Aetna Inc.

PRESSMAN WELFARE FUND

Sparks Glencoe, MD 21152

May 03, 2021

Dear Sir or Madam:

Thank you for giving us the opportunity to present this proposal. We believe you will find the proposal addresses all primary aspects of your requested benefits package. Based on your quote, this proposal includes the following components:

Executive Summary – Our response to the current business climate

Financial Information – rate details

Quote Conditions – general quotation assumptions and disclosures

Plan and Benefit Information – detailed plan designs for the rates and premium illustrated in this proposal

Census Summary – recap of census information entered for the quote

Sitematch Information – medical/dental product availability

Sincerely,

EXECUTIVE SUMMARY

Aetna has helped protect people against the risks and uncertainties of life for over 150 years. We strive to continually evolve in order to meet the changing needs of our customers while keeping true to our values. To accomplish this, our strategic vision centers on the following areas for all of our products and services:

Integration - Information - Innovation

Through the increased use of integrated data analysis, predictive modeling, integrated care services, and technology initiatives, we can identify and assist members who may benefit from services today or may likely need services in the future.

Since this enables us to develop a more complete picture of customer and member needs, we can help our customers control costs, enjoy easier administration, and provide their employees with access to information to help them become better educated about their benefits and the value inherent in those benefits. The balance of this summary will explain how we are able to accomplish this for you.

Aetna Dental/Medical Integration® (DMI)

This Industry leading program is automatically included at no additional charge for employers who have both Aetna dental and our medical coverage. The DMI program is comprised of enhanced benefits, including an extra cleaning, full coverage for certain periodontal services and a variety of outreach methods to at-risk members who are not currently seeking dental care. Ask about the Aetna Dental/Medical Integration program and let us help you avoid potential costs and risks that could negatively impact a person's overall well-being.

Integrated Health and Disability (IHD)

High-impact conditions are affecting employees and productivity at an increasing rate. Research has also shown that employees who file disability claims have a much higher medical spend on average than employees who do not file disability claims. Recognizing this, our services include a free, closely integrated medical and disability case management process that provides focused case management and individualized contact for claimants who have our medical and disability plans.

With Integrated Health and Disability (IHD), we use our rich data management tools to help predict when disabilities may occur and take early steps toward disability prevention. When a disability does occur, our team of skilled clinicians works together to co-manage cases and refer members to applicable medical management programs. By focusing on getting employees back to health and work, our clinicians work to improve outcomes - to everyone's advantage.

Single Source for a Comprehensive Benefits Package

Our integrated product portfolio and services enable customers to assemble a robust benefits package through a single source. We can offer customers the advantage of efficiencies and ease of administration as a direct result of using a single source for their total benefits needs. Efficiencies also extend to members. By offering a wide-ranging benefits package through one carrier, members need only access one set of information tools to learn more about the benefits and services available to them, thereby reaping the advantages of simplification. In this manner, members are encouraged to use their benefits more extensively - another key advantage for the customer.

Leadership in Consumer-Directed Health Care

Navigating the new world of consumer-directed health plans calls for a company with a strong history of innovation and the right expertise for the times. Aetna is an established leader in providing value-added, consumer-directed health plans. Since the launch of our first generation of consumer-directed plans in September of 2001, (we were the first national carrier to offer these), we have firmly positioned ourselves as a leader and innovator in consumer-directed health plans.

Our portfolio of consumer-directed products features a variety of plan designs that include integrated health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending accounts (FSAs). With each product comes access to innovative decision-making tools to help members make informed decisions about their care.

Proactive Approach to Medical Management

A clear example of how Integration, Information and Innovation benefit our customers is in the area of medical management. Ultimately, it is the individual treating physician who manages the patient's care. However, we

believe we play an important role by helping members and physicians access information and covered services to maximize the potential of successful treatment outcomes.

The emphasis is on member empowerment and strong, early, and effective disease and case management programs as well as the continuum of care for the patient, stressing concurrent review and discharge planning for hospitalizations and case management.

Active Measures to Help Control Benefits Cost

To counter the nationally escalating cost of benefits, we continue to explore innovative ways to help control costs while ensuring members have access to information resources and technology. As a result, we have instituted a series of measures in an effort to meet the industry-wide challenge of holding premiums and fees down while offering members comprehensive coverage. We believe improvements in health care and outcomes lead to better control of health care costs. Like our predictive modeling and MedQuery℠ tools, our case management and disease management programs are designed to allow us to identify at-risk populations proactively, and to provide real-time assistance to help coordinate, facilitate and improve quality of care. This also helps our members better understand and comply with their care regimen. We can help improve members' health and assist controlling health care costs by increasing member access to information through programs and technology such as Informed Healthr Line, Aetna InteliHealthr, and Aetna Navigator™.

Decision-making Support for Members

We seek to engage members in making informed, quality health care decisions. We believe that our members are best served when provided with tools that promote their understanding of their own health needs and empower them to participate - and connect - with their physicians in the medical treatment process.

Our suite of technological tools allows us to offer employees increased engagement and accountability for their health plan.

Customer-focused, Leading Edge Technology

We are delivering on our promise to provide customers with the most comprehensive suite of tools and services offered by today's technology. Whether it is reducing the time for claim payments to physicians, providing members with 24-hour access to personalized benefits information or offering customers the ease of online benefits administration, we are taking advantage of technology to enhance the services we provide to our customers.

In general, we hold a technology edge in electronic reporting, web-based member tools, consumer-directed information tools, data management and predictive modeling, and electronic claim adjudication. Where others focus solely on discounts, we also consider technology a means to allow members to take control of the demand side of the total cost equation for our customers.

Comprehensive and Extensive Networks

Access to care is a paramount consideration for customers in the selection of a company that can best provide widespread medical delivery networks for their employees. Recognizing the importance of this principle, our uncompromising focus on providing access to care in as many geographic locations as possible is an advantage that distinguishes our services in the marketplace. Our inclusive network strategy allows us to offer our customers and their employees one of the most comprehensive networks available in the industry, regardless of product. Our underlying philosophy for network development is to promote access to stable provider networks with cost-effective, high-quality providers. Our goal is to build relationships with our providers that promote a positive impact on member care and enhance customer satisfaction. Our strategy incorporates three basic underlying concepts: access, cost appropriateness, and quality.

Innovating to Meet the Evolving Needs of our Customers

Flexible, cost-effective dental plans - With over 35 years' experience in the dental marketplace, we offer a wide array of products. We can provide the advantages of a managed dental plan and still offer employees the option to choose any licensed dentist from our extensive national network. Members of all dental plans are able to access a variety of our internet tools such as Aetna Navigator, DocFindr and InteliHealth Dental.

Benefits for part-time and temporary employees - Our Aetna Affordable Health Choices℠ plans provide limited benefits to employees who have historically been unable to access employee benefits, offering affordable medical, dental, life, disability, vision and pharmacy coverage administered through payroll deduction. We have created affordable benefits packages that help employers reduce their costs of recruitment, hiring, and training employees as well as creating a way to retain these employees longer.

Conclusion

We harness the power of information to help our customers and their employees make better, more informed decisions. The result is our customers have the ability to control costs more effectively, and their employees have more information to help them stay healthier and more productive.

We can gather aggregated data and integrate it across our areas of service to get a more complete picture of each customer's overall needs. We use this information to select and develop plans and options that are best suited to the customer and their workforce.

Along with powerful data, our philosophy is to deliver outstanding service to customers and their employees as defined by the quality of each interaction and service experience. We accomplish this by:
•Focusing on improving key processes that affect our customers
•Deploying technology to further improve service and operating efficiencies
•Focusing on continually increasing the quality of the total experience for our customers

We appreciate the opportunity to demonstrate how we can meet your needs through using the power of Integration, Information and Innovation.

PRESSMAN WELFARE FUND
Industry Code: 8631
Proposed Effective Date: 01/01/2022

DENTAL RATES/FEES & COSTS

Option: MD FOC - DMO/PPO Max 1000 - with ortho
Policy Period: 12 months

Product Pkg: FOC DMO®/PPOD
Specialty Networks: None
Subgroup: All Employees
Location(s): DC, MD, PA, VA
Funding: Prospective
Non-Student Age: 26 **Student Age:** 26

Plan Feature	DMO Benefit	PPO In Network	PPO Out of Network
Plan Type	100/90/60	N/A	N/A
OV Copay	$5	N/A	N/A
Coins - Preventive	100%	100%	100%
Coins - Basic	90%	70%	70%
Coins - Major	60%	40%	40%
Endo / Perio 3	N/A	70%	70%
Endo / Perio Other	N/A	70%	70%
General Anesthesia (Buy Up)	N/A	40%	40%
Deductible	N/A	$50	$50
Ded Applicability	N/A	B,M	B,M
Fam Deductible	N/A	3X	3X
CY Max	N/A	$1,000	$1,000
R&C Percentile	N/A	N/A	PPO Max
Extend Network	N/A	Exclude	N/A
Waiting Period	None	None	None
Ortho Elig	Child Only	Child Only	Child Only
Ortho Coins/Copay	$2,300	50%	50%
Ortho LT Max	N/A	$1,000	$1,000
Removal of Ortho Work in Progress Exclusion (Buy Up)	Exclusion applies	Exclusion applies	Exclusion applies
Dental Implants (Buy Up)	N/A	Excluded	Excluded
Crown Build Ups	Included	40%	40%
Crown Lengthening	Included	70%	70%
Fluoride Increase Age Limit	N/A	To age 16	To age 16
Sealants Remove Age Limit	N/A	To age 16	To age 16
Posterior Composite	N/A	Not Covered	Not Covered
Prosthetic Replacement	N/A	8 Years	8 Years
Incentive Annual Max Increase Amount	N/A	Does not apply	Does not apply
Incentive Number of Increase	N/A	Does not apply	Does not apply

Tier	Lives	Rate	Monthly Cost
Single	40	20.20	
Couple	20	40.10	
EE + Child(ren)	2	52.90	
Family	19	72.60	
	81		3,095.20

For members residing in Texas, a) PDN substitutes the reference to PPO Dental, b) if a PDN plan is shown, your In- and Out-of Network benefits are the In-Network benefits shown above.

In Virginia, the DMO® Plan is known as the DNO (Dental Network Only) Plan.

The Patient Protection and Affordable Care Act imposes a new fee/assessment, the Health Insurer Fee (HIF). This rate quote includes an allocation of 0.0% for HIF.

QUOTE CONDITIONS

GENERAL

The quotes in this proposal are non-binding and do not constitute an offer of coverage. Any offer is subject to final underwriting review by us, as permitted by applicable law, we reserve the right not to extend an offer or to change pricing and/or other terms specified in this proposal based on that review.

Quotes have been based on the information entered into our Internet-based quoting system. Additional information may be required to complete the underwriting and installation process. Rates and/or product availability may change if any of the following occur:

- Participation assumptions are not met or there is a change in the contribution strategy
- Actual enrolled census deviates from information provided
- The number of eligible lives and/or participation changes at any time prior to the next rate change
- The information provided to us is incorrect or incomplete
- Medical conditions are reviewed where permitted
- Benefit levels change from those specified in this proposal
- There is an increase in number of retired enrollees
- There is an increase in COBRA enrollees.

Plans summarized in this proposal are subject to additional terms, conditions and limitations specified in applicable coverag e contracts. Copies of coverage contracts are available upon request.

All our standard plan provisions, definitions, terms and conditions of coverage, exclusions and limitations, and claim payment or administrative practices will apply for items not specifically outlined in the proposal.

Changes to product availability, actuarial factors, and state/federal laws may alter the proposal at the time of final underwriting and installation.

Quotes are based on the assumptions that all information provided to us is correct and complete, that the employer is a legitimate employer group, and that the group is in sound financial condition.

The contract situs is assumed to be the state/s of MD.

No commissions will be paid on coverage unless the agent is properly licensed and appointed prior to the initial coverage dat e.

We have various programs for compensating agents, brokers and consultan ts. If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which we have made to your producer, or other material relationships your producer may have with us, you may contact your producer or your account representative. Information regarding our programs for compensating producers is also available at: www.aetna.com.

Notification of acceptance of the proposal must be communicated in writing to us no later than 30 days prior to the effective date. Otherwise, late acceptance may cause a delay in contract issue, online ID card generation, and other pertinent insurance information. Late submission may also result in an invalid proposal and require postponement of the effective date.

Dependent children can be covered through a specified age and extended through a later specified age if a full-time student. The ages vary by state.

This proposal assumes that we will be the sole carrier except where we will allow a competitor's plan along with our medical plan.

Participation, eligibility, and contribution results must meet our minimum requirements and applicable state requirements for the employer to be eligible under the quoted plans. As permitted by applicable law, coverage may be terminated o r non-renewed if these participation, eligibility and contribution requirements are not met at any point in the future.

All proposals are only available to corporations, sole proprietorships, and partnerships. Associations, Taft-Hartley Groups, MEWAs, PEOs (Professional Employer Organizations/Employee Leasing Firms), or multiple employer groups of any kind are not eligible for coverage through this rating application. Closed groups are not eligible.

Except in Arizona, Coverage is for full-time employees working a minimum of 25 hours per week. Temporary and seasonal employees as well as 1099 independent contractors are not eligible for coverage. The benefits described in this proposal mus t be offered to all eligible employees.

This proposal assumes that late enrollees will not be covered until the next regularly scheduled open enrollment period after individual application has been made. Special enrollment rules may apply with respect to late enrollees experiencing certain life events.

New employees must complete the waiting period designated by their employer prior to enrolling in one of our plans. The wait ing period must be consistently applied within a class of employees.

Employees declining coverage may be required under state law to complete a waiver of coverage form.

New eligible dependents or employees must be added within 31 calendar days of their eligibility date or such other period as may be required by applicable law.

In accordance with the terms of the Group Agreement, rates and other adjustments may be made to the quotation with a 30-day notice unless otherwise required by state regulations.

State and Federal legislation/regulations, including HIPAA, take precedence over any and all quote conditions.

Rates may be affected if there is a material change in the plan of benefits offered or a change in claim payment requirements, procedures, account structures, or any other changes affecting the manner or cost of paying benefits that is initiated by the customer or required because of legislative or regulatory action.

Late payment charges may be assessed after the expiration of a 31-day grace period.

QUOTE CONDITIONS

DENTAL INSURANCE*

Quoting and Pricing Information

- Coverage is assumed to be effective on 01/01/2022. Initial rates assume a 12-month contract year. Final rates will be guaranteed for 12 months provided there is not a change in the total base eligible and/or enrolled lives of plus/ minus 10 percent within the first year. Should this occur, Aetna reserves the right to re-underwrite the customer as a new group where permitted by applicable law. Proposed rates are also subject to change due to any state rate filing requirements, approvals, or adjustments based on regulatory determinations.
- Plans are available to groups of two to 25 eligible employees if packaged with a medical plan. Plans are available to groups of 26 or more eligible employees on a standalone basis. Orthodontia coverage is available to groups with 10 or more eligible employees.
- For some plans, coverage may not be available for employees and their dependents located outside specified service area boundaries.
- Dependent children can be covered through a specified age and extended through a later specified age if attending school on a regular basis. The ages vary by state.
- Plans and rates shown in this quote are based on the group having an existing, in-force Dental plan. We reserve the right to change the proposed plan and rates if this is not the case.
- PPO Max plans out-of-network benefits are limited to in-network negotiated fees.
- **Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.**
- DMO and DMO Select are not an available option in AK, AL, AR, GU, LA, ME, MS, MT, ND, NH, PR, SC, SD, VI, VT and WY.
- Limited (varying by state) DMO Non-Participating benefits are included for plans contracts written in: CT, IL, KY, MA and OH and for plan contracts written and members residing in OK.

  Participation Requirements:

  Plans and rates shown in this quote are based on employee participation of 60% - 89% in the dental plan. Aetna reserves the right to change the proposed plan and rates or decline coverage if this is not the case.

- Rates shown in this quote are based on a commission level of no commissions.

Employee and Dependent Information

- Coverage for retirees is not available for groups with less than 51 eligible employees. For groups with 51 or more eligible employees, retirees cannot compose more than 20 percent of the total number of eligible employees.
- Late Entrant exclusions do not apply for DMO contracts written in the State of Texas.
- Late Entrant exclusions do not apply to contracts written in the state of Maine and to Maine residents.

Colorado: Fully Insured Dental new business cases when the contract is issued in CO -- Pediatric Dental Coverage

This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a stand-alone plan or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

Florida DMO Quotes - Any employer, group, or organization that pays or contributes to the premium of a group health insurance plan or dental service plan corporation which provides dental coverage only upon the condition that services be rendered by an exclusive list of dentists or groups of dentists shall provide an alternative to enable the insured to have a free choice of dentist. The employer, group, or organization shall pay or contribute an equal dollar amount toward either alternative elected by the insured. The provisions of this section do not require the commingling of costs and claims experience between the two alternative plans.

Massachusetts -- Minimum Creditable Coverage

This dental plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

*Not applicable to Vital Savings by Aetna^{SM}. Please reference the Vital Savings by Aetna^{SM} Program Summary and Fee Sheet for Vital Savings by Aetna^{SM} quote conditions.

Attention customers with Massachusetts residents: You should be aware that our network of preferred providers in Massachusetts has providers mainly in the following counties: Barnstable, Berkshire, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester. Members' out of pocket expenses will be higher if they do not see an in-network provider and, in some plans, benefits may not be available at all for out-of-network providers.

New York - Fully Insured Dental new business cases when the contract is issued in NY
For contributory plans, New York state insurance law says, employers must insure not less than 50% of eligible employees or, if less, 5 or more of such employees. To ensure compliance with this law, Aetna requires New York customers to provide updated employee census information on an annual basis.

NY,CO and NJ:
Producers (Brokers, Agents, Consultants): Licensed and appointed producers may earn compensation in the form of a commission on the sale of this product. The amount of compensation varies depending on a number of factors, including customer segment and the products selected. Aetna offers additional bonus programs to its producers, which may also apply. Please consult your broker for additional information concerning his/her compensation for this sale, including commission and any applicable bonus programs. The producer is prohibited by law from altering the amount of compensation received from Aetna based in whole or in part on the sale.

> Salaried employees may earn compensation on the sale of Aetna products based on the services they provide, including providing quotes on, and explanations of, Aetna products. The compensation varies depending on a number of factors, including customer segment and products selected. Combining all factors, and excluding limited-benefit plans, compensation for each product quoted averages less than 0.80% of the total first year annual premium. Aetna offers additional bonus programs, which may also apply. Neither Aetna nor the employee has material ownership interests in the other. The employee may not alter the amount of compensation received from Aetna. You may obtain additional information about the compensation expected to be received by eligible employees, based in whole or in part on the sale of an Aetna product, or alternative options presented, by contacting Aetna at https://www.aetna.com/about-aetna-insurance/contact-us/forms/employer/transparency.html.

Washington – Temporomandibular Joint (TMJ) Disorders:
A Non-surgical TMJ offering is available for purchase resulting in rate impact to all DMO & PPO non-small group business with a Washington contract state. If purchased, a TMJ $1000 annual maximum and, $5000 lifetime maximum applies to dental services related to the treatment of TMJ disorders. To ensure compliance with this State Mandate, Aetna requires Washington customers to complete an acceptance/denial of purchase for Non-Surgical TMJ coverage at the time of sale.

Dental EOB's: We make EOBs available through our secure Navigator website for subscribers who have registered to use Navigator and for whom we have a valid email address. We send members an email when a new EOB is available. All other members receive paper EOBs. If a member receiving EOBs electronically prefers paper EOBs, they can get them by telling us that is their preference.

Patient Protection and Affordable Care Act – Fees and Assessments
The Patient Protection and Affordable Care Act imposes a Health Insurer Fee (the "Fee"). The Fee became effective on January 1, 2014. The Fee will be suspended for 2017, but reinstated starting in 2018. This rate quote includes, where permitted, the estimated proportionate allocation of the Fee for the years where the Fee is applicable.

Aetna reserves the right to modify these rates, or otherwise recoup such Fee if estimates are materially insufficient.

Health Insurer Fee
Health Insurance Providers Fee (HIF) is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS.

Per the Omnibus bill signed on December 20, 2019, HIF has been repealed for 2021 and beyond.

This rate quote includes, as applicable, an estimated proportionate allocation of expenses associated with the HIF. Aetna reserves the right to modify these rates, or otherwise recoup such fees, based on future regulatory guidance or subsequent state regulatory approval.

Dental PPOII - Dental PPO II is a vendor based program that offers access to contracted rates for dental claims that may otherwise be paid at billed charges under the out-of-network portion of the Dental PPO plan. The third party vendors participating in the Dental PPO II Program network are considered participating providers and services rendered by such providers will be reimbursed in accordance with the terms of the Customer's plan as in-network service.

Dental Out of Network Savings Program –Dental Out of Network Savings program is available for Indemnity and PPO dental plans that determine the Recognized Charge for out-of-network services based on FAIR Health data; it is not, however, available for dental benefits that are embedded with a medical plan. Aetna contracts with third-party network vendors that, in turn, have contracted with dentists who have agreed to charge discounted rates. Those dentists are still considered out-of-network providers, and the services they provide will be covered in accordance with your plan's benefits for out-of-network services.

Proposals for Aetna Dental PPO (including the Freedom-of-Choice plan design and Texas PDN) may not be offered to groups that have Assurant Employee Benefits or Sunlife as the incumbent Dental PPO carrier, unless the Aetna Dental PPO is quoted and sold along with an Aetna Medical plan.

CENSUS SUMMARY

Dental Summary*

Age	Single		Family		Waived	
	M	F	M	F	M	F
<30	5	1	0	0	0	0
30-34	2	1	1	0	0	0
35-39	0	0	2	0	0	0
40-44	2	1	1	0	0	0
45-49	4	3	4	1	0	0
50-54	1	0	12	3	0	0
55-59	7	0	8	0	0	0
60-64	9	3	6	2	0	0
65+	0	1	1	0	0	0

* The number of lives represents all lives submitted in this quote. Please see the applicable Benefit, Rate & Premium Information page for the eligible lives quoted.

SELECTED PRODUCTS/PROGRAMS SITEMATCH SUMMARY

Sitematch summary information included in this proposal may be limited to the group headquarters state.

DENTAL

Employee Subgroup: All Employees
Option: 1

With Network Access

Product/Program	State	Net ID	Network Name	Employees	Totals
FOC DMO®/PPOD				2	
DMO®	DC	2124	Washington, D.C.		
PPOD	DC	1842	Maryland and Metro D.C.		
FOC DMO®/PPOD				2	
DMO®	MD	2067	Northern Maryland (ALIC)		
PPOD	MD	1842	Maryland and Metro D.C.		
FOC DMO®/PPOD				33	
DMO®	MD	2067	Northern Maryland (ALIC)		
PPOD	MD	1842	Maryland and Metro D.C.		
FOC DMO®/PPOD				33	
DMO®	MD	2123	Southern Maryland (ALIC)		
PPOD	MD	1842	Maryland and Metro D.C.		
FOC DMO®/PPOD				1	
DMO®	PA	2130	Southeastern PA		
PPOD	PA	1841	Eastern Pennsylvania/Dela		
FOC DMO®/PPOD				10	
DMO®	VA	2087	Northern Virginia		
PPOD	VA	1843	Virginia except Metro DC		
Total Employees With FOC DMO®/PPOD Network Access					**81**

Without Network Access

State	Employees	Totals
Total Employees Without Network Access		**0**

Network Access Summary

Product/Program	Access Percent
FOC DMO®/PPOD	**100%**
Without Network Access	**0%**

For members residing in the state of Texas, PDN substitutes the reference to PPO Dental.

For members residing in Virginia, DNO substitutes the reference to DMO Dental.

FREEDOM OF CHOICE - DMO® / PPO
DMO® DENTAL PLAN DESIGN AND BENEFITS

For Option: 1
For Subgroup: All Employees
Network/Service Area: Northern Maryland (ALIC), Northern Virginia, Southeastern PA, Southern Maryland (ALIC), Washington, D.C.

Plan Features	DMO Benefits
Office Visit Copayment	$5
Coverage Levels	
Preventive & Diagnostic	100%
Basic Restorative	90%
Major Restorative	60%
Orthodontics	
Orthodontia Eligibility	Dependent Children Only (appliance must be placed prior to age 20)
Orthodontia Coinsurance or Fixed Copay Amount	$2,300 Copay
Orthodontia Lifetime Maximum	None
Removal of Orthodontia Work in Progress Exclusion (Buy Up)	Standard Exclusions Apply
Covered Dental Services	
The coverage levels for some common dental services are shown below. See your coverage booklet for a complete list of covered services.	
Visits and Exams	
Oral examination visit - (limited to 4 exams per year)	100%
Prophylaxis, including scaling and polishing (2 per year)	100%
Fluoride (1 application per year for children under age 16)	100%
Sealants (1 treatment per tooth every 3 years on permanent molars only for children under age 16)	100%
Oral hygiene instruction	100%
X-rays	
Bitewing x-rays (1 set per year)	100%
Full mouth series (1 set every 3 years)	100%
Periapical x-rays	100%
Endodontics	
Pulpotomy	90%
Root canal therapy, anterior or bicuspid tooth, with x-rays and cultures	90%
Apicoectomy	90%
Root canal therapy, molar teeth, with x-rays and cultures	60%
Minor Restorations	
Amalgam (silver) fillings	90%
Composite fillings (anterior teeth only)	90%
Stainless steel crowns	90%
Periodontics	
Scaling and root planing (4 separate quadrants every 2 years)	90%
Gingivectomy (1 per quadrant every 3 years)	90%
Osseous surgery (1 per quadrant every 3 years)	60%
Oral Surgery	
Incision and drainage of abscess	90%
Uncomplicated extractions	90%
Surgical removal of erupted tooth	90%
Surgical removal of impacted tooth (soft tissue)	90%
Surgical removal of impacted tooth (full or partial bony)	60%
Prosthodontics/Major Restorations	
Inlays/Onlays	60%
Crowns	60%
Bridges	60%

Plan Features	DMO Benefits
Full & partial dentures	60%
Denture repairs	60%
Dental Impants	No Coverage
Pontics	60%
Anesthesia	
General Anesthesia / IV Sedation	60%
Space Maintainers	100%
Dental Dependent Age Selections	
Non Student Age:	26
Student Age:	26
Non Student: Dependent Age Termination of Coverage	End of Month
Student: Dependent Age Termination of Coverage	End of Month
Installation Code	3
Contribution	
Voluntary	No
Employee Contribution	25%

FREEDOM OF CHOICE - DMO® / PPO
PPO DENTAL PLAN DESIGN AND BENEFITS

For Option: 1
For Subgroup: All Employees
Network/Service Area: Eastern Pennsylvania/Dela, Maryland and Metro D.C., Virginia except Metro DC

Plan Features	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$50 The deductible for PPO/PDN Dental benefits applies to Basic and Major Services.	$50 The deductible for PPO/PDN Dental benefits applies to Basic and Major Services.
Family Deductible	3X Individual	3X Individual
Calendar Year Maximum	$1,000	$1,000
Coverage Levels		
Preventive & Diagnostic	100%	100%
Basic Restorative	70%	70%
Major Restorative	40%	40%
Endo / Perio 3 *	70%	70%
Endo / Perio Other	70%	70%
R&C Percentile		PPO Max Plan
Extend Network	Exclude	
Orthodontics		
Orthodontia Eligibility	Dependent Children Only (appliance must be placed prior to age 20)	Dependent Children Only (appliance must be placed prior to age 20)
Orthodontia Coinsurance	50% Coinsurance	50% Coinsurance
Orthodontia Lifetime Maximum	$1,000	$1,000
Removal of Orthodontia Work in Progress Exclusion (Buy Up)	Standard Exclusions Apply	Standard Exclusions Apply
Visits and Exams		
Oral examination visit - (limited to 2 routine and 2 other exams per year)	100%	100%
Prophylaxis, including scaling and polishing (2 per year)	100%	100%
Fluoride (1 application per year)	100%	100%
Sealants (1 treatment per tooth every 3 years on permanent molars only)	100%	100%
X-rays		
Bitewing x-rays (1 set per year)	100%	100%
Full mouth series (1 set every 3 years)	100%	100%
Periapical x-rays	100%	100%
Endodontics		
Pulpotomy	70%	70%
Root canal therapy, anterior or bicuspid tooth, with x-rays and cultures	70%	70%
Apicoectomy	70%	70%
* Root canal therapy, molar teeth, with x-rays and cultures	70%	70%
Minor Restorations		
Amalgam (silver) fillings	70%	70%
Composite fillings (anterior teeth only)	70%	70%
Stainless steel crowns	70%	70%
Periodontics		
Scaling and root planing (4 separate quadrants every 2 years)	70%	70%
Gingivectomy (1 per quadrant every 3 years)	70%	70%
* Osseous surgery (1 per quadrant every 3 years)	70%	70%
Crown Lengthening	70%	70%
Oral Surgery		

Incision and drainage of abscess	70%	70%
Uncomplicated extractions	70%	70%
Surgical removal of erupted tooth	70%	70%
Surgical removal of impacted tooth (soft tissue)	70%	70%
* Surgical removal of impacted tooth (full or partial bony)	70%	70%
Prosthodontics/Major Restorations		
Inlays/Onlays	40%	40%
Crowns	40%	40%
Crown Build Ups	40%	40%
Bridges	40%	40%
Full & partial dentures	40%	40%
Denture repairs	40%	40%
Pontics	40%	40%
Dental Implants (Buy Up)	Standard Exclusions Apply	Standard Exclusions Apply
Fluoride Increase Age Limit	To age 16	To age 16
Sealants Remove Age Limit	To age 16	To age 16
Posterior Composite	Not Covered	Not Covered
Prosthetic Replacement	8 Years	8 Years
Anesthesia		
General Anesthesia / IV Sedation	40%	40%
Space Maintainers	100%	100%
Dental Dependent Age Selections		
Non Student Age:	26	26
Student Age:	26	26
Non Student: Dependent Age Termination of Coverage	End of Month	End of Month
Student: Dependent Age Termination of Coverage	End of Month	End of Month
Contribution		
Voluntary	No	No
Employee Contribution	25%	25%

For members residing in Texas, a) PDN substitutes the reference to PPO Dental, b) your In - and Out-of Network benefits are the In-Network benefits shown above.

DENTAL LIMITATIONS & EXCLUSIONS*

Oral exams are limited to four per year for DMO dental plans, and two routine and two other exams per year for PPO and Indemnity dental plans.

Under a DMO dental plan, services performed by specialists, including general anesthesia, are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna. Copayments under the DMO plan are based on the dentist's reasonable and customary fees.

Emergency Dental Care
Under a DMO dental plan, if you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Under an Indemnity dental plan, benefits payable are limited to the prevailing (usual and customary) charge level, as determined by Aetna per the terms of your benefit plan.

*Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Some of the Services not covered under the plan are:
1. Those for services or supplies which are covered in whole or in part:
(a) Under any other part of this Dental Care Plan; or
(b) Under any other plan of group benefits provided by or through your employer.
2. Those for services and supplies to diagnose or treat a disease or injury that is not:
(a) A non-occupational disease; or
(b) A non-occupational injury.
3. Those for services not listed in the Dental Care Schedule that applies; unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost; missing; or stolen appliance; and those for replacement of appliances that have been damaged due to abuse; misuse; or neglect.
5. Those for: plastic; reconstructive; or cosmetic surgery; or other dental services or supplies which are primarily intended to improve; alter; or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for; or in connection with: services; procedures; drugs; or other supplies that are determined by Aetna to be experimental; or still under clinical investigation by health professionals.
7. Those for: dentures; crowns; inlays; onlays; bridgework; or other appliances or services used for the purpose of splinting; to alter vertical dimension to restore occlusion; or correcting attrition; abrasion; or erosion.
8. Those for any of the following services:
(a) An appliance; or modification of one; if an impression for it was made before the person became a covered person;
(b) A crown; bridge; or cast or processed restoration; if a tooth was prepared for it before the person became a covered person;
(c) Root canal therapy; if the pulp chamber for it was opened before the person became a covered person.
9. Those for services that Aetna defines 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.
10. Those for services intended for treatment of any Jaw Joint Disorder; unless otherwise specified in the Booklet-Certificate.
11. Those for Space Maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment; unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation unless specifically covered. For plans which cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a Dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a Dentist.
15. Those in connection with a service given to a person age five or more if that person becomes a covered person other than: (a) during the first 31 days the person is eligible for this coverage; or (b) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:
(a) After the end of the twelve month period starting on the date the person became a covered person; or
(b) As a result of accidental injuries sustained while the person was a Covered Person; or
(c) For a Primary Care Service in the Dental Care Schedule that applies shown under the headings Visits and Exams; and X-rays and Pathology.
16. Those for services given by a Non-Par Dental Provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown; cast; or processed restoration unless:
(a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
(b) The tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics; crowns; cast or processed restorations made with high noble metals; unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; unless otherwise specified in the Booklet-Certificate.
20. Those for services needed solely in connection with non-covered services.
21. Those for services done where there is no evidence of pathology; dysfunction; or disease other than covered preventive services

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Dental Care Plan coverage is subject to the following rules:

Replacement Rule: The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable bridges; or fixed bridgework is covered only if one of the following terms is met:
(a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental Care Plan coverage must have been in force for the covered person when the extraction took place.
(b) The existing denture; crown; cast or processed restoration; removable bridge; or bridgework cannot be made serviceable; and was installed at least five years under a DMO dental plan and at least eight years under a PPO or Indemnity dental plan before its replacement. However, if under a PPO or Indemnity dental plan a prosthetic replacement buy up is selected, then its replacement is at least five years.
(c) 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.

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures; removable bridges; and fixed bridgework is subject to the requirements that such dentures; removable bridges; and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed at least five years under a DMO dental plan and eight years under a PPO or Indemnity dental plan before its replacement. This rule not applicable to California and Texas members. However, if under a PPO or Indemnity dental plan a prosthetic replacement buy up is selected, then its replacement is at least five years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition; Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
(a) The service must be listed on the Dental Care Schedule;
(b) The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a Par 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:
(a) The Copayment for the approved less costly service; plus
(b) The difference in cost between the approved less costly service and the more costly covered service.

Consult Aetna's on-line provider directory for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time this provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or Member Services at the toll-free number on your online ID card.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract or any part of one. For a complete description of the benefits available to you, including procedures, exclusions and limitations, please request a copy of your specific plan documents, which may include the Group Insurance Certificate or Booklet, Group Insurance Policy and any applicable riders to your plan. All the terms and conditions of your plan or program are subject to and governed by applicable contracts, laws, regulations and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available in all areas. All benefits are subject to coordination of benefits.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental benefits are provided or administered by: Aetna Life Insurance Company, Aetna Dental of California Inc., Aetna Health Inc. and Aetna Dental Inc.

In Arizona, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc.; PPO and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.

For members residing in the state of Texas, PDN substitutes the reference to PPO Dental.

In Virginia, the DMO® Plan is known as the DNO (Dental Network Only) Plan.

* Not applicable to Vital Savings by Aetna℠

For members of a 100/0/0 plan: Replacement rule, Tooth Missing but not Replaced rule, Alternate Treatment rule, and Emergency Dental Care may not apply.