Schedule of benefits

Preferred provider organization (PPO) dental plan

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared for:

Employer:	Apple Bank for Savings
Contract number:	MSA-0812491
Schedule of benefits:	1B
Plan name:	PPO Dental High Benefit Plan
Plan effective date:	January 1, 2026
Plan issue date:	February 19, 2026

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits lists the **eligible dental services**, **deductibles**, **payment percentage**, maximums, and other limits that apply to the services you get under this plan.

How to read your schedule of benefits

- When we say:
  - "In-network coverage" we mean that you get care from **in-network providers**.
  - "Out-of-network coverage" we mean that you can get care from **out-of-network providers**.
- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflects the **deductibles** and **payment percentage** amounts under your plan.
- You must pay any **deductibles** and your part of the **payment percentage**.
- The **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the **payment percentage** amount the plan pays. You are responsible for paying any remaining **payment percentage**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year maximums** and **lifetime maximums**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate limits for **in-network providers** and **out-of-network providers** unless we state otherwise. See later in this schedule of benefits for information about limits.

Important note:
All **covered benefits** are subject to a **Calendar Year deductible** and **payment percentage** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at https://www.aetna.com/
- Call us at 1-877-238-6200

This schedule of benefits replaces any schedule of benefits previously in effect under the plan of benefits. Keep this schedule of benefits with your booklet.

General coverage provisions

This section explains the:

- **Deductibles**
- Maximums

Calendar Year deductible

Eligible dental services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible dental services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

Individual deductible

You pay for **eligible dental services** each **Calendar Year** before this plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Calendar Year**.

Family deductible

You pay for **eligible dental services** each **Calendar Year** before this plan begins to pay. After the amount paid for **eligible dental services** reaches this family **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Calendar Year**. To satisfy this family **deductible** for the rest of the **Calendar Year**, the combined **eligible dental services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a **Calendar Year**. When this happens in a **Calendar Year**, the individual **deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

Lifetime orthodontic treatment deductible

Orthodontic treatment eligible dental services applied to the out-of-network **deductible** will be applied to satisfy the in-network **deductible**. Orthodontic **eligible dental services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductible**.

The **orthodontic treatment deductible** is separate from any other **deductibles** for the plan and applies separately to you and each of your covered dependents. Once you have reached the **orthodontic treatment deductible**, this plan will begin to pay benefits for covered **orthodontic treatment** expenses for the rest of your lifetime.

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

This **Calendar Year maximum** applies to in-network and out-of-network **eligible dental services** combined.

Specific dental care lifetime maximum

This is the most this plan will pay, after you have paid any **deductible**, for specific dental care treatment expenses incurred by any one covered person during their lifetime for **eligible dental services**.

These specific dental care **lifetime maximums** apply to in-network and out-of-network **eligible dental services** combined.

Any expenses applied to satisfy a specific dental care **lifetime maximum** will not be applied to satisfy any **lifetime maximum**.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

Plan features

Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

Deductibles	**In-network coverage Amounts**	**Out-of-network coverage Amounts**
Calendar Year deductible*	Individual $50 Family $150	Individual $50 Family $150
***Important note:**	The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses.	The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses.

Lifetime orthodontic treatment deductible

You have to meet your lifetime **orthodontic treatment deductible** before this plan pays for benefits.

Deductible	**In-network coverage amount**	**Out-of-network coverage amount**
Lifetime **orthodontic treatment deductible**	$50	$50

Payment percentage

The **payment percentage** listed below reflects the plan **payment percentage**. This is the **payment percentage** amount that the plan pays. You are responsible for paying any remaining **payment percentage**.

Expenses	**In-network coverage Payment percentage**	**Out-of-network coverage Payment percentage**
Type A expenses	100% of the **negotiated charge**	100% of the **recognized charge**
Type B expenses	80% of the **negotiated charge**	80% of the **recognized charge**
Type C expenses	50% of the **negotiated charge**	50% of the **recognized charge**

Orthodontic treatment payment percentage

Expense	**In-network coverage Payment percentage**	**Out-of-network coverage Payment percentage**
Orthodontic treatment	50% of the **negotiated charge**	50% of the **recognized charge**

Calendar Year maximum

Maximums	**In-network coverage Amounts**	**Out-of-network coverage Amounts**
Calendar Year maximum	$2,000	$2,000

Specific dental care lifetime maximum

Eligible dental service	In-network coverage Amounts	Out-of-network coverage Amounts
Orthodontic treatment	$1,500	$1,500

Eligible dental services

Type A expenses: Diagnostic & preventive care

Visits and exams

- Oral evaluations, (2 routine exams and 2 problem focused exams per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of fluoride if you are under age 18, (1 application per year)
- Scaling - moderate/severe inflammation, full mouth (2 treatments per year, frequency combined with prophylaxis)
- Application of hydroxyapatite regeneration medicament - per tooth (1 application every 3 years)
- Testing for cracked tooth (frequency combined with oral evaluations)

Space maintainers - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Type B expenses: Basic restorative care

Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit

Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations
- Placement of interim direct restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (primary teeth only, excludes temporary crowns)
- Recementation
- Excavation of a tooth resulting in the determination of non-restorability

Oral surgery

- Extractions - coronal remnants - deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth
  - Soft tissue
  - Partially bony
  - Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Excisional biopsy of minor salivary glands
- Coronectomy

Periodontics

- Periodontal maintenance procedures following active therapy (2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)

- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)
- Osseous surgery, (including flap and closure)
- Osseous surgery, (including flap and closure)
- Soft tissue graft procedures
- Full mouth debridement (1 per lifetime)
- Clinical crown lengthening, hard tissue

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid
  - Molar
- Pulpal regeneration
- Hemisection
- Retrograde filling
- Root amputation

General anesthesia and intravenous sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service - Only for impacted wisdom teeth procedure

Type C expenses: Major restorative care

Restorative - Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic **injury**, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 5 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown
- Removal of an indirect restoration on a natural tooth
- Core buildup

Prosthodontics - The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 5 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible).
  - Complete upper and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance
- Accessing and retorquing loose implant screw - per screw
- Cleaning and inspection of occlusal guard - per appliance

Type: Orthodontics treatment expenses

- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Appliance therapy to control harmful habits.
- Orthodontic retention
- Repair of orthodontic appliance

Important note:
The following apply:

- Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only:
  - As treatment for decay or acute traumatic **injury**.
  - When teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.
- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Additional eligible dental services

We will provide additional **eligible dental services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of benefits

We will waive the **Calendar Year deductible** and **payment percentage** for the additional **eligible dental services** above.

The plan **payment percentage** applied to the additional **eligible dental services** will be:

Expense	**In-network coverage Payment Percentage**	**Out-of-network coverage Payment Percentage**
Additional **eligible dental services**	100%	100%