SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

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SAMBA Dental and Vision Plan

DMO® Dental Plan Option
PPO Dental Plan Option

Summary Plan Description

Effective January 1, 2027

Visit our website at www.SambaPlans.com

Introduction and Plan Highlights

The SAMBA Federal Employee Benefit Association offers the Dental and Vision Plan (hereafter referred to as "Plan") which has been designed to help pay the cost of dental and vision care for you and your eligible dependents. The benefits and provisions of the Plan as of January 1, 2027, are described in this Summary Plan Description (SPD).

The Plan offers a choice between two Dental Plan Options:

OPTION 1: Dental Maintenance Organization (DMO®) Plan Option

Simply select a Primary Care Dentist who participates in the Aetna Dental Maintenance Organization (DMO®). Benefits are payable when treatment is performed by your Primary Care Dentist, with many services covered at 100%.

OPTION 2: Preferred Provider Organization (PPO) Plan Option

Featuring the Aetna PPO network dental nationwide. This is a fee-for-service plan that may provide coverage for treatment from any dentist. Plus, you get an opportunity to save on out-of-pocket expenses when you receive care from a dentist participating in the Aetna PPO network.

PLUS – Both Options Include Vision Benefits

Regardless of which Dental Plan Option you choose, Plan members receive vision care benefits. Through EyeMed Vision Care® our members have access to a nationwide network of providers to receive benefits for routine eye examinations, eye dilation, frames and lenses, or contact lenses. In addition to your covered benefits, you will be eligible to receive discount vision care services and products.

This Plan is governed by the Employment Retirement Income Security Act of 1974 ("ERISA"). Both Dental Plan Options are managed by Aetna Dental®. Vision Benefits are administered by EyeMed Vision Care®. The DMO® Dental Plan Option is underwritten by the Aetna Life Insurance Company of Hartford, Connecticut (called Aetna). SAMBA self-insures the PPO Dental Plan Option and the Plan's Vision Benefits.

The benefits and provisions described in this document may vary based upon your specific geographic service area. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this SPD. The SAMBA Dental and Vision Plan is a stand-alone program that is not obligated to comply with the Affordable Care Act's market reforms. SAMBA reserves the right to modify or terminate the Plan at any time.

The SAMBA Dental and Vision Plan is not a FEDVIP plan.

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SECTION 1 – Dental and Vision Plan

Enrollment and Eligibility

Applications for coverage are available on SAMBA's website at ***www.SambaPlans.com*** or may be requested from the SAMBA office by calling **(800) 638-6589**.

The SAMBA Dental and Vision Plan is an employee organization benefit which is available exclusively to permanent full-time or part-time employees of a SAMBA eligible employing agency or who are retired from a SAMBA eligible employing agency under any established retirement program. For purposes of this section, the term "SAMBA eligible employing agency" means any branch, department, or agency of the United States Government, including, without limitation, the U.S. Postal Service, the U.S. Courts, and SAMBA.

You may request enrollment in the SAMBA Dental and Vision Plan at any time throughout the year, however, applications for enrollment received after October 1 of any given year will not be effective until at least January of the following year (see "When Coverage Begins" on page 2). To request coverage, complete the SAMBA Dental and Vision Plan Enrollment Form and submit it to SAMBA.

Note: No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee. Additionally, if previously enrolled in the Plan and coverage was terminated for any reason, there is a 24-month waiting period to become eligible to re-enroll (see **"Termination of Coverage"** on page 3).

Your eligible dependents may be enrolled only if you are enrolled in this Plan. Eligible dependents under the Plan consist of your legal spouse and your unmarried dependent child(ren) who are under age 26.*

Under the Plan, an eligible dependent "child" means a member's **unmarried** recognized: 1) natural child; 2) stepchild; or 3) legally adopted child. The Plan will recognize a child as: 1) natural if the birth certificate names the member as one of the parents or if the member produces an affidavit of parenthood that conforms with applicable local law; 2) stepchild, if a child of your spouse lives with you in a regular parent-child relationship; or 3) adopted, provided the member has legally adopted the child in accordance with applicable law.

A child is deemed legally "dependent" on a member for purposes of coverage only if: 1) the child lives with the employee in a regular parent-child relationship; 2) the employee makes regular and substantial contributions to support the child; or 3) the child is the subject of a qualified medical child support order obligating the employee, although a non-custodial parent, to provide health insurance coverage for the child.

For the purpose of 2) above, listed are examples of proof of regular and substantial support. The Plan Administrator may require more than one of the following as proof of support:

- Evidence of eligibility as a dependent child for benefits under State or Federal programs;
- Proof of inclusion of the child as a dependent on your income tax returns;
- Canceled checks, money orders, or receipts for periodic payments from you for or on behalf of the child; or
- Evidence of goods or services which show regular and substantial contributions of considerable value.

For the purpose of 3) above, the Plan will issue benefits directly to either the child or the child's custodial parent or legal guardian.

Note: *Children are no longer eligible under your coverage upon marriage or attainment of age 26. However, dependent children older than age 26 incapable of self-support as defined under a Federal Employees Health Benefit Program ("FEHBP") are eligible for Self Only coverage provided you are enrolled under the SAMBA Dental and Vision Plan.

Upon Enrollment

Upon enrollment, you must choose from one of the two Dental Plan Options — the DMO® Plan or the PPO Dental Plan — and indicate which coverage level you are selecting (Self Only, Self + One, or Self + Family). Additionally, if you are choosing the DMO® Plan you must elect a Primary Care Dentist for each family member enrolling in the Plan. If the DMO® Plan is not currently offered in your area of residency, you are only eligible to enroll in the PPO Dental Plan. You may contact the DMO® Member Hotline at **(800) 843-3661** to obtain the status of the DMO® Plan for your service area.

When Coverage Begins

You will receive a confirmation letter advising you of your effective date in the Dental and Vision Plan Option you choose. Additional material will be sent after your application is processed.

If you are enrolling in the PPO Dental Plan Option, coverage will generally be effective the first day of the following month after your completed enrollment form is received in the SAMBA office.

If you are enrolling in the DMO® Plan Option, your completed enrollment form must be received in the SAMBA office by the 10th day of the month for coverage to be effective the first day of the following month. Enrollment forms received after the 10th day of any month may have a two-month delay before coverage under this Option is in effect.

Note: Applications for enrollment received during the months of October through December will not be activated prior to January 1 of any given year.

Your dependent's coverage will begin on the later of:

- Your eligibility date; or
- The date the dependent first becomes an eligible dependent.

Your Contribution

You are responsible for paying the full premium contributions for you and your dependents' coverage. The current cost of the Plan is provided under separate cover. *SAMBA reserves the right to adjust the member contribution based primarily on the Plan's experience.* Should the Plan require an adjustment in the premium, the member will be notified 30 days in advance of such adjustment. Notification will be sent by U.S. mail to the Plan member's current address on record.

Change in Family Status

If you enrolled under Self + One or Self + Family coverage and have a change in "family status," you must notify SAMBA of such change within 30 days. The following events are considered as a change in "family status:"

- Marriage, divorce, or legal separation
- Birth or adoption of a child, or a change in custody ruling
- Death of a dependent
- Loss of a dependent's eligibility for coverage

Changing Plans

You may request an enrollment change from one dental plan option to another at any time. See "When Coverage Begins" (above) for when your new coverage option will take effect. *In the event you have the DMO® Plan and your provider opts out of this coverage, you must notify SAMBA in writing to request a change to the PPO Dental Plan. When SAMBA is notified by Aetna that DMO® Plan coverage is no longer available statewide, SAMBA will notify our members (at least 30 days prior to the event) and automatically transfer their coverage into the PPO Plan option.*

Note: Changes from one plan option to another must be received in writing by SAMBA and cannot be accepted telephonically by SAMBA or Aetna.

Coordination of Benefits

The purpose of a group health care program is to help you pay for covered expenses, but not to result in total benefits greater than the covered expenses incurred. Therefore, the dental or vision benefits that, without these rules, would be payable for you or your covered dependents' health care expenses may be reduced so that the total benefits from this and any other group plan will not be more than the total allowable expenses. For the coverage described in this brochure, allowable expenses are the reasonable and customary charges for a service or supply that are covered, at least in part, by one or more health, dental, or vision plans covering the patient receiving the treatment. When a plan provides benefits in the form of services, the cash value for each service rendered will be considered both an allowable expense and a benefit paid.

The following rules are used to determine which plan is primary (the plan that determines benefits first) and which plan is secondary:

- **Employee or Spouse:** the plan that covers the patient as an employee is primary.
- **Dependent Children:**

  (a) Parents not separated or divorced: If a child is covered as a dependent by both parents' coverage, the plan of the parent whose birthday falls earlier in the year is considered primary (month and day).

  (b) Parents are separated or divorced: If a child is covered as a dependent by two or more programs of separated or divorced parents, benefits are determined in this order:

  First: the plan of the parent with custody of the child

  Second: the plan of the spouse, if applicable, of the parent with custody of the child

  Third: the plan of the parent that does not have custody of the child

  (c) If one of the plans does not have a Coordination of Benefits provision, the plan without a Coordination of Benefits provision will always be primary.

  (d) If none of the above rules determine the order of benefits, the plan that covered the person the longest period of time is primary.

Note: DMO® coverage plans in New Jersey and Texas do not have a Coordination of Benefits provision. Therefore, DMO® coverage is always primary in these two states.

Termination of Coverage

Your coverage will terminate under this Plan on the earliest of any of the following dates:

- If enrolled in the DMO® Plan Option – the last day of the month in which we receive your written request for voluntary termination provided your request is received in the SAMBA office by the 10th of the month (or the 2nd pay period after we receive your request if paying through payroll allotment).

  Note: DMO® termination requests received after the 10th day of any month may have a two-month delay before coverage actually terminates.
- If enrolled in the PPO Dental Plan Option – the last day of the month in which we receive your written request for voluntary termination, provided your request is received in the SAMBA office by the 10th of the month (or the 2nd pay period after we receive your request if paying through payroll allotment);
- The date you cease to make the required premium payments when due;
- The date you enter active full-time military service for any country (full-time military service does not include service of one month or less). You must notify SAMBA immediately regarding your active military status;
- The date you are no longer employed by a Federal agency (does not include retirement). You must notify SAMBA immediately upon leaving employment with a Federal agency; or
- The date the Plan is terminated.

Your dependent's coverage will terminate under this Plan on the earliest of any of the following dates:

- The date your coverage terminates;
- The date your dependent enters active military service for any country (full-time military service does not include service of one month or less); or
- The date your dependent ceases to be an Eligible Dependent.

Note: It is your responsibility to notify us when you or one of your dependents loses eligibility. Notification should be received by SAMBA within 30 days of the event (whenever possible). **There will be no refund of premium if this requirement is not met.**

Termination of coverage for any reason for you or your eligible dependents restricts re-enrollment in the SAMBA Dental and Vision Plan for 24 consecutive months from the date of termination.

SECTION 2 – DMO® Plan Benefits

Overview

The DMO® Plan Option covers many of the charges incurred for the preventive and corrective dental care you and your eligible dependents receive. The DMO® Plan Option is underwritten by Aetna. Aetna has arranged for Primary Care Dentists and Specialty Dentists to furnish the services under this DMO® Plan Option.

When you enroll in the DMO® Plan Option, you and your eligible dependents will need to choose their own ***Primary Care Dentist*** **(PCD)**. To locate PCD providers in your area, call Aetna's toll-free DMO® Member Hotline at **(800) 843-3661** or visit SAMBA's website at **www.SambaPlans.com**.

You and/or your dependents may change their PCD selection by calling Aetna's toll-free DMO® Member Hotline at **(800) 843-3661**. Provided your request is placed by the 10th of the month, your change in PCD will generally take effect the first day of the following month.

Except for emergency care, services must be furnished or prescribed by your DMO® PCD to receive coverage under the Plan. For certain dental care, your PCD may prescribe care by a participating Specialty Dentist (see *Specialty Referrals* on page 15).

SAMBA has contracted with Aetna to be the underwriter and administrator of the DMO® Plan. Aetna arranges for the provision of dental care services. However, neither Aetna nor SAMBA themselves are providers of dental care services, and therefore, cannot guarantee any results or outcomes. Participating dentists and other providers are independent contractors and are neither employees nor agents of Aetna or SAMBA. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change.

Shown on the "Summary of Dental Benefits – DMO® Plan" (see below) are the eligible services along with the associated copayment amounts you pay under this DMO® Plan.

Note: Certain DMO® Plan benefits and limitations described in this booklet may vary for different service areas. All benefits and limitations are subject to the Group contract. A DMO® Plan booklet-certificate is available upon request.

Summary of Dental Benefits – DMO® Plan

CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	$0
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary care giver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral, Occlusal Image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source and dectector	$0
D0251	Extra-oral - dental radiographic image	$0
D0270	Bitewing - single radiographic image	$0

CODE	PROCEDURE	PATIENT PAYS
D0272	Bitewing - two radiographic images	$0
D0273	Bitewing - three radiographic images	$0
D0274	Bitewing - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 images	$0
D0330	Panoramic Image	$0
D0391	Interpretation of diagnostic image	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D1110	Prophylaxis - Adult	$0
D1120	Prophylaxis - Child	$0
D1206	Application of topical fluoride varnish (child)	$0
D1208	Topical application of fluoride - excluding varnish (child)	$0
D1330	Oral hygiene instruction	$0
D1351	Sealant - per tooth	$0
D1352	Preventive Resin Restoration	$0
D1353	Sealant repair - per tooth	$0
D1354	Interim caries arresting medicament application, per tooth	$0
D1355	Caries preventive medicament application - per tooth	$0
D1510	Space maintainer - fixed unilateral	$0
D1516	Space maintainer - fixed bilateral, maxillary	$0
D1517	Space maintainer - fixed bilateral, mandibular	$0
D1520	Space maintainer - removable unilateral	$0
D1526	Space maintainer - removable bilateral, maxillary	$0
D1527	Space maintainer - removable bilateral, mandibular	$0
D1551	Recement or rebond bilateral space maintainer - maxillary	$12
D1552	Recement or re-bond bilateral space maintainer - mandibular	$12
D1553	Recement or re-bond unilateral space maintainer - per quad	$6
D1556	Removal of fixed unilateral space maintainer - per quad	$6
D1557	Removal of fixed bilateral space maintainer - maxillary	$12
D1558	Removal of fixed bilateral space maintainer - mandibular	$12
D1575	Distal shoe space maintainer - fixed - unilateral	$0
D2140	Amalgam - 1 surface primary or permanent	$0
D2150	Amalgam - 2 surface primary or permanent	$0
D2160	Amalgam - 3 surface primary or permanent	$0
D2161	Amalgam - 4+ surface primary or permanent	$0
D2330	Resin-based composite 1 surface, anterior	$0
D2331	Resin-based composite 2 surface, anterior	$0
D2332	Resin-based composite 3 surface, anterior	$0
D2335	Resin-based composite 4+ surface, anterior (or involving incisal angle)	$42
D2390	Resin-based composite crown, anterior	$0

CODE	PROCEDURE	PATIENT PAYS
D2391	Resin-based composite 1 surface, posterior	$49
D2392	Resin-based composite 2 surface, posterior	$63
D2393	Resin-based composite 3 surface, posterior	$77
D2394	Resin-based composite 4+ surface, posterior	$106
D2510	Inlay - metallic 1 surface	$189
D2520	Inlay - metallic 2 surface	$189
D2530	Inlay - metallic 3 surface	$189
D2542	Onlay - metallic 2 surface	$200
D2543	Onlay - metallic 3 surface	$200
D2544	Onlay - metallic 4+ surface	$200
D2610	Inlay - porcelain/ceramic 1 surface	$189
D2620	Inlay - porcelain/ceramic 2 surface	$189
D2630	Inlay - porcelain/ceramic 3+ surface	$189
D2642	Onlay - porcelain/ceramic 2 surface	$200
D2643	Onlay - porcelain/ceramic 3 surface	$200
D2644	Onlay - porcelain/ceramic 4+ surface	$200
D2650	Inlay - composite/resin 1 surface	$189
D2651	Inlay - composite/resin 2 surface	$189
D2652	Inlay - composite/resin 3 surface	$189
D2662	Onlay - composite/resin 2 surface	$200
D2663	Onlay - composite/resin 3 surface	$200
D2664	Onlay - composite/resin 4+ surface	$200
D2710	Crown - resin-based composite, indirect	$207
D2712	Crown - 3/4 resin-based composite, indirect	$151
D2720	Crown - resin with high noble metal	$207
D2721	Crown - resin with predominantly base metal	$207
D2722	Crown - resin with noble metal	$207
D2740	Crown - porcelain/ceramic substrate	$207
D2750	Crown - porcelain fused to high noble metal	$207
D2751	Crown - porcelain fused to predominantly base metal	$207
D2752	Crown - porcelain fused to noble metal	$207
D2753	Crown - porcelain fused to titanium and titanium alloys	$207
D2780	Crown - 3/4 cast high noble metal	$207
D2781	Crown - 3/4 cast predominantly based metal	$207
D2782	Crown - 3/4 cast noble metal	$207
D2783	Crown - 3/4 porcelain/ceramic	$207
D2790	Crown - full cast high noble metal	$207
D2791	Crown - full cast predominantly base metal	$207
D2792	Crown - full cast noble metal	$207
D2794	Crown - titanium	$207
D2910	Recement inlay, onlay or partial coverage restoration	$0
D2915	Recement cast or prefab post and core	$0

CODE	PROCEDURE	PATIENT PAYS
D2920	Recement crown	$0
D2921	Reattachment of tooth fragment, incisal edge or cusp	$4
D2929	Prefab porcelain/ceramic crown - primary tooth	$0
D2930	Prefab, stainless steel crown - primary tooth	$0
D2931	Prefab, stainless steel crown - permanent tooth	$0
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$0
D2940	Placement of interim direct restoration	$0
D2950	Core buildup, including any pins	$123
D2951	Pin retention - in addition to restoration	$0
D2952	Post & core in addition to crown	$101
D2989	Excavation of a tooth resulting in the determination of non-restorability	$0
D2990	Resin infiltration of lesion	$0
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration)	$0
D3221	Pulpal debridement, primary and permanent teeth	$14
D3222	Partial pulpotomy	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$0
D3310	Root canal therapy - anterior (excluding final restoration)	$0
D3320	Root canal therapy - bicuspid (excluding final restoration)	$0
D3330	Root canal therapy - molar (excluding final restoration)	$161
D3331	Treatment of root canal obstruction, nonsurgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal root repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$110
D3347	Retreatment of previous root canal therapy - bicuspid	$110
D3348	Retreatment of previous root canal therapy - molar	$266
D3410 (1)	Apicoectomy/periradicular surgery - anterior	$0
D3421 (1)	Apicoectomy/periradicular surgery - bicuspid (first root)	$0
D3425 (1)	Apicoectomy/periradicular surgery - molar (first root)	$0
D3426 (1)	Apicoectomy/periradicular surgery - each additional root	$0
D3430 (1)	Retrograde filling - per root	$0
D3450 (1)	Root Amputation - per root	$66
D3471 (1)	Surgical repair of root resorption - anterior	$0
D3472 (1)	Surgical repair of root resorption - premolar	$0
D3473 (1)	Surgical repair of root resorption - molar	$0
D3501 (1)	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$44
D3502 (1)	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$59
D3503 (1)	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$74
D4210 (1)	Gingivectomy or bingivoplasty - 4 or more teeth - per quadrant	$91

CODE	PROCEDURE	PATIENT PAYS
D4211 (1)	Gingivectomy or bingivoplasty - 1-3 teeth - per quadrant	$39
D4212 (1)	Gingivectomy to allow access, per tooth	$13
D4240 (1)	Gingival flap procedure, including root planing - 4 or more teeth - per quadrant	$90
D4241 (1)	Gingival flap procedure, including root planing - 1-3 teeth - per quadrant	$55
D4245 (1)	Apically positioned flap	$74
D4249	Clinical crown lengthening, hard tissue	$88
D4260 (1)	Osseous surgery (including flap entry and closure) - 4 or more teeth - per quadrant	$147
D4261 (1)	Osseous surgery (including flap entry and closure) - 1-3 teeth - per quadrant	$88
D4268 (1)	Surgical revision procedure, per tooth	$59
D4270 (1)	Pedicle soft tissue graft procedure	$116
D4273 (1)	Subepithelial connective tissue graft, per tooth	$68
D4275 (1)	Soft tissue allograft	$237
D4276 (1)	Connective tissue/pedicle graft, per tooth	$112
D4277 (1)	Free soft tissue graft - first tooth	$48
D4278 (1)	Free soft tissue graft - each additional tooth	$24
D4283 (1)	Autogenous connective tissue graft	$37
D4285 (1)	Non-autogenous connective tissue graft	$130
D4341	Periodontal scaling and root planing - 4 or more teeth - per quadrant	$37
D4342	Periodontal scaling and root planing - 1-3 teeth - per quadrant	$22
D4346	Scaling in presence of generalized moderate/severe gingival inflamation - full mouth, after oral evaluation	$35
D4355	Debridement	$70
D4910	Periodontal Maintenance	$25
D4920	Unscheduled dressing change (by someone other than treating dentist)	$11
D5110 (2)	Complete denture - maxillary	$231
D5120 (2)	Complete denture - mandibular	$231
D5130	Immediate denture - maxillary	$237
D5140	Immediate denture - mandibular	$237
D5211 (2)	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$231
D5212 (2)	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$231
D5213 (2)	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$237
D5214 (2)	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$237
D5221	Immediate max partial dental - resin base (including any conventional clasps, rests and teeth)	$266
D5222	Immediate mand partial dental - resin base (including any conventional clasps, rests and teeth)	$266
D5223	Immediate max partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$273
D5224	Immediate mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$273
D5225 (2)	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$264
D5226 (2)	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$264
D5227 (2)	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$264

CODE	PROCEDURE	PATIENT PAYS
D5228 (2)	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$264
D5282 (2)	Removable unilateral partial denture - one piece cast metal (including clasps and teeth) - maxillary	$231
D5283 (2)	Removable unilateral partial denture - one piece cast metal (including clasps and teeth) - mandibular	$231
D5284 (2)	Removable unilateral partial denture - one piece flex base (including clasps and teeth) - per quad	$132
D5286 (2)	Removable unilateral partial denture - one piece resin (including clasps and teeth) – per quad	$116
D5410	Adjust complete denture - maxillary	$11
D5411	Adjust complete denture - mandibular	$11
D5421	Adjust partial denture - maxillary	$11
D5422	Adjust partial denture - mandibular	$11
D5511	Repair broken complete denture base - mandibular	$35
D5512	Repair broken complete denture base - maxillary	$35
D5520	Replace missing or broken teeth - complete denture (each tooth)	$30
D5611	Repair resin partial denture base - mandibular	$35
D5612	Repair resin partial denture base - maxillary	$35
D5621	Repair cast partial framework - mandibular	$35
D5622	Repair cast partial framework - maxillary	$35
D5630	Repair or replace broken clasp	$35
D5640	Replace broken teeth - per tooth	$30
D5650	Add tooth to existing partial denture	$35
D5660	Add clasp to existing partial denture	$33
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$110
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$110
D5710	Rebase complete maxillary denture	$110
D5711	Rebase complete mandibular denture	$110
D5720	Rebase maxillary partial denture	$110
D5721	Rebase mandibular partial denture	$110
D5725	Rebase hybrid prosthesis	$110
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (lab)	$53
D5751	Reline complete mandibular denture (lab)	$53
D5760	Reline maxillary partial denture (lab)	$53
D5761	Reline mandibular partial denture (lab)	$53
D5765	Soft liner for complete or partial removable denture - indirect	$53
D5820 (3)	Interim partial denture (maxillary)	$99
D5821 (3)	Interim partial denture (mandibular)	$99
D5850	Tissue conditioning, maxillary	$44
D5851	Tissue conditioning, mandibular	$44

CODE	PROCEDURE	PATIENT PAYS
D5876	Add metal substructure to acrylic full denture (per arch)	$35
D6010	Endosteal implant - surgical placement	$1,215
D6013	Surgical placement of mini implant	$756
D6056	Prefabricated abutment - includes placement	$440
D6058	Abutment supported porcelain/ceramic crown	$207
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$207
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$207
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$207
D6062	Abutment supported cast metal crown (high noble metal)	$207
D6063	Abutment supported cast metal crown (predominantly base metal)	$207
D6064	Abutment supported cast metal crown (noble metal)	$207
D6065	Implant supported porcelain/ceramic crown	$207
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy or high noble)	$207
D6067	Implant supported metal crown (titanium, titanium alloy or high noble metal)	$207
D6068	Abutment supported retainer for porcelain/ceramic FPD	$207
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$207
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$207
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$207
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$207
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$207
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$207
D6075	Implant supported retainer for ceramic FPD	$207
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$207
D6077	Implant supported retainer for FPD - high noble alloys	$207
D6080	Implant maintenance procedures	$88
D6081	Scaling/debridement in presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$11
D6082	Implant sup crown - porcelain/ predominantly base alloys	$207
D6083	Implant sup crown - porcelain fused to noble alloys	$207
D6084	Implant sup crown - porcelain/titanium and titanium alloys	$207
D6086	Implant sup crown - predominantly base alloys	$207
D6087	Implant sup crown - noble alloys	$207
D6088	Implant sup crown - titanium and titanium alloys	$207
D6094	Abutment supported crown - Titanium	$207
D6097	Abutment sup crown - porcelain/titanium and titanium alloys	$207
D6098	Implant sup retainer - porcelain/predominantly base alloys	$207
D6099	Implant sup retainer for FPD - porcelain/noble alloys	$207
D6110	Implant abut sup removable dent-max	$231
D6111	Implant abut sup removable dent-mand	$231
D6112	Implant abut sup removable dent-max	$231
D6113	Implant abut sup removable dent-mand	$231
D6114	Implant abut sup fixed dent-max	$231
D6115	Implant abut sup fixed dent-mand	$231

CODE	PROCEDURE	PATIENT PAYS
D6116	Implant abut sup fixed dent-max	$231
D6117	Implant abut sup fixed dent-mand	$231
D6120	Abutment sup retainer - porcelain/titanium and titanium alloys	$207
D6121	Implant sup retainer for metal FPD - predominantly base alloys	$207
D6122	Implant sup retainer for metal FPD - noble alloys	$207
D6123	Abutment sup retainer for metal FPD - titanium and titanium alloys	$207
D6195	Abutment sup retainer - porcelain/titanium and titanium alloys	$207
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$49
D6205	Pontic - indirect resin based composite	$207
D6210	Pontic - cast high noble metal	$207
D6211	Pontic - cast predominantly base metal	$207
D6212	Pontic - cast noble metal	$207
D6214	Pontic - titanium	$207
D6240	Pontic - porcelain fused to high noble metal	$207
D6241	Pontic - porcelain fused to predominantly base metal	$207
D6242	Pontic - porcelain fused to noble metal	$207
D6243	Pontic - porcelain fused to titanium and titanium alloys	$207
D6245	Pontic - porcelain/ceramic	$207
D6250	Pontic - resin with high noble metal	$207
D6251	Pontic - resin with predominantly base metal	$207
D6252	Pontic - resin with noble metal	$207
D6545	Retainer - cast metal for resin-bonded fixed prosthesis	$189
D6548	Retainer - porcelain/ceramic for resin-bonded fixed prosthesis	$189
D6549	Resin retainer - resin bonded prosthesis	$104
D6600	Inlay - porcelain/ceramic, 2 surface	$189
D6601	Inlay - porcelain/ceramic, 3+ surface	$189
D6602	Inlay - cast high noble metal, 2 surface	$210
D6603	Inlay - cast high noble metal, 3+ surface	$210
D6604	Inlay - cast predominantly base metal, 2 surface	$189
D6605	Inlay - cast predominantly base metal, 3+ surface	$189
D6606	Inlay - cast noble metal, 2 surface	$210
D6607	Inlay - cast noble metal, 3+ surface	$210
D6608	Onlay - porcelain/ceramic, 2 Surface	$200
D6609	Onlay - porcelain/ceramic, 3+ surface	$200
D6610	Onlay - cast high noble metal, 2 surface	$221
D6611	Onlay - cast high noble metal, 3+ surface	$221
D6612	Onlay - cast predominantly base metal, 2 surface	$200
D6613	Onlay - cast predominantly base metal, 3+ surface	$200
D6614	Onlay - cast noble metal, 2 surface	$221
D6615	Onlay - cast noble metal, 3+ surface	$221
D6624	Inlay - titanium	$210
D6634	Onlay - titanium	$221

CODE	PROCEDURE	PATIENT PAYS
D6710	Crown - indirect resin based composite	$207
D6720	Crown - resin with high noble metal	$207
D6721	Crown - resin with predominantly base metal	$207
D6722	Crown - resin with noble metal	$207
D6740	Crown - porcelain/ceramic	$207
D6750	Crown - porcelain fused to high noble metal	$207
D6751	Crown - porcelain fused to predominantly base metal	$207
D6752	Crown - porcelain fused to noble metal	$207
D6753	Crown - porcelain fused to titanium and titanium alloys	$207
D6780	Crown - 3/4 cast high noble metal	$207
D6781	Crown - 3/4 cast predominantly base metal	$207
D6782	Crown - 3/4 cast noble metal	$207
D6783	Crown - 3/4 porcelain/ceramic	$207
D6784	Crown 3/4 - titanium and titanium alloys	$207
D6790	Crown - full cast high noble metal	$207
D6791	Crown - full cast predominantly base metal	$207
D6792	Crown - full cast noble metal	$207
D6794	Crown - titanium	$207
D6930	Recement fixed partial denture	$20
D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210 (1)	Surgical removal of erupted tooth	$0
D7220 (1)	Removal of impacted tooth - soft tissue	$0
D7230 (1)	Removal of impacted tooth - partially bony	$55
D7240 (1)	Removal of impacted tooth - completely bony	$85
D7241 (1)	Removal of impacted tooth - completely bony, with unusual surgical complications	$85
D7250 (1)	Surgical removal of residual tooth roots	$16
D7251	Coronectomy - intentional partial tooth removal	$39
D7280 (1)	Surgical access of unerupted tooth	$27
D7282 (1)	Mobilization of erupted or malpositioned tooth to aid eruption	$33
D7283	Placement of device to facilitate eruption of impacted tooth	$7
D7284 (1)	Excisional biopsy of minor salivary glands	$83
D7285 (1)	Biopsy of oral tissue - hard (bone, tooth)	$55
D7286 (1)	Biopsy of oral tissue - soft	$55
D7287 (1)	Cytological sample collection	$28
D7310 (1)	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces – per quadrant	$20
D7311 (1)	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces – per quadrant	$10
D7320 (1)	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces – per quadrant	$28
D7321 (1)	Alveoloplasty not in conjunction with extractions - 1-3 teeth or tooth spaces – per quadrant	$14
D7510 (1)	Incision and drainage of abcess - intraoral soft tissue	$22
D7511 (1)	Incision and drainage of abcess - intraoral soft tissue - complicated	$24

CODE	PROCEDURE	PATIENT PAYS
D7961 (1)	Buccal / labial frenectomy (frenulectomy)	$26
D7962 (1)	Lingual frenectomy (frenulectomy)	$26
D7963 (1)	Frenuloplasty	$28
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$11
D9222	Deep sedation/general anesthesia - first 15 minutes	$109
D9223	Deep sedation/general anesthesia - each 15 minute increment	$87
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	$125
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof	$100
D9239	Intravenous conscious sedation/analgesia - first 15 minutes	$109
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	$87
D9246	Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof	$65
D9247	Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof	$52
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9311	Consultation with a medical health care professional	$0
D9932	Denture cleaning and inspection of removable complete denture, maxillary	$25
D9933	Denture cleaning and inspection of removable complete denture, mandibular	$25
D9934	Denture cleaning and inspection of removable partial denture, maxillary	$25
D9935	Denture cleaning and inspection of removable partial denture, mandibular	$25
D9936	Cleaning and inspection of occlusal guard - per appliance	$15
D9942	Repair and/or reline of occlusal guard	$18
D9943	Occlusal guard adjustment	$19
D9944	Occlusal guard - hard appliance, full arch	$173
D9945	Occlusal guard - soft appliance, full arch	$150
D9946	Occlusal guard - hard appliance, partial arch	$90
D9951	Occlusal adjustment - limited	$35
D9952	Occlusal adjustment - complete	$96
	Additional charge per unit for full mouth rehabilitation	$125
Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.		
Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost for gold/high noble metal.		
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.		
(2) Includes relines, adjustments, rebases within the 1st six months.		
Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.		
(3) Eligible on Anterior Teeth only.		
Services may be subject to age and frequency limitations. See your booklet for details.		
ORTHODONTICS		
Comprehensive Orthodontic Treatment - Includes exam, records, retention, and appliance		
	Adolescent - excludes transitional dentition	$2,000
	Adult - excludes transitional dentition	$2,000

Note: Dental codes are subject to change throughout the year

Eligible Charges

A charge is eligible under the DMO® Plan if **all** of these conditions are met:

- Services are performed by your participating DMO® Dentist; by a Participating Specialist Dentist for a dental condition requiring specialized care if the care is not available from the person's Primary Care Dentist and if the Primary Care Dentist has referred the covered person to the Participating Specialist Dentist, and provided Aetna approves coverage for the treatment; or by a Participating Specialist Dentist for orthodontic treatment;
- It is for a dental service furnished to you or your eligible dependent;
- The dental service is described in the "Summary of Dental Benefits – DMO® Plan;"
- The person receiving treatment is covered by the DMO® Plan when the charge is incurred. A charge is considered incurred on the date the service is furnished;
- The service is not excluded under the Plan, see "Exclusions" on page 18; and
- If, while enrolled in the DMO® Plan, you incur dental charges with a non-participating dentist for other than emergency dental care, a limited benefit may apply depending on the state in which you live. For specific information about non-participating benefits and whether they apply to you, call the DMO® Member Hotline at **(800) 843-3661**.

Emergency Dental Care under the DMO® Plan

DMO® Plan participating dentists will arrange for treatment of your dental emergencies at the DMO® Plan level of benefits. But, if the emergency occurs more than 50 miles from home, you have limited coverage for certain treatment by a non-participating dentist. (*Subject to state requirements. Out-of-area emergency dental care may be reviewed by Aetna.)* The services must be needed to relieve pain or prevent the worsening of a condition that would be caused by delay of treatment. Due to state variations, out-of-area emergency care reimbursement may vary. Covered persons should contact the DMO® Member Hotline at **(800) 843-3661** and speak with a Member Service Representative for specific information on emergency treatment.

Extension of Benefits

The protection of a person receiving treatment under the DMO® Plan will be extended for certain charges incurred in the 30 days after the date the person ceases to be a covered person. These are charges to complete a dental service begun while the person was covered by the DMO® Plan. They include, but are not limited to: 1) an appliance, or modification of an appliance, for which an impression was taken while the person was covered; and 2) a crown, bridge, or gold restoration for which the tooth was prepared while the person was covered.

If you or your dependent are totally disabled *(see "Definitions and Terms You Should Know" on page 36)* when your DMO® coverage ceases, benefits will be available for the individual while they continue to be totally disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received including those delivered and installed prior to the end of that 12-month period. Dental benefits will cease when the person becomes covered under any group plan with like benefits.

Specialty Referrals

Under the DMO® dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.

DMO® members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Aetna has opened direct access for DMO® members to orthodontic services.

Plan Coverage Rules

Alternate Treatment Rule: Many dental conditions can be properly treated in more than one way. The DMO® Plan is designed to help pay dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care. Thus, if a condition is being treated for which two or more services included in the applicable *"Summary of Dental Benefits – DMO® Plan"* are suitable under customary dental practices, the benefit payment will be based on the listed services that, according to a determination made by Aetna for the DMO® Plan, would produce a professionally satisfactory result.

Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- the service must be listed on the Summary of Dental Benefits – DMO® Plan;
- the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- the copayment for the approved less costly service; plus
- the difference in cost between the approved less costly service and the more costly covered service.

Replacement Rule: The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.
- The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are:

- needed to replace one or more natural teeth that were removed while this policy was in force for the covered person;
- not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years; and
- not replacements for missing teeth, including congenital defects, prior to effective date of coverage.

Special Provisions for Orthodontic Treatments

Coverage for orthodontic treatment is limited to those services and supplies listed on the "Summary of Dental Benefits – DMO® Plan" *Orthodontics* (see page 14).

Aetna has arranged for Participating Specialist Dentists to furnish the Orthodontic Procedures.

Comprehensive orthodontic treatment is limited to a lifetime maximum of:

- One full course of active, usual and customary orthodontic treatment, plus post-treatment retention.

Coverage for services and supplies is **not provided** for any of the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition; or
- Lingually placed direct bonded appliances and arch wires (i.e., “invisible braces”).

If an eligible person obtains orthodontic treatment under the comprehensive orthodontic treatment coverage, the following limitation will apply:

- A full course of comprehensive orthodontic treatment received under the comprehensive orthodontic treatment coverage would apply toward the lifetime maximum for comprehensive orthodontic treatment under the Plan.

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the eligible person became covered for the benefits.

Plan Limitations and Other Clarifications

Diagnostic

- Oral exam (limited to 2 routine/preventive and 2 problem focused exams per calendar year)
- Bitewing x-rays (limited to 2 sets per calendar year)
- Panoramic x-ray (considered an entire denture series; limited to 1 set every 3 years)

Preventive

- Prophylaxis (limited to 2 treatments per calendar year, including scaling and polishing)
- Topical application of fluoride (limited to 1 treatment per calendar year to children under age 18)
- Sealants (limited to once per tooth every 3 calendar years, permanent molars only)

Periodontics

- Scaling and root planing (limited to 4 separate quadrants per calendar year)
- Subgingival curettage (limited to 4 separate quadrants per calendar year)

Space Maintainers

- Includes all adjustments within 6 months after installation

Endodontics

- Includes local anesthetics, where necessary

Oral Surgery

- Includes local anesthetics, where necessary, and post-operative care

Exclusions

The DMO® Plan does not cover charges for the following:

- Services which are not necessary or not customarily performed for dental care;
- Services and supplies listed as *not provided for* under the "Special Provisions for Orthodontic Treatments" (see page 16);
- Anything not furnished by a dentist, except x-rays ordered by a dentist and services by a licensed dental hygienist under the dentist's supervision;
- An appliance, or modification of an appliance, or service where an impression was made before the patient was covered; a crown, bridge or restoration for which the tooth was prepared before the patient was covered or root canal therapy if the pulp chamber was opened before the patient was covered;
- Services for the treatment of problems of the jaw joint, including a) temporomandibular joint syndrome; b) craniomandibular disorders; or c) other conditions of the joint linking the jaw bone and skull, and of the complex muscles, nerves and other tissues related to that joint;
- A restoration or crown, unless a) it is treatment for decay or traumatic injury and teeth that cannot be restored with a filling material; or b) the tooth is an abutment to a covered partial denture or fixed bridge;
- A crown, restoration, denture or fixed bridge (or addition of teeth to one) if the work involves a replacement or modification of a crown, restoration, denture or bridge installed less than five years before;
- A denture, removable or fixed bridge, or other prosthetic service involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered and such tooth was not an abutment for a denture, removable bridge or fixed bridge installed during the preceding five years;
- Services for cosmetic purposes except to the extent needed to repair an injury. Facings on molar crowns and pontics are always considered cosmetic;
- Replacement of lost, missing or stolen appliances or replacement of appliances that have been damaged due to abuse, misuse or neglect;
- Appliances, restorations, and procedures to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion;
- Services due to a) an injury arising out of, or in the course of, any employment for wage or profit; or b) disease covered, with respect to such employment, by any workers' compensation law, occupational disease law, or similar legislation;
- Broken appointments;
- Charges for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under investigation by health professionals;
- Services that are defined as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
- Services needed solely in connection with non-covered services.
- Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth and;
- Any portion of a charge for a service in excess of the usual and prevailing charge (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for dental care of a comparable nature, by a person of similar training and experience).

Plan exclusions will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.

SECTION 3 – PPO Dental Plan Benefits

Overview

The PPO Dental Plan Option is a fee-for-service plan that SAMBA self-insures. SAMBA has contracted with Aetna to manage the Plan's benefits. Aetna arranges for the provision of dental care services. However, neither Aetna nor SAMBA themselves are providers of dental care services, and therefore, cannot guarantee any dental results or outcomes. Participating dentists and other providers are independent contractors and are neither employees nor agents of Aetna or SAMBA. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change.

Under the PPO Dental Plan, you have your choice of dentists including any of the providers participating in the **Aetna Dental PPO Network**. The Aetna Dental PPO is a network of licensed dentists who have agreed to provide dental care to covered individuals at discounted fees. In-Network benefits will apply when you use a PPO provider. For more information regarding the Aetna Dental PPO or to locate a participating provider, call **(800) 445-2283** or visit **www.SambaPlans.com**.

The PPO Dental Plan has four coverage types: Preventive Services (Class A), Basic Services (Class B), Major Services (Class C), and Orthodontic Services (Class D). The Plan deductibles, waiting periods, maximums, services, and the benefit percentages of eligible charges are shown below.

Important Things to Know About the PPO Dental Plan Benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for In-Network PPO services.
- The Plan includes a calendar year deductible for Out-of-Network services that must be satisfied before the Plan will pay Class B and Class C services. The Out-of-Network calendar year deductible is $50 per person, $150 per family.
- There is no annual benefit maximum for In-Network services. Class A, Class B, and Class C Out-of-Network services are subject to a $2,500 annual maximum per covered person.
- Orthodontic services have a lifetime benefit maximum of $3,000 In-Network or $1,500 Out-of-Network, per covered person.
- There is a six-month waiting period for Major Services (Class C) (see "Waiting Period" definition on page 36).
- There is a 12-month waiting period for Orthodontic Services (Class D) (see "Waiting Period" definition on page 36).
- In-Network Services – You pay the coinsurance percentage of the PPO network allowance for covered services. You are not responsible for charges above that allowance.
- Out-of-Network Services – If the dentist you use is not part of the PPO network, benefits will be considered out-of-network. Because these providers are not part of our network, we pay for these services based on an out-of-network Plan allowance. You are responsible for the difference between the out-of-network Plan allowance and the billed amount.

List of Dental Services – PPO Dental Plan

The lists on the following pages illustrate services covered, the percentage you will pay for eligible charges, when the calendar year deductible applies, and when there is a waiting period. The list is divided into coverage type: **Preventive Services (Class A)**, **Basic Services (Class B)**, **Major Services (Class C)**, and **Orthodontic Services (Class D)**.

Preventive Services (Class A)

Important things you should keep in mind about these benefits:

- **There is no deductible**
- **You Pay:**
  - **In-Network: 0% of eligible charges**
  - **Out-of-Network: 30% of eligible charges up to the Plan allowance, plus any difference between the Plan allowance and the billed amount**

Visits, Exams, X-rays and Pathology

- Routine/preventive exam (limited to 2 per calendar year)
- Problem focused exam (limited to 2 per calendar year)
- Full mouth x-ray (limited to 1 every three calendar years)
- Bitewings (limited to 2 sets per calendar year)
- Panoramic x-ray (considered an entire denture series; limited to 1 set every 3 years)
- Prophylaxis (limited to 3 treatments In-Network or 2 treatments Out-of-Network per calendar year, including scaling and polishing)
- Topical application of fluoride (limited to 1 treatment per calendar year to children under age 18)
- Periodontal maintenance (limited to 2 treatments per calendar year)

Basic Services (Class B)

Important things you should keep in mind about these benefits:

- **There is no deductible for In-Network services**
- **There is a calendar year deductible of $50 per person ($150 per family) for Out-of-Network services**
- **You Pay:**
  - **In-Network: 30% of eligible charges**
  - **Out-of-Network: 40% of eligible charges up to the Plan allowance, plus any difference between the Plan allowance and the billed amount**

Visits, Exams, X-rays and Pathology

- Intra-oral x-ray
- Occlusal x-ray
- Extra-oral x-ray – single film
- Extra-oral x-ray – each additional film
- Facial x-ray
- Diagnostic casts

Basic Services (Class B) – *continued*

Visits, Exams, X-rays and Pathology *(continued)*

- Microscopic exam
- Palliative (emergency) treatment of dental pain, minor procedures
- Consultation by a specialist
- House call
- Office visit, during regularly scheduled office hours (no operative services performed)
- Office visit, after regularly scheduled office hours

Space Maintainers *(Includes all adjustments within 6 months after installation)*

- Fixed – unilateral type
- Fixed – bilateral type
- Removable – unilateral type
- Removable – bilateral type
- Recementation of space maintainer
- Appliance for minor treatment to control harmful habits (fixed or removable)

Amalgam Restorations *(Excludes inlays, crowns (other than stainless steel) and bridges. Multiple restorations on one surface will be considered as a single restoration.)*

- Amalgam – deciduous (one or more surfaces)
- Amalgam – permanent (one or more surfaces)
- Pin retention – per tooth

Synthetic Restorations *(Excludes inlays, crowns (other than stainless steel) and bridges. Multiple restorations on one surface will be considered as a single restoration.)*

- Silicate cement (per restoration)
- Composite resin one – three surfaces
- Pin retention – per tooth
- Composite resin involving incisal angle

Crown Restorations

- Stainless steel (when teeth cannot be restored with a filling material)
- Recement inlays
- Recement crowns
- Fillings (sedative)

Endodontics

- Root canal therapy (devitalized teeth only, including x-rays and cultures but excluding final restoration) – single rooted, bi-rooted, or tri-rooted
- Apicoectomy
- Pulp cap – direct (excluding final restoration)

Basic Services (Class B) – *continued*

Endodontics *(continued)*

- Pulp cap – indirect (excluding final restoration)
- Retrograde filling
- Rubber dam isolation

Periodontics

- Subgingival curettage or root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants per calendar year
- Gingivectomy (including post-surgical visits) per quadrant
- Gingivectomy (treatment per tooth – fewer than five teeth)
- Osseous surgery (including post-surgical visits)
- Occlusal adjustment (limited) – related to periodontal surgery
- Occlusal adjustment (complete) – related to periodontal surgery
- Special period device – related to bruxism
- Crown lengthening
- Guided tissue regeneration
- Chemotherapy agent

Repairs to Dentures

- Repair broken complete or partial denture
- Adding tooth to partial denture to replace extracted tooth
- Replace additional teeth

Other Prosthetic Services

- Recement bridge

Oral Surgery

- Simple extractions
- Surgical removal of erupted teeth
- Removal of impacted teeth
- Alveolectomy (edentulous) per quadrant
- Alveolectomy (in addition to removal of teeth) per quadrant
- Alveoplasty with ridge extension, per arch
- Removal of exostosis
- Excision of hyperplastic tissue, per arch
- Incision and drainage of abscesses
- Removal of odontogenic cyst or tumor
- Sialolithotomy – removal of salivary calculus
- Tooth transplantation
- Frenectomy

Basic Services (Class B) – *continued*

Anesthetics

- General anesthesia and intravenous sedation, only when provided in conjunction with a surgical procedure.
- Local anesthesia not in conjunction with a surgical procedure.
- Analgesia (includes nitrous oxide)

Major Services (Class C)

Important things you should keep in mind about these benefits:

- **There is no deductible for In-Network services**
- **There is a calendar year deductible of $50 per person ($150 per family) for Out-of-Network services**
- **The Plan's six-month waiting period for Major Services (Class C) may apply** (see "Waiting Period" definition on page 36)**.**
- **You Pay:**
  - **In-Network: 50% of eligible charges**
  - **Out-of-Network: 50% of eligible charges up to the Plan allowance, plus any difference between the Plan allowance and the billed amount**

Inlay Restorations

- Inlay – one surface
- Inlay – two surfaces
- Inlay – three surfaces
- Onlay per tooth

Crown Restorations

- Plastic (acrylic)
- Plastic with gold
- Plastic with nonprecious metal
- Plastic with semiprecious metal
- Porcelain
- Porcelain with gold
- Porcelain with nonprecious metal
- Porcelain with semiprecious metal
- Gold (full cast)
- Nonprecious metal (full cast)
- Semi-precious metal (full cast)
- Gold (3/4 cast)

Major Services (Class C) – *continued*

Crown Restorations *(continued)*

- Cast post and core in addition to crown
- Steel post and composite or amalgam in addition to crown
- Crown buildups – including pins
- Labial veneer

Implant Services

- Surgical placement of implant body and related services

Complete Dentures *(Allowance includes 6 months post-delivery care. Specialized techniques are not covered.)*

- Complete upper denture
- Complete lower denture
- Immediate upper denture
- Immediate lower denture

Partial Dentures *(Allowance includes up to and including 10 units, teeth or clasps, and 6 months post-delivery care.)*

- Upper or lower – with bar and two clasps, acrylic or cast base
- Removable unilateral partial denture – one piece casting, gold or chrome, clasp attachments, per unit including pontics
- Each additional clasp with rest
- Each additional tooth
- Denture adjustment

Denture Rebasing and Relining *(Covered if more than 6 months after installation)*

- Rebasing of upper or lower denture, partial or complete
- Relining denture (office reline)
- Laboratory reline denture

Other Prosthetic Services

- Stress breaker
- Denture, partial or stay plate
- Tissue conditioning

Bridge Pontics

- Cast gold
- Cast nonprecious metal
- Cast semiprecious metal
- Porcelain fused to gold

Major Services (Class C) – *continued*

Bridge Pontics *(continued)*

- Porcelain fused to nonprecious metal
- Porcelain fused to semiprecious metal
- Plastic processed to gold
- Plastic processed to nonprecious metal
- Plastic processed to semiprecious metal

Abutment Inlays

- Inlay – 2 surfaces
- Inlay – 3 or more surfaces
- Cast metal retainer

Abutment Crowns

- Plastic processed to gold
- Plastic processed to nonprecious metal
- Plastic processed to semiprecious metal
- Porcelain fused to gold
- Porcelain fused to nonprecious metal
- Porcelain fused to semiprecious metal
- Gold (3/4 cast)
- Gold (full cast)
- Nonprecious metal (full cast)
- Semi-precious metal (full cast)

Orthodontic Services (Class D)

Important things you should keep in mind about these benefits:

- **There is no deductible**
- **There is a lifetime maximum of $3,000 In-Network or $1,500 Out-of-Network for orthodontic services.**
- **The Plan's 12-month waiting period for Orthodontic Services (Class D) may apply** (see "Waiting Period" definition on page 36)**.**
- **You Pay:**
  - **In-Network: 50% of eligible charges and all charges in excess of the $3,000 benefit limit**
  - **Out-of-Network: 50% of eligible charges up to the Plan allowance, plus any difference between the Plan allowance and the billed amount and all charges in excess of the $1,500 benefit limit**

Orthodontics

- Comprehensive orthodontic treatment
- Post treatment stabilization
- Interceptive orthodontic treatment
- Limited orthodontic treatment

Eligible Charges

An “eligible charge” under the PPO Dental Plan is a charge made by the dentist for treatment furnished to you or your eligible dependents, provided the service:

- Is in the “List of Dental Services – PPO Dental Plan”
- Is part of an approved “Treatment Plan” which is described below
- Is not excluded under the Program, see “Exclusions” under the PPO Dental Plan” on page 29.

An expense will be considered an incurred eligible charge:

- For an appliance or modification of an appliance – on the date the impression is taken.
- For a crown, bridge, or gold restoration – on the date the tooth is prepared.
- For root canal therapy – on the date the pulp chamber is opened.
- For all other services – on the date the service is received.

Annual and Lifetime Maximum

Annual Maximum – Under the PPO Dental Plan, there is no annual maximum for In-Network benefits for you or your eligible dependents. Out-of-Network benefits are limited to $2,500 per covered person per calendar year for eligible charges under Preventive Services (Class A), Basic Services (Class B), and Major Services (Class C) combined. Once the $2,500 Out-of-Network annual maximum has been reached, no additional Out-of-Network benefits are payable for the remainder of the calendar year. In-Network benefits remain available without an annual maximum.

Lifetime Maximum – Under the PPO Dental Plan, payable benefits for Orthodontic Services are limited to a lifetime per person maximum of $3,000 In-Network or $1,500 Out-of-Network. Orthodontic benefits may not be cross applied between In-Network and Out-of-Network lifetime benefit maximums.

Predetermination of Benefits ("Treatment Plan")

You and your eligible dependents may have benefits under the PPO Dental Plan predetermined. "Predetermination of Benefits" is a process that allows an individual and their dentist to know in advance what estimated benefits would be payable under this coverage for a proposed course of treatment ("Treatment Plan").

Under Predetermination of Benefits, the dentist completes an Aetna claim form and sends it to Aetna (see "When You Have a Claim," on page 33) before any dental services are performed. The form will be reviewed by Aetna and returned to the dentist showing estimated benefits.

Aetna may request supporting preoperative x-rays or other diagnostic records in connection with predetermination of benefits. In computing the estimated benefits, Aetna may consider alternate dental services that are suitable for care of a specific condition. This will be done only if those alternate services would produce a professionally acceptable result as determined by Aetna.

Predetermination of Benefits is recommended under the PPO Dental Plan if a proposed Treatment Plan is expected to involve charges of $300 or more.

Extension of Benefits

The protection of a person receiving treatment under the PPO Dental Plan will be extended for charges incurred in 30 days after the person ceases to be a covered person for Basic Services listed under the "List of Dental Services – PPO Dental Plan," provided benefits would have been paid had the coverage remained in effect.

Plan Coverage Rules

Alternate Treatment Rule: Many dental conditions can be properly treated in more than one way. The PPO Plan is designed to help pay dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care. Thus, if a condition is being treated for which two or more services included in the applicable *"List of Dental Services – PPO Plan"* are suitable under customary dental practices, the benefit payment will be based on the listed services that, according to a determination made by Aetna for the PPO Plan, would produce a professionally satisfactory result.

Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- The service must be listed on the List of Dental Services – PPO Plan;
- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- The copayment for the approved less costly service; plus
- The difference in cost between the approved less costly service and the more costly covered service.

Replacement Rule: The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable dentures; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.
- The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are:

- needed to replace one or more natural teeth that were removed while this policy was in force for the covered person;
- not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years; and
- not replacements for missing teeth, including congenital defects, prior to effective date of coverage.

Special Provisions for Orthodontic Treatments

Coverage for orthodontic treatment is limited to those services and supplies listed on the "List of Dental Services – PPO Dental Plan" *Orthodontic Services* (see page 26).

A dentist's charges for services and supplies for orthodontic treatment are included as Covered Dental Expenses. In addition to all other terms of the dental benefit:

- The benefit rate will be the Payment Percentage for orthodontic treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. It applies even if there is a break in coverage.

Coverage for services and supplies are **not provided** for any of the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition; or
- Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces").

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became eligible for orthodontic benefits under the Plan (i.e., must be enrolled in the Plan for a 12-month period – see definition of "Waiting Period" on page 36).

Exclusions

The PPO Dental Plan does not cover charges for the following:

- Services which are not necessary or not customarily performed for dental care;
- Services and supplies listed as *not provided for* under the "Special Provisions for Orthodontic Treatments" (see page 28);
- Anything not furnished by a dentist, except x-rays ordered by a dentist and services by a licensed dental hygienist under the dentist's supervision;
- An appliance, or modification of an appliance, or service where an impression was made before the patient was covered; a crown, bridge or restoration for which the tooth was prepared before the patient was covered or root canal therapy if the pulp chamber was opened before the patient was covered;
- Services for the treatment of problems of the jaw joint, including a) temporomandibular joint syndrome; b) craniomandibular disorders; or c) other conditions of the joint linking the jaw bone and skull, and of the complex muscles, nerves and other tissues related to that joint;
- A restoration or crown, unless a) it is treatment for decay or traumatic injury and teeth that cannot be restored with a filling material; or b) the tooth is an abutment to a covered partial denture or fixed bridge;
- A restoration, crown, denture or fixed bridge (or addition of teeth to one) if the work involves a replacement or modification of a crown, restoration, denture or bridge installed less than five years before;
- A denture, removable or fixed bridge, or other prosthetic service involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered and such tooth was not an abutment for an implant, denture, removable bridge or fixed bridge installed during the preceding five years;
- Services for cosmetic purposes except to the extent needed to repair an injury. Facings on molar crowns and pontics are always considered cosmetic;
- Replacement of lost, missing, or stolen appliances or replacement of appliances that have been damaged due to abuse, misuse, or neglect;
- Appliances, restorations, and procedures to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion;
- Broken appointments;
- Completion of claim forms or filing of claims;
- Oral hygiene instruction;
- Charges for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under investigation by health professionals;
- Services that are defined as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
- Services needed solely in connection with non-covered services.
- Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth;
- Sealants under the PPO Dental Plan; and
- Any portion of a charge for a service in excess of the usual and prevailing charge (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for dental care of a comparable nature, by a person of similar training and experience).

Plan exclusions will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.

SECTION 4 – Vision Benefits

Overview

Vision benefits are provided at no additional cost to all eligible members and their eligible dependents that are enrolled in either of the Dental Plan Options available under the SAMBA Dental and Vision Plan *(i.e., DMO® or PPO Dental Plan Options)*. The Plan provides coverage for routine vision exams and procedures, along with eyeglasses and contact lenses.

You may receive services from a vision care provider of your choice. Through our association with EyeMed Vision Care®, your out-of-pocket costs will be lower when you choose an EyeMed Select Network provider. In addition to the benefits you receive for routine eye exams, eyeglasses, and/or contact lenses, in-network discounts are available on additional products and services once your maximum in-network benefits for the applicable benefit period have been used.

EyeMed Vision Care's Select Network of providers includes private practitioners and national retailers; Lenscrafters®, Target Optical, America's Best Contacts & Eyeglasses, MyEyeDr, and most Pearle Vision locations. To locate EyeMed Vision Care Select Network providers near you and to verify their continued participation, visit **www.SambaPlans.com** or call EyeMed's Customer Care Center at **866-299-1358**.

List of Vision Services and Benefits

The benefits summary chart below shows the member's out-of-pocket costs for covered in-network and out-of-network services and supplies, along with any available in-network discounts offered by the Plan.

Note: Benefits for eye exams, frames and lenses, or contact lenses are payable once per calendar year for both in-network and out-of-network services. Benefit allowances provide no remaining balance for future use within the same benefit period.

	Your In-Network Cost	Out-of-Network Reimbursement*
Exam	$10 copay	Up to $30
Dilation as necessary	$0	
Refraction	$0	
Retinal Imaging	Up to $39	N/A
Eyeglasses	$0 copay; $150 allowance for frame, lens, and lens options, plus 20% off any balance over $150	Up to $75
Additional pair	40% off a complete pair	
Contact Lenses**		
Conventional	$0 copay; $140 allowance, plus 15% off balance over $140	Up to $75
Disposable	$0 copay; $140 allowance, you pay any balance over $140	Up to $75
Medically necessary	$0 copay; paid in full by the Plan	Up to $75
Additional conventional contact lenses	15% off conventional contact lenses	
Lasik or PRK***		
from US Laser Network	15% off retail price or 5% off promotional price	N/A

Frequency of benefit limited to once per calendar year for eye exam, eyeglasses or contact lenses

*You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim form for reimbursement. You will be reimbursed up to the amount shown on the chart.

**For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes. Contact lenses are in lieu of frames and lenses.

Note: Contact lens and eyeglasses allowance are a one-time use benefit and are not a declining balance. Members are to use their full allowance at the time of initial service, as balances will not be available for future visits within the same benefit period.

***Lasik and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Please note that since Lasik and PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. Members should call (877) 5LASER6 for the nearest facility and to receive authorization for the discount.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or plan number, located on the front of your ID card. Confirm the provider is an in-network provider. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to verify your eligibility.

When you receive services at a participating EyeMed Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceed any allowances and applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses. (See the benefit summary chart on page 30.)

Using Out-of-Network Providers

If you receive services from an out-of-network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the benefit summary chart on page 30. To receive your out-of-network reimbursement, complete and sign a Vision Services Claim Form and mail it directly to EyeMed for processing. See ***When You Have a Claim*** on page 33.

Eligible Charges

An “eligible charge” is a charge made for an eye examination and/or eye dilation provided by a licensed Doctor of Ophthalmology and Optometry and eyeglass lenses and/or frames or contact lenses prescribed by a Doctor.

Exclusions

The following services and supplies are not covered under the Plan’s Vision Care Benefits:

- Orthoptics, vision training, subnormal vision aids and any associated supplemental testing;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Aniseikonic lenses;
- Corrective eyewear required by an employer as a condition of employment and safety eyewear;
- Charges for services and supplies for a work-related sickness or injury;
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount);
- Two pairs of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care;
- Services rendered after the date an insured person ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order;

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available;
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim, and Pro Design;
- Visual Display Terminal (VDT) exam;
- Applicable taxes; and
- Services and supplies not included in the "List of Vision Services and Benefits” (see page 30).

SECTION 5 – General Information

When You Have a Claim

Claims should be filed promptly. Claims should be made within 90 days after obtaining the service or as soon thereafter as reasonably possible. Failure to file on a timely basis may invalidate your claim because the Dental and Vision Plan will not pay benefits for claims submitted more than two years from the date the expense is incurred (except where the member is legally incapable).

Complete the appropriate claim form *(i.e., dental or vision).* ***See below for how to obtain claim forms and where claim forms should be sent.***

DMO® Plan Option

Under the DMO® Plan, you generally will not have to submit a claim form for dental services. **In the event of emergency dental care,** call the toll-free DMO® Member Hotline at **800-843-3661** to obtain instructions for filing your claim.

PPO Dental Plan Option

Completed "Dental Benefits Request" claim forms and pretreatment estimates should be sent directly to Aetna Dental for processing. Mail to:

Aetna Dental
Group Dental Claim Division
P.O. Box 14094
Lexington, KY 40512-4094

To obtain a "Dental Benefits Request" form, you may contact Aetna toll free at **800-445-2283**, print the form from the SAMBA website at **www.SambaPlans.com**, or call SAMBA at **800-638-6589**.

Vision Benefits

When you receive services at a participating EyeMed Network provider, the provider will file your claim for you. You will have to pay the cost of any services or eyewear that exceed any allowances or copayments. You will also owe state sales tax, if applicable, and the cost of non-covered expenses.

Should you receive vision care services from an out-of-network (OON) provider, your completed Vision Services Claim Form should be sent directly to EyeMed for processing.

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111
Fax: 866-293-7373

To obtain an OON vision claim form you may contact SAMBA toll free at **800-638-6589** or print the form from the SAMBA website at **www.SambaPlans.com**.

Claim Appeal Procedures

If you want to appeal a denied claim, you or an authorized representative must send a written appeal to the Plan no later than 180 days after the date you received the notice of denial. The request must explain the reasons why you believe the Plan's initial decision was incorrect and attach all documents which you think will help the Plan decide your appeal.

Dental claim appeals should be mailed to:

Aetna
P. O. Box 14080
Lexington KY 40512-4094
Attn: Appeals Coordinator

Vision claim appeals should be mailed to:

EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 513-492-4999

The Plan generally will decide your appeal within 60 days following its receipt, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. Upon making a decision, the Plan Administrator will send you a written decision which will explain the reasons for its decision and will refer to those provisions of the Plan on which it is based.

To help prepare the appeal, the claimant may arrange with the Plan for an opportunity to review and copy, free of charge, all relevant materials and Plan documents under the Plan's control relating to the claim, including those that involve any expert review(s) of the claim. If a written request for a review is not filed within the required 180-day period, the claimant will lose the right to a review of the denial of the claim and the Plan's initial decision will become final, binding, and conclusive.

On all timely submitted appeals, the Plan will:

- Provide a claimant the opportunity to appeal an adverse benefit determination for a full and fair review which does not afford deference to the initial adverse benefit determination;
- Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- Provide that when an adverse benefit determination is based, in whole or in part, on a medical judgment (i.e. medical necessity, experimental/investigational), the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Definitions and Terms You Should Know

Abutment: Tooth or root that retains or supports a bridge or a fixed or removable prosthesis.

Anesthesia:

Local – The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

General – The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anesthetic: A drug that produces loss of feeling or sensation either generally or locally.

Appliance: A device used to provide function or therapeutic (healing) effect.

Fixed – One that is cemented to the teeth or attached by adhesive materials.

Prosthetic – Used to provide replacement for a missing tooth.

Bitewing: Dental x-ray showing approximately the coronal (crown) halves of the upper and lower teeth.

Bridgework:

Fixed – Artificial teeth (pontics) retained with crowns or inlays cemented to the natural teeth, which are used as abutments.

Removable – A partial denture retained by attachments which permit removal of the denture. Normally held by clasps.

Calendar Year: January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Crown: The portion of a tooth covered by enamel.

Dental Hygienist: A person who has been trained and licensed by the state to perform dental cleaning under the direction of a licensed dentist to remove calcareous deposits and stains from the surfaces of the teeth, and in providing additional services and information on the prevention of oral disease.

Dentist: A person who is either: a) a licensed dentist acting within the scope of the license; or b) any other doctor furnishing dental services that the doctor is licensed to perform.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license.

Emergency Care: Dental services for palliative treatment furnished to a covered person by a dentist (other than your Primary Care Dentist or a Specialty Dentist) more than 50 miles from the covered person's home address. *The services must be needed to relieve pain or to prevent worsening of a condition that would be caused by delay.*

Fluoride: A solution of fluorine that is applied topically to the teeth for the purpose of preventing dental decay.

Impression: A negative reproduction of a given area. Example: in bridgework, an impression of a tooth (abutment) which has been prepared for an inlay or crown.

Inlay: A restoration made to fit a prepared tooth cavity and then centered into place.

Occlusal: Pertains to a closure, such as the contact between the teeth of the upper and lower jaws.

Ophthalmologist: A doctor who specializes in the diagnosis and medical and surgical treatment of diseases and defects of the eye and related structures.

Optician: A person whose services include the preparation or ordering of ophthalmic lenses based on a prescription and the furnishing of eyeglass frames and who is legally qualified to perform such services in the jurisdiction in which the services are rendered.

Optometrist: A person trained and licensed to examine and test the eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids and by establishing programs of visual training.

Onlay: An occlusal rest or restoration that is extended to cover the entire surface of the tooth.

Partial Denture: A prosthesis that replaces one or more, but less than, all of the teeth and associated structures and that is supported by the teeth and/or the gums; may be removable or fixed, one side or two sides.

Periapical: Enclosing or surrounding the tissues and bony sockets of the teeth.

Primary Care Dentist: (Under the DMO®) A dentist who has agreed with Aetna to participate in the DMO® Network and to furnish dental services to covered persons. Also, a substitute dentist arranged for by a Primary Care Dentist. A Primary Care Dentist will furnish Basic Services and some Specialty Services shown in the "Summary of Dental Benefits – DMO® Plan."

Pontic: The part of a fixed bridge which replaces a missing tooth or teeth.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or a dental hygienist.

Prosthesis: An artificial replacement of one or more natural teeth and/or associated structures.

Restoration: A broad term applied to any inlay, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth or teeth.

Root Canal Therapy: (Endodontic Therapy) Treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.

Scale: To remove calculus (tartar) and stains from teeth with special instruments.

Specialty Dentist: A dentist with a special practice who has agreed to furnish to covered persons some of the dental services which are Specialty Services in the "Summary of Dental Benefits – DMO® Plan" which applies to the DMO® Plan, **when prescribed by a Primary Care Dentist**.

Topical: Painting the surface of teeth as in fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Totally Disabled: Under the DMO® Plan, "totally disabled" means that due to injury or illness: 1) you are not able to engage in your customary occupation and are not working for pay or profit; and 2) your dependent is not able to engage in most of the normal activities of a person of like age and gender in good health.

Usual and Prevailing: A charge for a service that it is the prevailing (reasonable and customary) fee in the same area for dental care of a comparable nature. A charge that exceeds the prevailing fee for charges generally made in the area for dental care of comparable nature is above the reasonable and customary fee. The area and range are as determined by Aetna.

Waiting Period: Under the PPO Dental Plan, "waiting period" means 1) Major Services – the covered individual must be enrolled for a consecutive six-month period before coverage of Major Services begins and 2) Orthodontic Services – the covered individual must be enrolled for a consecutive 12-month period before coverage of Orthodontic Services begins.

If an eligible dependent's effective date is later than your effective date of coverage, the waiting period for the eligible dependent begins on the effective date of coverage for the eligible dependent.

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at SAMBA's office, all Plan documents filed by SAMBA with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. This examination may take place between the hours of 10:00 a.m. and 3:00 p.m., Monday through Friday, except holidays.
- Obtain copies of these Plan documents upon written request to SAMBA's Executive Director, who may request a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Board of Directors is required by law to furnish upon request, each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including an employer, SAMBA, or any other person, may discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are

steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact SAMBA's office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Employee Benefits Security Administration, U.S. Department of Labor.

Plan Information

Name of Plan: SAMBA Group Plan (the Plan). All benefit programs that SAMBA sponsors for its membership, including, without limitation, this Dental and Vision Plan, the SAMBA Health Benefit Plan, and all other insured and self-insured programs, constitute one employee welfare benefit plan within the meaning of ERISA, the federal law that governs this Plan.

Plan Sponsor: Special Agents Mutual Benefit Association (SAMBA), 11301 Old Georgetown Road, Rockville, MD 20852; (301) 984-1440 • (800) 638-6589

Employer ID Number: EIN #52-1074154

Plan Number: PN 501

Plan Administrator: The Plan is administered and maintained by SAMBA, at the address listed above *(see "Plan Sponsor")*. However, both Dental Plan options are managed by Aetna® Dental and the DMO® Dental Plan is underwritten by the Aetna Life Insurance Company of Hartford, Connecticut (called Aetna). First American Administrators, Inc./EyeMed manages the vision plan. SAMBA self-insures the PPO Dental Plan and Plan's Vision Benefits.

Type of Administration: The administration of the Dental and Vision Plan is under the supervision of the Plan Administrator (SAMBA). The duty of the Plan Administrator is to see that the provisions of the Dental and Vision Plan are carried out for the benefit of the persons entitled to participate without discrimination among participants.

Amendment or Termination of Plan: This Plan, including any program under the Plan, may be amended or terminated at any time by SAMBA. If the Plan is terminated, SAMBA may use plan assets to pay benefits outstanding as of the later of the date the termination is adopted or is effective, and Corporation expenses. Any remaining assets will be allocated by a Board of Directors' resolution that conforms with applicable law and does not adversely affect the Code Section 501(c)(9) qualified status of the Corporation. If the Plan is merged with another plan or plan assets are transferred to another plan, plan assets will be allocated according to the merger or acquisition agreement's terms.

Agent for Service of Legal Process: Corporation Guarantee & Trust Co., 1150 Connecticut Ave., N.W., Suite 900, Washington, D.C. 20036. Legal Process may also be served on the Executive Director at SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800.

Plan Year: All financial records of the Plan are kept on a fiscal year of January 1 through December 31.

Cost of Benefits and Plan Funding: Premiums for this Dental and Vision Plan are paid by you, the Plan Participants. SAMBA self-insures a portion of this Plan (see Plan Administrator above). Reserves and other funds for this Plan are held by SAMBA in the SAMBA Group Insurance Plan Trust. PNC Bank of Baltimore, Maryland, serves as Trustee of the Trust.

Continuation of Coverage (COBRA)

This section is intended to provide you with specifics pertaining to COBRA and your rights related to COBRA Continuation of Coverage under the Dental and Vision Plan.

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

COBRA Continuation of Coverage is available to certain former employees, retirees, spouses, former spouses, and dependent children when coverage is lost as a result of certain qualifying events. Qualifying events are certain instances that would cause an individual to lose health coverage. The type of qualifying event will determine who are the qualified beneficiaries and the amount of time that a plan must offer health coverage under COBRA. Qualifying events are described as follows:

Qualifying Events for Employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

Qualifying Events for Spouses:

- Voluntary or involuntary termination of the covered employee's employment for reasons other than gross misconduct
- Reduction in the number of hours worked by the covered employee
- Covered employee becomes entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Loss of "dependent child" status under the Plan

Duration of Coverage: Coverage under COBRA may continue for up to 18 months for qualified employees, spouses and dependent children. When a spouse or dependent child obtains COBRA individually (such as a result of a divorce), COBRA may be continued for up to 36 months. Special rules for disabled individuals and certain family members may extend the maximum periods of coverage up to 11 months for that individual. In addition, certain dependents may have further rights to COBRA in the event that the employer files for bankruptcy under Chapter 11 of the Federal Bankruptcy Code.

Notice Procedures: Generally, your COBRA rights are described in this Summary Plan Description (SPD). Additionally, notice requirements are triggered for Plan Administrators and qualified beneficiaries when a qualifying event occurs. Plan Administrators, upon receiving notice of a qualifying event, must provide an election notice to a qualified beneficiary of their right to elect COBRA coverage. The notice must be provided in person or by first class mail within 14 days after the Plan Administrator receives notice that a qualifying event has occurred. If you have any questions concerning COBRA continuation, contact the SAMBA Group Plans Department.

Note: A qualified beneficiary must notify the Plan Administrator of a qualifying event within 60 days after divorce or legal separation or a child's ceasing to be covered as a dependent under Plan rules.

Election: Qualified beneficiaries will be given at least 60 days to elect continuation of coverage under COBRA. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary. Each qualified beneficiary may choose to independently elect COBRA coverage. If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. Then, the Program need only provide continuation of coverage beginning on the date the waiver is revoked.

Coverage: COBRA coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event and will cease at the end of the maximum period. *It may end earlier if:*

- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.
- After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the coverage continues.
- After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

Paying for COBRA Coverage: Beneficiaries who elect coverage under COBRA may be required to pay the Plan up to 100 percent of the cost to the Plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer, plus 2 percent for administrative costs.

Your Responsibilities: Under COBRA, the employee or a family member has the responsibility to inform SAMBA within 60 days of a divorce, legal separation, or the date on which a child loses dependent status under the Plan. Such notification must be in writing and should be mailed to SAMBA, Attention Group Plans Department. It is recommended that you send such notice by certified mail, return receipt requested, in order to preclude the possibility of a dispute over when SAMBA received notification of an eligible event. ***There will be no refund of premium if this requirement is not met.***

Additionally, you (or your spouse or dependent) are required to give notice to the Plan that you (or your spouse or dependent) have been determined to be disabled within 60 days after the determination is made by Social Security and within 30 days of the date of any final determination that you (or your spouse or dependent) are no longer disabled.



11301 Old Georgetown Road
Rockville, Maryland 20852-2800

(301) 984-1440
or
(800) 638-6589

Visit our website at www.SambaPlans.com

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