

HOW THE PLAN WORKS

Understanding Your Options Under the Plan

There are two coverage options available under the Dental Plan:

PPO - This option provides a preferred level of benefits and reduced paperwork when you choose **in-network providers** for your dental care, yet gives you the flexibility to go **out-of-network** when you choose. You choose between **in-network** or **out-of-network providers** each time you need dental care, but using **in-network providers** can help reduce your costs.

DMO – This option provides coverage through participating personal and specialty dentists with no deductible and lower out-of-pocket expenses for most services. This option covers 100% of certain basic and specialty services and 75% of others as summarized in “Appendix B.” The **DMO** covers 50% of eligible charges for orthodontic treatment.

If you are an International Assignee, you will be eligible for the International Dental option offered through **Aetna Global Benefits**. Your coverage will be similar to the **in-network** benefits shown for the **PPO option**. Please refer to the Certificate of Coverage through **Aetna Global Benefits**, or contact **Aetna Global Benefits** customer service for more information (see “Important Contacts”).

Not everyone needs dental coverage. You can decide not to receive dental coverage, by electing No Coverage. However, if you choose No Coverage, you cannot elect coverage for two Plan Years, unless you experience a **qualified status change**.

If you elect to participate in the Dental Plan, you have a choice of three coverage categories:

- *Individual* – for yourself only
- *Two-Person* – for you and one **eligible dependent**
- *Family* – for you and two or more **eligible dependents**

Your share of the cost for dental coverage depends on the option and coverage category you select.