- Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)]

**[ORAL SURGERY (Includes local anesthetics and routine post-operative care)**

- Extractions, uncomplicated
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Root removal, exposed root
- Removal of foreign body from soft tissue
- Suture of soft tissue injury]

**[TYPE C EXPENSES]**

**[RESTORATIONS]**

- Inlays
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Onlays
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Crowns (including build-ups when necessary)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
  - Post and core
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal]

**[DENTURES AND PARTIALS]** (includes relines, rebases, and adjustments within 6 months after installation).

- Full (upper and lower)
- Partial
- Stress breakers (per unit)
- Stayplates
- Crown and bridge repairs
- Adding teeth to an existing denture
- Full and partial denture repairs
- Relining/rebasing dentures (including adjustments within six months after installation)
- Occlusal guard (for bruxism only) limited to 1-4 every 1-5 years]

**[VISITS AND EXAMS]**

- Adjunctive pre-diagnostics tests (limited to 2-6 visits per year)]

**[PERIODONTICS]**

- Full mouth debridement (limited to 1-4 per lifetime)
- Local delivery of antimicrobial agents]

**[ORAL SURGERY]**

- Brush biopsy]

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**[SPECIALTY DENTAL SERVICES  
TYPE B EXPENSES]**

**[ENDODONTICS (Includes local anesthetics where necessary)]**

- Apexification/recalcification
- Apicoectomy/periradicular surgery (per tooth) - first root
- Apicoectomy (per tooth) - each additional root
- Retrograde Filling
- Root Amputation
- Hemisection
  - Retreatment of previous root canal therapy
    - Anterior
    - Bicuspid
    - Molar
- Molar root canal therapy]

**[ORAL SURGERY (Includes local anesthetics where necessary and post-operative care)]**

- Surgical removal or root tip, root recovery
- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula]

**[PERIODONTICS]**

- Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 per quadrant every 1-5 years)
- Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site, every 1-5 years)
- Gingival flap procedure - per quadrant
- Occlusal adjustment (other than with an appliance or by restoration)
- Clinical Crown Lengthening – Hard Tissue]

**[TYPE C EXPENSES]**

**[ENDODONTICS (Includes local anesthetics where necessary)]**

- Molar root canal therapy, including necessary X-rays]

**[INTRAVENOUS SEDATIONS AND GENERAL ANESTHESIA]**

**[ORAL SURGERY (Includes local anesthetics where necessary and post-operative care)]**

- Surgical removal of impacted teeth
  - Partially bony
  - Completely bony
  - Completely bony with unusual surgical implications]

**[PERIODONTICS]**

- Osseous surgery (including flap entry and closure), per quadrant limited to 1-4 per quadrant, every 1-5 years
- Soft tissue graft procedure
- Bone grafts – first site in quadrant (limited to 1-4 per lifetime)
- Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)]

**[ORTHODONTICS]**

- Orthodontic screening exam
- Orthodontic diagnostic records
- Orthodontic retention
- Comprehensive orthodontic treatment of adult or adolescent dentition
- Post treatment stabilization
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits]

## [Out-of-Network] Benefits

This Dental Care Schedule applies to covered services and supplies provided by [out-of-network] providers. The plan covers only the services and supplies in the list below.

### Important Note:

The “Amount Payable” shown in the Dental Care Schedule applies only to services and supplies provided by [out-of-network] providers. The amounts shown are *not copays*. They are the maximum charges eligible for coverage under the plan for the service listed.

**Applies to services provided by [out-of-network] providers**  
**PRIMARY DENTAL SERVICES**  
**[TYPE A EXPENSES]**

	<b>Amount Payable</b>
<b>[VISITS AND EXAMS]</b>	
Office visit for oral examination (limited to 2-6 visits per year)	\$12.00
Emergency palliative treatment	12.00
Prophylaxis (cleaning) (limited to 2-6 treatments per year)	
Adult	26.00
Child	14.00
Topical application of fluoride (limited to 1-4 treatments per year and to covered persons under age 14-30)	16.00
Oral hygiene instruction	12.00
Sealants; per tooth (limited to 1-2 application every 1-5 years for permanent bicuspids and molars and to covered persons under age 14-30)	10.00
Pulp vitality test	8.00]
<b>[X-RAYS AND PATHOLOGY]</b>	
Bitewing x-rays (limited to 1-4 set per year)	8.00
Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every 1-5 years)	14.00
Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)	12.00
Periapical x-rays (single films, up to 13-25)	6.00
Intra-oral; occlusal view; maxillary or mandibular	8.00
Extra-oral upper or lower jaw	12.00
Biopsy and histopathologic examination of oral tissue	27.00]

[TYPE B EXPENSES]

	<b>Amount Payable</b>
<b>[ENDODONTICS]</b>	
Pulp capping	\$ 3.00
Pulpotomy	27.00
Surgical exposure for rubber dam isolation	26.00
Root canal therapy; including necessary X-rays	
Anterior	80.00
Bicuspid	96.00
1 surface	12.00
2 surfaces	16.00
3 surfaces	26.00
4 or more surfaces or incisal angle	30.00
Retention pins	14.00
Stainless steel crowns	26.00
Prefabricated resin crowns (excluding temporary crowns)	60.00]
<b>[RESTORATIONS AND REPAIRS]</b>	
Amalgam restoration	
1 surface	12.00
2 surfaces	16.00
3 surfaces	24.00
4 or more surfaces	26.00
Resin-based composite restoration (other than for molars)	
Recementing inlays; crowns; bridges; space maintainers	16.00
Tissue conditioning for dentures	26.00]
<b>[PERIODONTICS]</b>	
Scaling and root planing (limited to 1-4 separate quadrants every 1-2 years)	40.00
Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)	40.00]
<b>[ORAL SURGERY - Includes local anesthetics and routine post-operative care]</b>	
Extraction- exposed root or erupted tooth	27.00
Surgical removal of erupted tooth	32.00
Surgical removal of impacted tooth (soft tissue)	40.00
Excision of hyperplastic tissue	32.00
Excision of pericoronal gingival	40.00
Incision and drainage of abscess	20.00
Crown exposure to aid eruption	26.00
Removal of foreign body from soft tissue	20.00
Suture of soft tissue injury	20.00]

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**[TYPE C EXPENSES]**

	<b>Amount Payable</b>
<b>[RESTORATIONS</b>	
Inlays	
1 surface	\$60.00
2 surfaces	80.00
3 or more surfaces	80.00
Onlays	
2 surfaces	80.00
3 surfaces	80.00
4 or more surfaces	80.00
Crowns (including build-ups when necessary)	120.00
Resin	120.00
Resin with noble metal	120.00
Resin with base metal	120.00
Porcelain	120.00
Porcelain with noble metal	120.00
Porcelain with base metal	120.00
Base metal (full cast)	120.00
Noble metal (full cast)	120.00
Metallic (3/4 cast)	27.00
Post and core	27.00
Pontics	
Base metal (full cast)	20.00
Noble metal (full cast)	20.00
Porcelain with noble metal	20.00
Porcelain with base metal	20.00
Resin with noble metal	20.00
Resin with base metal	20.00]
 <b>[DENTURES AND PARTIALS - (includes relines; rebases and adjustments within 6 months after installation)</b>	
Full (Upper or Lower)	120.00
Partial	120.00
Stress breakers (per unit)	40.00
Interim partial denture; (stayplates); anterior only	40.00
Crown and bridge repairs	27.00
Adding teeth to an existing denture	40.00
Full and partial denture repairs	27.00
Relining/rebasing dentures (including adjustments within 6 months after installation)	40.00
Occlusal guard (for bruxism only); (limited to 1-4 every 1-5 years)	40.00]
 <b>[SPACE MAINTAINERS - Includes all adjustments within 6 months after installation</b>	
Fixed; band type	40.00
Removable acrylic with round wire clasp	32.00
Removable appliance to correct habits	32.00
Fixed or cemented appliance to correct habits	40.00]

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**[TYPE C EXPENSES]**

**Amount  
Payable**

**[VISITS AND EXAMS]**

Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)

\$9]

**[PERIODONTICS]**

Full mouth debridement (limited to 1-4 per lifetime)

\$40

Local delivery of antimicrobial agents

\$20]

**[ORAL SURGERY]**

Brush biopsy

\$9]

**SPECIALTY SERVICES**  
**[TYPE B EXPENSES]**

	<b>Amount Payable</b>
<b>[ENDODONTICS</b> - Includes local anesthetics where necessary.	
Apexification/recalcification - per visit	\$32.00
Apicoectomy	
First root	60.00
Each additional root	40.00
Retrograde Filling	14.00
Root Amputation	27.00
Hemisection	27.00]
 <b>[ORAL SURGERY</b> - Includes local anesthetics where necessary and post-operative care	
Removal of residual root	27.00
Removal of odontogenic cyst	40.00
Closure of oral fistula	48.00
Removal of foreign body from bone	20.00
Sequestrectomy	20.00
Frenectomy	40.00
Transplantation of tooth or tooth bud	48.00
Alveoplasty in conjunction with extractions - per quadrant	27.00
Alveoplasty not in conjunction with extractions - per quadrant	40.00
Removal of exostosis	60.00
Sialolithotomy; removal of salivary calculus	36.00
Closure of salivary fistula	36.00]
 <b>[PERIODONTICS</b>	
Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 quadrant; every 1-5 years)	40.00
Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site; every 1-5 years)	20.00
Gingival flap procedure - per quadrant	60.00
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	20.00
Entire mouth	40.00
Clinical Crown Lengthening - Hard Tissue	20.00]

**[TYPE C EXPENSES]**

	<b>Amount Payable</b>
<b>[ENDODONTICS</b> - Includes local anesthetics where necessary	
Complex molar root canal therapy	\$120.00]
<b>[INTRAVENOUS SEDATION AND GENERAL ANESTHESIA</b> (only when <b>medically necessary</b> and provided in conjunction with another covered procedure) – per 15-minute segment	20.00]
<b>[ORAL SURGERY</b> - Includes local anesthetics where necessary and post-operative care	
Surgical removal of impacted tooth	
Partially bony	53.00
Completely bony	60.00
Completely bony with unusual surgical complications	64.00]
<b>[PERIODONTICS</b>	
Osseous surgery (including flap entry and closure) - per quadrant (limited to 1-4 per quadrant; every 1-5 years)	80.00
Bone grafts - first site in quadrant (limited to 1-4 per lifetime)	40.00
Bone grafts - each additional site per quadrant (limited to 1-4 per lifetime)	25.00]
<b>[ORTHODONTICS</b>	
Comprehensive orthodontic treatment of adolescent and adult dentition	
Post treatment stabilization	
Lifetime maximum:	\$400.00]

[Policyholder: ABC Company  
Group Policy Number: 123456  
Effective Date: January 1, 2004]

**Aetna life Insurance Company**  
**[Limited][Comprehensive] Dental Expense Insurance**  
**[Schedule of Benefits]**

**PLAN FEATURES**

<b>[Calendar Year Deductible</b>	\$25-200 Individual \$500-600 Family
The calendar year <b>deductible</b> applies to all <b>covered expenses</b> except Type A Expenses.]	
<b>[Lifetime Individual Deductible</b>	\$25-200
The lifetime individual <b>deductible</b> applies to all <b>covered expenses</b> except Type A Expenses.]	

**[Calendar Year Deductible Carryover** Applies]

**[Calendar Year Family Deductible Limit** Applies]

**[Individual Deductible** \$25-200]

**[Family Deductible** \$50-600]

[**Covered expenses** that are subject to the **deductible** include **Prescription Drug**, Dental, Vision, and Hearing expenses provided under **Aetna Medical, Prescription Drug, Dental, Vision, Hearing plan.**]

**[Orthodontic Deductible** \$25-1,000

The orthodontic **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the orthodontic **deductible**, the plan will begin to pay benefits for covered orthodontic expenses for the rest of the calendar year.]

**Aetna life Insurance Company**  
**[Limited][Comprehensive] Dental Expense Insurance**  
**Schedule of Benefits**

**[Plan Coinsurance**

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

<b>PLAN COINSURANCE</b>	
<b>Type A Expenses</b>	70%-100%
<b>Type B Expenses</b>	30%-100%
<b>Type C Expenses</b>	30%-100%
<b>Orthodontic Treatment</b>	30%-100%]

**[Plan Coinsurance**

<b>PLAN COINSURANCE</b>	
<b>Type A Expenses</b>	70%-100%
<b>Type B Expenses</b>	100% up to the Schedule Limit shown on the Dental Care Schedule.
<b>Type C Expenses</b>	100% up to the Schedule Limit shown on the Dental Care Schedule.]

**[Plan Coinsurance Limit**

For certain **covered expenses**, the amount you are required to pay is limited. In addition to your plan **coinsurance** limit, which applies separately to you and each of your covered dependents, there is also a family limit.

**Individual Plan Coinsurance Limit:**

Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

**Aetna life Insurance Company**  
**[Limited][Comprehensive] Dental Expense Insurance**  
**Schedule of Benefits**

- When your share or your covered dependent's share of **covered expenses** reaches \$25-\$20,000 in a calendar year, your plan will pay 100% of that person's **covered expenses** for the rest of the calendar year and the next calendar year.

**Family Plan Coinsurance Limit:**

Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

- When your share of **covered expenses** applied to **coinsurance** limits for two or more family members reaches \$50-\$60,000 in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year and the next calendar year.]

[Certain **covered expenses** do not apply toward the plan **coinsurance** limit and the family plan **coinsurance** limit. These include:

- Expenses paid at 50% or less.
- Expenses applied toward a **deductible** or **copay** amount.
- Expenses above the **recognized charge**.
- Expenses incurred because you failed to obtain necessary **precertification**.
- **Covered Expenses** incurred for the following:  
List all **covered expense** categories]

**[Calendar Year Maximum Benefit**

Calendar Year Maximum Benefit \$250-10,000

The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year is called the calendar year maximum benefit.

**Covered expenses** that are subject to the Calendar Year Maximum Benefit include **Prescription Drug**, Dental, Vision, and Hearing expenses provided under **Aetna Medical, Prescription Drug**, Dental, Vision, Hearing plan.]

**[Orthodontic Lifetime Maximum Benefit**

Orthodontic Lifetime Maximum Benefit \$400-5,000

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

**Aetna life Insurance Company**  
**[Limited][Comprehensive] Dental Expense Insurance**  
**Schedule of Benefits**

**Lifetime Maximum Benefit**

**Lifetime Maximum Benefit** \$1,000-50,000

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

**Covered expenses** that are subject to the **Lifetime Maximum Benefit** include **Prescription Drug**, Dental, Vision, and Hearing expenses provided under **Aetna Medical, Prescription Drug, Dental, Vision, Hearing plan.**]

**Lifetime Maximum Benefit Automatic Yearly Restoration**

At the beginning of each new benefit period, the amount up to \$100-5,000 which:

- (1) Has been counted against your **Lifetime Maximum Benefit**; and
- (2) Has not been previously restored

will automatically be restored without action on your part. Evidence of good health will not be required. However, your insurance must be in force and restoration is not available during the "extended insurance period".]

[Policyholder: ABC Company  
 Group Policy Number: 123456  
 Effective Date: January 1, 2004]

**Aetna Life Insurance Company**  
**Comprehensive Dental Expense Insurance (PPO)**  
**[Schedule of Benefits]**

<b>PLAN FEATURES</b>		
<b>PLAN FEATURES</b>	<b>[NETWORK]</b>	<b>[OUT-OF-NETWORK]</b>
<b>[Calendar Year Deductible]</b> Individual \$25-200 Family \$50-600]	[Individual \$25-200 Family \$50-600]	[Individual \$25-200 Family \$50-600]
The calendar year <b>deductible</b> applies to all <b>covered expenses</b> except Type A Expenses.]		
<b>[Lifetime Individual Deductible]</b> \$25-200]	[\$25-200]	[\$25-200]

**[Network Calendar Year Deductible Carryover** Applies]

**[Network and Out-of-Network Calendar Year Family Deductible Limit** Applies]

**[Individual Deductible** \$25-200]

**[Family Deductible** \$50-600]

[**Covered expenses** that are subject to the **deductible** include **Prescription Drug**, Dental, Vision, and Hearing expenses provided under **Aetna Medical**, **Prescription Drug**, Dental, Vision, Hearing plan.]

**[Orthodontic Deductible**

The orthodontic **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the orthodontic **deductible**, the plan will begin to pay benefits for covered orthodontic expenses for the rest of the calendar year.]

	<b>[NETWORK]</b>	<b>[OUT-OF-NETWORK]</b>
[Orthodontic <b>Deductible</b> \$25-1,000]	[Orthodontic <b>Deductible</b> \$25-1,000]	[Orthodontic <b>Deductible</b> \$25-1,000]

[Schedule of Benefits]

<b>THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [NETWORK] PROVIDERS</b>	
<b>PRIMARY CARE DENTIST SERVICES</b>	
<b>[VISITS AND EXAMS]</b>	<b>Copayment Amount</b>
Oral examination (limited to total of 2-6 visits per year)	
Comprehensive	\$0-30
Periodic	\$0-25
Limited - problem focused	\$0-30
Detailed and extensive - problem focused	\$0-40
Re-evaluation - limited, problem focused	\$0-25
Emergency palliative treatment	\$0-75
Prophylaxis (cleaning), (limited to 2-6 treatments per year)	
Adult	\$0-40
Child	\$0-30
Topical application of fluoride (limited to 1-4 treatment per year and to covered persons under age 14-30)	\$0-30
Oral hygiene instruction	\$0-25
Sealants, per tooth (limited to 1-2 application every 1-5 years for permanent bicuspid and molars and to covered persons under age 14-30)	\$0-30
Pulp vitality test	\$0-30
Consultation	\$0-80
Diagnostic casts	\$0-35
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	\$0-125]
<b>[X-RAYS AND PATHOLOGY]</b>	
Bitewing x-rays (limited to 1-4 set per year)	\$0-25
Entire dental series, including bitewings, or panoramic film, limited to 1-8 set every 1-5 years)	\$0-45
Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)	\$0-45
Periapical x-ray (single films up to 13-25)	\$0-20
Intra-oral, occlusal view, maxillary or mandibular	\$0-30
Extra-oral upper or lower jaw	\$0-40
Biopsy and histopathologic examination of oral tissue	\$0-155]
<b>[ENDODONTICS]</b>	
Pulp cap	\$0-75
Pulpotomy	\$0-115
Root canal therapy, including necessary x-rays	
Anterior	\$0-500
Bicuspid	\$0-600]

[Schedule of Benefits]

<b>[RESTORATIONS AND REPAIRS (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal (“gold”) when used for services shown with an asterisk.]</b>	<b>Copayment Amount</b>
Amalgam restoration	
1 surface	\$0-90
2 surfaces	\$0-115
3 surfaces	\$0-145
4 or more surfaces	\$0-170
Resin-based composite restoration (other than for molars)	
1 surface	\$0-110
2 surfaces	\$0-130
3 surfaces	\$0-160
4 or more surfaces or incisal angle	\$0-190
Retention pins	\$0-50
Stainless steel crowns, prefabricated, primary tooth	\$0-155
Stainless steel crowns, prefabricated, permanent tooth	\$0-155
Recementing inlays or crowns	\$0-35
Recementing bridges	\$0-90
Tissue conditioning for dentures	\$0-115
Sedative filling	\$0-70
<b>Inlays and Onlays, metallic*</b>	\$0-815
<b>Crowns</b>	
Porcelain	\$0-815
Porcelain with metal (includes abutments)*	\$0-815
Metallic (full cast) (includes abutments)*	\$0-815
Metallic (3/4 cast)*	\$0-815
Cast post and core*	\$0-285
Prefabricated post and core	\$0-235
Core buildup including pins	\$0-190
<b>Pontics</b>	
Metallic (full cast)*	\$0-815
Porcelain with metal*	\$0-815
<b>Full mouth rehabilitation, per unit</b> (This means 6 or more covered units of crowns and/or pontics under one treatment plan.)	\$0-220]

[Schedule of Benefits]

	<b>Copayment Amount</b>
<b>[Dentures and Partials - (Includes relines, rebases and adjustments</b>	
within six months after installation. Adjustments within first six months	
are limited to four.)	
Complete, upper or lower	\$0-815
Partial, upper or lower	
Resin base	\$0-815
Cast metal base	\$0-970
Immediate, upper or lower (does not include charge for reline)	\$0-970
Adjust complete denture, upper or lower	\$0-55
Adjust partial denture, upper or lower	\$0-55
Repair broken acrylic, complete denture, upper or lower	\$0-100
Replace one tooth on complete denture	\$0-70
Repair acrylic, cast frame, broken clasp	\$0-115
Replace broken tooth, partial	\$0-100
Add tooth to existing partial denture	\$0-100
Add clasp to existing partial	\$0-105
Rebase, complete denture, upper or lower	\$0-315
Rebase, partial denture, upper or lower	\$0-315
Reline, complete denture, upper or lower (chairside)	\$0-170
Reline, partial denture, upper or lower (chairside)	\$0-170
Reline, complete denture, upper or lower (laboratory)	\$0-225
Reline, partial denture, upper or lower (laboratory)	\$0-225
Interim partial denture, upper or lower (stayplate), anterior only	\$0-350]
<b>[PERIODONTICS</b>	
Scaling and root planning, per quadrant (limited to 1-4 separate quadrants every 1-2 years)	\$0-200
Scaling and root planning- 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)	\$0-55
Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)	\$0-100
Occlusal guard (for bruxism only), limited to 1-4 every 1-5 years	\$0-345
Full mouth debridement (limited to 1-4 per lifetime)	\$0-175
Local delivery of antimicrobial agents	\$0-175]
<b>[ORAL SURGERY - Includes local anesthetics and routine post-operative care</b>	
Extraction- exposed root or erupted tooth	\$0-105
Surgical removal of erupted tooth	\$0-195
Surgical removal of impacted tooth (soft tissue)	\$0-250
Incision and drainage of intraoral abscess	\$0-125
Surgical exposure of impacted or unerupted tooth to aid eruption	\$0-320
Root removal - exposed root	\$0-125
Brush biopsy	\$0-110]

[Schedule of Benefits]

<b>[SPACE MAINTAINERS</b> –(only when needed to preserve space resulting from premature loss of deciduous teeth) Includes all adjustments within six months after installation	<b>Copayment Amount</b>
Fixed	\$0-315
Removable	\$0-500
Recement space maintainer	\$0-30]

[Schedule of Benefits]

<b>SPECIALTY SERVICES</b>	
	<b>Copayment Amount</b>
<b>[ENDODONTICS - Includes local anesthetics where necessary</b>	
Apicoectomy/periradicular surgery	
Anterior	\$0-450
Bicuspid, first root	\$0-490
Molar, first root	\$0-720
Each additional root	\$0-220
Retrograde filling, per root	\$0-120
Root amputation, per root	\$0-265
Molar root canal therapy	\$0-720]
<b>[ORAL SURGERY-Includes local anesthetics where necessary and post-operative care</b>	
Surgical removal of root tip, root recovery	\$0-70
Frenectomy	\$0-325
Alveoplasty in conjunction with extractions - per quadrant	\$0-190
Alveoplasty not in conjunction with extractions - per quadrant	\$0-175
Surgical removal of impacted tooth	
Partially bony	\$0-315
Completely bony	\$0-375
Completely bony with unusual surgical complications	\$0-410]
<b>[PERIODONTICS</b>	
Gingivectomy or gingivoplasty - per quadrant, limited to 1-4 per quadrant, every 1-5 years	\$0-375
Gingivectomy or gingivoplasty - per tooth, limited to 1-4 per site, every 1-5 years	\$0-100
Gingival flap procedure - per quadrant (limited to 1-2 quadrant every 1-3 years)	\$0-325
Gingival flap procedure- 1-3 teeth one per quadrant (limited to 1-2 per site every 1-3 years)	\$0-200
Occlusal adjustment (other than with an appliance or restoration)	
Limited	\$0-75
Complete	\$0-220
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1-4 per quadrant, every 1-5 years	\$0-690
Clinical Crown Lengthening – Hard Tissue	\$0-255
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	\$0-600
Bone grafts - each additional site in quadrant (limited to 1-4 per lifetime)	\$0-400]
<b>[ANESTHESIA (only when provided in conjunction with another covered procedure)</b>	
Deep sedation/General anesthesia - first 30 minutes	\$0-565
Deep sedation/General anesthesia - each additional 15 minutes	\$0-315
Intravenous conscious sedation/Analgesia – first 30 minutes	\$0-565
Intravenous conscious sedation/Analgesia – each additional 15 minutes	\$0-315]

[Schedule of Benefits]

<b>[ORTHODONTICS]</b>	
Orthodontic screening exam (when no Orthodontic Procedure is performed)	\$0-60
Orthodontic diagnostic records	\$0-315
Comprehensive orthodontic treatment of adolescent and adult dentition	\$0-4,000
Orthodontic retention	\$0-625]

[Schedule of Benefits]

<b>THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [OUT-OF-NETWORK] PROVIDERS</b>	
<b>PRIMARY CARE DENTIST SERVICES</b>	
<b>[TYPE A EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[VISITS AND EXAMS]</b>	
Office visit for oral examination (limited to 2-6 visits per year)	\$12
Emergency palliative treatment	\$12
Prophylaxis (cleaning) (limited to 2-6 treatments per year)	
Adult	\$26
Child	\$14
Topical application of fluoride (limited to 1-4 treatments per year and to covered persons under age 14-30)	\$16
Oral hygiene instruction	\$12
Sealants; per tooth (limited to 1-2 application every 1-5 years for permanent bicuspids and molars and to covered persons under age 14-30)	\$10
Pulp vitality test	\$8]
<b>[X-RAYS AND PATHOLOGY]</b>	
Bitewing x-rays (limited to 1-4 set per year)	\$8
Entire dental series; including bitewings; or panoramic film (limited to 1-8 set every 1-5 years)	\$14
Vertical bitewing x-rays (limited to 1-4 set every 1-5 years)	\$12
Periapical x-rays (single films, up to 13-25)	\$6
Intra-oral; occlusal view; maxillary or mandibular	\$8
Extra-oral upper or lower jaw	\$12
Biopsy and histopathologic examination of oral tissue	\$27]

[Schedule of Benefits]

<b>[TYPE B EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[ENDODONTICS]</b>	
Pulp cap	\$3
Pulpotomy	\$27
Surgical exposure for rubber dam isolation	\$26
Root canal therapy; including necessary x-rays	
Anterior	\$80
Bicuspid	\$96]
<b>[RESTORATIONS AND REPAIRS]</b>	
Amalgam restoration	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$24
4 or more surfaces	\$26
Resin-based composite restoration (other than for molars)	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$26
4 or more surfaces or incisal angle	\$30
Retention pins	\$14
Stainless steel crowns	\$26
Prefabricated resin crowns (excluding temporary crowns)	\$60
Recementing inlays; crowns; bridges; space maintainers	\$16
Tissue conditioning for dentures	\$26]
<b>[PERIODONTICS]</b>	
Scaling and root planing (limited to 1-4 separate quadrants every 1-2 years)	\$40
Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)	\$40]
<b>[ORAL SURGERY - Includes local anesthetics and routine post-operative care]</b>	
Extraction- exposed root or erupted tooth	\$27
Surgical removal of erupted tooth	\$32
Surgical removal of impacted tooth (soft tissue)	\$40
Excision of hyperplastic tissue	\$32
Excision of pericoronal gingival	\$40
Incision and drainage of abscess	\$20
Crown exposure to aid eruption	\$26
Removal of foreign body from soft tissue	\$20

[Policyholder: ABC Company  
Group Policy Number: 123456  
Effective Date: January 1, 2004]

**[Schedule of Benefits]**

Suture of soft tissue injury	\$20
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[Schedule of Benefits]

<b>[TYPE C EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[RESTORATIONS]</b>	
<b>Inlays</b>	
1 surface	\$60
2 surfaces	\$80
3 or more surfaces	\$80
<b>Onlays</b>	
2 surfaces	\$80
3 surfaces	\$80
4 or more surfaces	\$80
<b>Crowns (including build-ups when necessary)</b>	
Resin	\$120
Resin with noble metal	\$120
Resin with base metal	\$120
Porcelain	\$120
Porcelain with noble metal	\$120
Porcelain with base metal	\$120
Base metal (full cast)	\$120
Noble metal (full cast)	\$120
Metallic (3/4 cast)	\$27
Post and core	\$27
<b>Pontics</b>	
Base metal (full cast)	\$20
Noble metal (full cast)	\$20
Porcelain with noble metal	\$20
Porcelain with base metal	\$20
Resin with noble metal	\$20
Resin with base metal	\$20]
<b>[Dentures and Partial] - (includes relines; rebases and adjustments within six months after installation)</b>	
Full (Upper or Lower)	\$120
Partial	\$120
Stress breakers (per unit)	\$40
Interim partial denture; (stayplates); anterior only	\$40
Crown and bridge repairs	\$27
Adding teeth to an existing denture	\$40

[Policyholder: ABC Company  
Group Policy Number: 123456  
Effective Date: January 1, 2004]

**[Schedule of Benefits]**

Full and partial denture repairs	\$27
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**[Schedule of Benefits]**

	<b>Amount Payable by Aetna</b>
Relining/rebasing dentures (includes adjustments within six months after installation)	\$40
Occlusal guard (for bruxism only); (limited to 1-4 every 1-5 years)	\$40]
<b>[SPACE MAINTAINERS</b> - Includes all adjustments within six months after installation	
Fixed; band type	\$40
Removable acrylic with round wire clasp	\$32
Removable appliance to correct habits	\$32
Fixed or cemented appliance to correct habits	\$40]
<b>[VISITS AND EXAMS</b>	
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	\$9]
<b>[PERIODONTICS</b>	
Full mouth debridement (limited to 1-4 per lifetime)	\$40
Local delivery of antimicrobial agents	\$20]
<b>[ORAL SURGERY</b>	
Brush Biopsy	\$9]

[Schedule of Benefits]

<b>SPECIALTY SERVICES [TYPE B EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[ENDODONTICS - Includes local anesthetics where necessary.</b>	
Apexification/recalcification - per visit	\$32
Apicoectomy	
First root	\$60
Each additional root	\$40
Retrograde Filling	\$14
Root Amputation	\$27
Hemisection	\$27]
<b>[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care</b>	
Removal of residual root	\$27
Removal of odontogenic cyst	\$40
Closure of oral fistula	\$48
Removal of foreign body from bone	\$20
Sequestrectomy	\$20
Frenectomy	\$40
Transplantation of tooth or tooth bud	\$48
Alveoplasty in conjunction with extractions - per quadrant	\$27
Alveoplasty not in conjunction with extractions - per quadrant	\$40
Removal of exostosis	\$60
Sialolithotomy; removal of salivary calculus	\$36
Closure of salivary fistula	\$36]
<b>[PERIODONTICS</b>	
Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 quadrant; every 1-5 years)	\$40
Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site; every 1-5 years)	\$20
Gingival flap procedure - per quadrant	\$60
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	\$20
Entire mouth	\$40
Clinical Crown Lengthening - Hard Tissue	\$20]

[Schedule of Benefits]

<b>[TYPE C EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[ENDODONTICS - Includes local anesthetics where necessary</b>	
Complex Molar Root Canal Therapy	\$120]
<b>[INTRAVENOUS SEDATION AND GENERAL ANESTHESIA (only when medically necessary and provided in conjunction with another covered procedure) – per 15-minute segment</b>	\$20]
<b>[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care</b>	
Surgical removal of impacted tooth	
Partially Bony	\$53
Completely Bony	\$60
Completely Bony with unusual surgical complications	\$64]
<b>[PERIODONTICS</b>	
Osseous surgery (including flap entry and closure) - per quadrant(limited to 1-4 per quadrant; every 1-5 years	\$80
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	\$40
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	\$25]
<b>[ORTHODONTICS</b>	
Comprehensive orthodontic treatment of adolescent and adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	\$400]

[Schedule of Benefits]

<b>THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [OUT-OF-NETWORK] PROVIDERS</b>	
<b>PRIMARY CARE SERVICES</b>	
<b>SCHEDULE</b>	
<b>[TYPE A EXPENSES]</b>	
	<b>Amount Payable by Aetna</b>
<b>[VISITS AND EXAMS]</b>	
Office visit for oral examination (limited to 2-6 visits per year)	\$12
Emergency palliative treatment	\$12
Prophylaxis (cleaning) (limited to 2-6 treatments per year)	
Adult	\$26
Child	\$14
Topical application of fluoride (limited to 1-4 treatment per year and to covered persons under age 14-30)	\$16
Oral hygiene instruction	\$12
Sealants; per tooth (limited to 1-2 application every 1-5 years for permanent molars and to covered persons under age 14-30)	\$10
Pulp vitality test	\$8
Consultation	\$12
Diagnostic casts	\$20]
<b>[X-RAYS AND PATHOLOGY]</b>	
Bitewing x-rays (limited to 1-4 set per year)	\$8
Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every 1-5 years)	\$14
Vertical bitewing x-rays (limited to 1-4 set every 1-5 years)	\$12
Periapical x-rays	\$6
Intra-oral; occlusal view; maxillary or mandibular	\$8
Extra-oral upper or lower jaw	\$12
Biopsy and histopathologic examination of oral tissue	\$27]
<b>[SPACE MAINTAINERS - Includes all adjustments within six months after installation.</b>	
Fixed; band type	\$40
Removable acrylic with round wire clasp	\$32
Recent space maintainer	\$10]

**[Schedule of Benefits]**

<b>[TYPE B EXPENSES]</b>	
<b>[ENDODONTICS]</b>	<b>Amount Payable by Aetna</b>
Pulp cap	\$3
Pulpotomy	\$27
Root canal therapy; including necessary x-rays	
Anterior	\$80
Bicuspid	\$96]
<b>[RESTORATIONS AND REPAIRS]</b>	
Amalgam restoration	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$24
4 or more surfaces	\$26
Resin restoration (other than for molars)	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$26
4 or more surfaces or incisal angle	\$30
Retention pins	\$14
Sedative filling	\$12
Stainless steel crowns	\$26
Prefabricated resin crowns (excluding temporary crowns)	\$60
Recementing inlays or crowns	\$16
Recementing bridges	\$16
Tissue conditioning for dentures	\$26]
<b>[PERIODONTICS]</b>	
Emergency treatment (abscess; acute periodontitis; etc.)	\$26
Subgingival curettage (limited to 1-4 separate quadrants; every 1-2 years)	\$40
Scaling and root planning (limited to 1-4 separate quadrants every 1-2 years)	\$40
Periodontal maintenance procedures following surgical therapy (limited to 1-2 per year)	\$40]

[Schedule of Benefits]

<b>[TYPE B EXPENSES (Continued)]</b>	
<b>[ORAL SURGERY - Includes local anesthetics and routine post-operative care.</b>	<b>Amount Payable by Aetna</b>
Extractions; uncomplicated	\$27
Surgical removal of erupted tooth	\$32
Surgical removal of impacted tooth (soft tissue)	\$40
Excision of hyperplastic tissue	\$32
Excision of pericoronal gingival	\$40
Incision and drainage of abscess	\$20
Crown exposure to aid eruption	\$26
Removal of foreign body from soft tissue	\$20
Suture of soft tissue injury	\$20]

[Schedule of Benefits]

<b>[TYPE C EXPENSES]</b>	
<b>[RESTORATIONS]</b>	<b>Amount Payable by Aetna</b>
<b>Inlays</b>	
1 surface	\$60
2 or more surfaces	\$80
<b>Onlays</b>	
2 surfaces	\$80
3 or more surfaces	\$80
<b>Crowns (including build-ups when necessary)</b>	
Resin	\$120
Resin with noble metal	\$120
Resin with base metal	\$120
Porcelain	\$120
Porcelain with noble metal	\$120
Porcelain with base metal	\$120
Base metal (full cast)	\$120
Noble metal (full cast)	\$120
Metallic (3/4 cast)	\$120
Post and core	\$27
<b>Pontics</b>	
Base metal (full cast)	\$20
Noble metal (full cast)	\$20
Porcelain with noble metal	\$20
Porcelain with base metal	\$20
Resin with noble metal	\$20
Resin with base metal	\$20]
<b>[Dentures and Partials - (includes relines; rebases and adjustments within six months after installation)</b>	
Full (Upper or Lower)	\$120
Partial	\$120
Stress breakers (per unit)	\$40
Interim partial denture; (stayplates); anterior only	\$40
Crown and bridge repairs	\$27
Adding teeth to an existing denture	\$40
Full and partial denture repairs	\$27
Relining/rebasing dentures (includes adjustments with six months after installation)	\$40
Occlusal guard (for bruxism only); (limited to 1-4 every 1-5 years)	\$40]

[Schedule of Benefits]

<b>[TYPE C EXPENSES - (Continued)]</b>	
<b>[VISITS AND EXAMS]</b>	<b>Amount Payable by Aetna</b>
Adjunctive pre-diagnostic tests (limited to 2-6 visits per year)	\$9]
<b>[PERIODONTICS]</b>	
Full mouth debridement (limited to 1-4 per lifetime)	\$40
Local delivery of antimicrobial agents	\$20]
<b>[ORAL SURGERY]</b>	
Brush biopsy	\$9]

[Schedule of Benefits]

<b>SPECIALTY CARE DENTAL SERVICES</b>	
<b>[TYPE B EXPENSES]</b>	
<b>[ENDODONTICS - Includes local anesthetics where necessary.</b>	<b>Amount Payable by Aetna</b>
Apexification/recalcification - per visit	\$32
Apicoectomy	
First root	\$60
Each additional root	\$40
Retrograde Filling	\$14
Root Amputation	\$27
Hemisection	\$27]
<b>[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.</b>	
Removal of residual root	\$27
Removal of odontogenic cyst	\$40
Closure of oral fistula	\$48
Removal of foreign body from bone	\$20
Sequestrectomy	\$20
Frenectomy	\$40
Transplantation of tooth or tooth bud	\$48
Alveoplasty in conjunction with extractions - per quadrant	\$27
Alveoplasty not in conjunction with extractions - per quadrant	\$40
Removal of exostosis	\$60
Sialolithotomy; removal of salivary calculus	\$36
Closure of salivary fistula	\$36]
<b>[PERIODONTICS</b>	
Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 quadrant; every 1-5 years)	\$40
Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site; every 1-5 years)	\$20
Gingival flap procedure - per quadrant	\$60
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	\$20
Entire Mouth	\$40
Clinical Crown Lengthening – Hard Tissue	\$20]

[Schedule of Benefits]

<b>[TYPE C EXPENSES]</b>	
<b>[ENDODONTICS - Includes local anesthetics where necessary.</b>	<b>Amount Payable by Aetna</b>
Complex Molar Root Canal Therapy	\$120
<b>INTRAVENOUS SEDATION AND GENERAL ANESTHESIA</b>	
- per 15-minute segment.	\$20
<b>ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.</b>	
Surgical removal of impacted tooth	
Partially bony	\$53
Completely bony	\$60
Completely bony with unusual surgical complications	\$64]
<b>[PERIODONTICS</b>	
Osseous surgery (including flap entry and closure) - per quadrant (limited to 1-4 per quadrant; every 1-5 years)	\$80
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	\$40
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	\$25]
<b>[ORTHODONTICS</b>	
Comprehensive orthodontic treatment of adolescent dentition	
Comprehensive orthodontic treatment of adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	\$400]

**Aetna Life Insurance Company**  
**Comprehensive Dental Expense Insurance**  
**[Schedule of Benefits]**

<b>APPLIES TO SERVICES PROVIDED BY [NETWORK] PROVIDERS PRIMARY CARE DENTIST SERVICES</b>	
<b>[VISITS AND EXAMS</b>	<b>Copayment Amount</b>
Oral examination (limited to total of 2-6 visits per year)	
Comprehensive	\$0-30
Periodic	\$0-25
Limited - problem focused	\$0-18
Detailed and extensive - problem focused	\$0-40
Re-evaluation - limited, problem focused	\$0-25
Emergency palliative treatment	\$0-75
Prophylaxis (cleaning), (limited to 2-6 treatments per year)	
Adult	\$0-40
Child	\$0-30
Topical application of fluoride (limited to 1-4 treatment per year and to covered persons under age 14-30)	\$0-30
Oral hygiene instruction	\$0-25
Sealants, per tooth (limited to 1-2 application every 1-5 years for permanent bicuspid and molars and to covered persons under age 14-30)	\$0-30
Pulp vitality test	\$0-30
Consultation	\$0-80
Diagnostic casts	\$0-35
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	\$0-\$125]
<b>[X-RAYS AND PATHOLOGY</b>	
Bitewing x-rays (limited to 1-4 set per year)	\$0-25
Entire dental series, including bitewings, or panoramic film, limited to 1-8 sets every 1-5 years)	\$0-45
Vertical bitewing x-rays (limited to 1-4 sets every 1-5 years)	\$0-45
Periapical x-ray (single films up to 13-25)	\$0-20
Intra-oral, occlusal view, maxillary or mandibular	\$0-30
Extra-oral upper or lower jaw	\$0-40
Biopsy and histopathologic examination of oral tissue	\$0-155]
<b>[ENDODONTICS</b>	
Pulp cap	\$0-75
Pulpotomy	\$0-115
Root canal therapy, including necessary x-rays	
Anterior	\$0-500
Bicuspid	\$0-600]

**Aetna Life Insurance Company**  
**Comprehensive Dental Expense Insurance**  
**[Schedule of Benefits]**

<b>[RESTORATIONS AND REPAIRS (Copayments for crowns and pontics are per unit.)</b>	
There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.	
	<b>Copayment Amount</b>
<b>Amalgam restoration</b>	
1 surface	\$0-90
2 surfaces	\$0-115
3 surfaces	\$0-145
4 or more surfaces	\$0-170
<b>Resin-based composite restoration (other than for molars)</b>	
1 surface	\$0-110
2 surfaces	\$0-130
3 surfaces	\$0-160
4 or more surfaces or incisal angle	\$0-190
<b>Retention pins</b>	\$0-50
<b>Stainless steel crowns, prefabricated, primary tooth</b>	\$0-155
<b>Stainless steel crowns, prefabricated, permanent tooth</b>	\$0-155
<b>Recementing inlays or crowns</b>	\$0-35
<b>Recementing bridges</b>	\$0-90
<b>Tissue conditioning for dentures</b>	\$0-115
<b>Sedative filling</b>	\$0-70
<b>Inlays and Onlays, metallic*</b>	\$0-815
<b>Crowns</b>	
Porcelain	\$0-815
Porcelain with metal (includes abutments)*	\$0-815
Metallic (full cast) (includes abutments)*	\$0-815
Metallic (3/4 cast)*	\$0-815
Cast post and core*	\$0-285
Prefabricated post and core	\$0-235
Core buildup including pins	\$0-190
<b>Pontics</b>	
Metallic (full cast)*	\$0-815
Porcelain with metal*	\$0-815
<b>Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.)</b>	<b>\$0-220]</b>

**Aetna Life Insurance Company**  
**Comprehensive Dental Expense Insurance**  
**[Schedule of Benefits]**

	<b>Copayment Amount</b>
<b>[Dentures and Partial</b> - (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)	
Complete, upper or lower	\$0-815
Partial, upper or lower	
Resin base	\$0-815
Cast metal base	\$0-970
Immediate, upper or lower (does not include charge for reline)	\$0-970
Adjust complete denture, upper or lower	\$0-55
Adjust partial denture, upper or lower	\$0-55
Repair broken acrylic, complete denture, upper or lower	\$0-100
Replace one tooth on complete denture	\$0-70
Repair acrylic, cast frame, broken clasp	\$0-115
Replace broken tooth, partial	\$0-100
Add tooth to existing partial denture	\$0-100
Add clasp to existing partial	\$0-105
Rebase, complete denture, upper or lower	\$0-315
Rebase, partial denture, upper or lower	\$0-315
Reline, complete denture, upper or lower (chairside)	\$0-170
Reline, partial denture, upper or lower (chairside)	\$0-170
Reline, complete denture, upper or lower (laboratory)	\$0-225
Reline, partial denture, upper or lower (laboratory)	\$0-225
Interim partial denture, upper or lower (stayplate), anterior only	\$0-350]
<b>[PERIODONTICS</b>	
Scaling and root planning, per quadrant (limited to 1-4 separate quadrants every 1-2 years)	\$0-200
Scaling and root planning- 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)	\$0-55
Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)	\$0-100
Occlusal guard (for bruxism only), limited to 1-4 every 1-5 years	\$0-345
Full mouth debridement (limited to 1-4 per lifetime)	\$0-175
Local delivery of antimicrobial agents	\$0-175]
<b>[ORAL SURGERY - Includes local anesthetics and routine post-operative care</b>	
Extraction- exposed root or erupted tooth	\$0-105
Surgical removal of erupted tooth	\$0-195
Surgical removal of impacted tooth (soft tissue)	\$0-250
Incision and drainage of intraoral abscess	\$0-125
Surgical exposure of impacted or unerupted tooth to aid eruption	\$0-320
Root removal - exposed root	\$0-125
Brush biopsy	\$0-110]

**Aetna Life Insurance Company**  
**Comprehensive Dental Expense Insurance**  
**[Schedule of Benefits]**

	<b>Copayment Amount</b>
<b>[SPACE MAINTAINERS</b> –(only when needed to preserve space resulting from premature loss of deciduous teeth) Includes all adjustments within six months after installation	
Fixed	\$0-315
Removable	\$0-500
Recent space maintainer	\$0-30]
<b>[SPECIALTY SERVICES</b>	
<b>The following specialty services will be covered when provided by a Primary Care Dentist.]</b>	
<b>[ENDODONTICS</b> - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	\$0-450
Bicuspid, first root	\$0-490
Molar, first root	\$0-720
Each additional root	\$0-220
Retrograde filling, per root	\$0-120
Root amputation, per root	\$0-265
Molar root canal therapy	\$0-720]
<b>[ORAL SURGERY</b> - Includes local anesthetics where necessary and post-operative care	
Alveoplasty in conjunction with extractions - per quadrant	\$0-190
Alveoplasty not in conjunction with extractions - per quadrant	\$0-175
Surgical removal of impacted tooth	
Partially bony	\$0-315
Completely bony	\$0-375
Completely bony with unusual surgical complications	\$0-410]
<b>[PERIODONTICS</b>	
Gingivectomy or gingivoplasty - per quadrant, limited to 1-2	
per quadrant, every 1-5 years	\$0-375
Gingivectomy or gingivoplasty - per tooth, limited to 1-2	
per site, every 1-5 years	\$0-100
Gingival flap procedure – per quadrant (limited to 1-2 quadrant every 1-3 years)	\$0-325
Gingival flap procedure- 1-3 teeth one per quadrant (limited to 1-2 per site every 1-3 years)	\$0-200
Occlusal adjustment (other than with an appliance or restoration)	
Complete	\$0-220
Osseous surgery (including flap entry and closure) - per quadrant, limited	
to 1-4 per quadrant, every 1-5 years	\$0-690
Clinical Crown Lengthening – Hard Tissue	\$0-255]

**Aetna Life Insurance Company  
 Comprehensive Dental Expense Insurance  
 [Schedule of Benefits]**

	<b>Copayment Amount</b>
<b>[ANESTHESIA (only when provided in conjunction with another covered procedure)]</b>	
Deep sedation/General anesthesia - first 30 minutes	\$0-565
Deep sedation/General anesthesia - each additional 15 minutes	\$0-315
Intravenous conscious sedation/Analgesia – first 30 minutes	\$0-565
Intravenous conscious sedation/Analgesia – each additional 15 minutes	\$0-315]
<b>[SPECIALTY SERVICES</b>	
<b>The following specialty services will be covered when provided by a Specialist Dentist.]</b>	
<b>[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care</b>	
Surgical removal of root tip, root recovery	\$0-325
Frenectomy	\$0-70]
<b>[PERIODONTICS</b>	
Occlusal adjustment (other than with an appliance or restoration)	
Limited	\$0-75
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	\$0-600
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	\$0-400]

<i>SERFF Tracking Number:</i>	<i>AENX-126102146</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42053</i>
<i>Company Tracking Number:</i>	<i>GH AR0143601F01</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>2009 Dental</i>		
<i>Project Name/Number:</i>	<i>2009 Dental/GH AR0143601F01</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-126102146 State: Arkansas  
Filing Company: Aetna Life Insurance Company State Tracking Number: 42053  
Company Tracking Number: GH AR0143601F01  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: 2009 Dental  
Project Name/Number: 2009 Dental/GH AR0143601F01

## Supporting Document Schedules

<b>Bypassed -Name:</b>	Flesch Certification	<b>Review Status:</b>	Approved-Closed	04/08/2009
<b>Bypass Reason:</b>	not applicable to schedule of benefits			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	04/08/2009
<b>Bypass Reason:</b>	not applicable			
<b>Comments:</b>				
<b>Satisfied -Name:</b>	Transmittal Document	<b>Review Status:</b>	Approved-Closed	04/08/2009
<b>Comments:</b>				
<b>Attachment:</b>				
Transmittal Document.PDF				

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT	7700013	001	60054	06-6033492	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	GH AR0143601F01
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
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<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

<b>9. Type of Insurance</b>	H10G Group Health - Dental
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<b>10. Product Coding Matrix Filing Code</b>	H10G.000 Health - Dental
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<b>11. Submitted Documents</b>	<input type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input checked="" type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____
	<input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
	<input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____
	<b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____

12.	<b>Filing Submission Date</b>	March 27, 2009
13.	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____
14.	<b>Date of Domiciliary Approval</b>	February 25, 2009
15.	<b>Filing Description:</b>	
<p>The purpose of this filing is to support the following options for our dental products:</p> <ol style="list-style-type: none"> <li>1. A new Lifetime Individual Deductible option for our traditional expense incurred dental and preferred provider dental plans.</li> <li>2. Addition of full mouth debridement, adjunctive pre-diagnostic tests, brush biopsy, and bone grafts services for our traditional expense incurred dental, preferred provider dental; and gatekeeper dental plans.</li> <li>3. Addition of clinical crown lengthening and localized delivery of antimicrobial agents for our gatekeeper dental plans only.</li> </ol>		

16.	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>John Ciesielski</u> Title <u>Product and Regulatory Affairs Manager</u></p>		
<p>Signature <u>John W Ciesielski</u> Date <u>3/27/09</u></p>		