# Schedule of Benefits

*(GR-29N 01-01 01)*

**Applies to the Managed Dental Coverage**

**Employer:** **University of Hartford**

**Group Policy Number:** **GP-724328**

**Issue Date:** November 11, 2019
**Effective Date:** January 1, 2020
**Schedule:** 1A
**Cert Base:** 1

For: Freedom of Choice DMO (Managed Dental Plan)

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

# Managed Dental Plan

## Schedule of Managed Dental Benefits *(GR-9N S-23-005)*

**Primary Care Dentists and Specialty Care Dentist (Network Dental Provider) Covered Expenses**
Coverage is provided only for services shown in the Dental Care Schedule (see *What the Plan Covers* section). This dental expense coverage is segmented into four service types. The **copayments** shown below apply. The "amount payable", shown on the List, will not apply when services are provided by **network providers**.

| **Dental Care Schedule** | **Copayment Amounts** | |
|---|---|---|
| **Service Type** | **Primary Care Services** | **Specialty Care Services** |
| **Type A Expenses** | 0% | Not Applicable |
| **Type B Expenses** | 0% | 0% |
| **Type C Expenses** | 40% | 40% |

| | |
|---|---|
| **Orthodontic Expenses** (Fixed Copay) | |
| Orthodontic screening exam | $30 |
| Orthodontic diagnostic records | $150 |
| Comprehensive orthodontic treatment of adult or adolescent dentition | $1,545 |
| Orthodontic retention | $275 |
| Orthodontic Lifetime Maximum: | 24 months of active treatment plus 24 months of retention. |
| **Dental Emergency Maximum:** | $100 |

**Out-of-Network Dental Provider Covered Expenses**
Coverage is provided only for services shown in the list of Covered Dental Services. The "Amount Payable" shown applies only to services and supplies provided by **out-of-network providers**. The amounts shown are *not* **copayments**. They are the maximum charges eligible for coverage under the plan for the service listed.

**Deductible Amount:** $100
The **deductible** does not apply to orthodontic services.

**Orthodontic Lifetime Maximum Benefit:** $400

**List of Covered Dental Services**
If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition, then the charge will be considered to have been made for a service that would have produced a professionally acceptable result, as determined by **Aetna**.

# Primary Care Services

## Schedule *(GR-9N-S-23-010-01)*

### Type A Services

| **Visits and Exams** | **Out-of-Network maximum Amount Payable by Aetna** |
|---|---|
| Office visit for oral examination (limited to 4 visits per year) | $12 |
| Emergency palliative treatment | $12 |
| Prophylaxis (cleaning) (limited to 2 treatments per year) | |
| Adult | $26 |
| Child | $14 |
| Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 18) | $16 |
| Oral hygiene instruction | $12 |
| Sealants; per tooth (limited to 1 application every 3 years for permanent molars) | $10 |
| Pulp vitality test | $8 |
| Consultation | $12 |
| Diagnostic casts | $20 |
| **X-Ray and Pathology** | |
| Bitewing x-rays (limited to 2 sets per year) | $8 |
| Entire series; including bitewings; or panoramic film (limited to 1 set every 3 years) | $14 |
| Vertical bitewing x-rays (limited to 1 set every 3 years) | $12 |
| Periapical x-rays | $6 |
| Intra-oral; occlusal view; maxillary or mandibular | $8 |
| Extra-oral upper or lower jaw | $12 |
| Biopsy and histopathologic examination of oral tissue | $27 |

### Type B Services

| **Endodontics** | |
|---|---|
| Pulp cap | $3 |
| Pulpotomy | $27 |
| Root canal therapy; including necessary x-rays | |
| Anterior | $80 |
| Bicuspid | $96 |

**Restorations and Repairs**

| | |
|---|---|
| Amalgam restoration | |
| 1 surface | $12 |
| 2 surfaces | $16 |
| 3 surfaces | $24 |
| 4 or more surfaces | $26 |
| Resin restoration (other than for molars) | |
| 1 surface | $12 |
| 2 surfaces | $16 |
| 3 surfaces | $26 |
| 4 or more surfaces or incisal angle | $30 |
| Retention pins | $14 |
| Sedative filling | $12 |
| Stainless steel crowns | $26 |
| Prefabricated resin crowns (excluding temporary crowns) | $60 |
| Recementing inlays or crowns | $16 |
| Recementing bridges and space maintainers | $16 |
| Tissue conditioning for dentures | $26 |

**Periodontics**

| | |
|---|---|
| Emergency treatment (abscess; acute periodontitis; etc.) | $26 |
| Scaling and root planning (limited to 4 separate quadrants every year) | $40 |
| Periodontal maintenance procedures following surgical therapy (limited to 2 per year) | $40 |

**Oral Surgery** - Includes local anesthetics and routine post-operative care.

| | |
|---|---|
| Extractions; exposed root or erupted tooth | $27 |
| Surgical removal of erupted tooth | $32 |
| Surgical removal of impacted tooth (soft tissue) | $40 |
| Excision of hyperplastic tissue | $32 |
| Excision of pericoronal gingival | $40 |
| Incision and drainage of abscess | $20 |
| Crown exposure to aid eruption | $26 |
| Removal of foreign body from soft tissue | $20 |
| Suture of soft tissue injury | $20 |

## Type C Services

**Restorations**

**Inlays**

| | |
|---|---|
| 1 surface | $60 |
| 2 or more surfaces | $80 |

**Onlays**

| | |
|---|---|
| 2 surfaces | $80 |
| 3 or more surfaces | $80 |

**Crowns** (including build-ups when necessary)

| | |
|---|---|
| Resin | $120 |
| Resin with noble metal | $120 |
| Resin with base metal | $120 |
| Porcelain | $120 |
| Porcelain with noble metal | $120 |
| Porcelain with base metal | $120 |
| Base metal (full cast) | $120 |
| Noble metal (full cast) | $120 |
| Metallic (3/4 cast) | $120 |
| Post and core | $27 |

**Pontics**

| | |
|---|---|
| Base metal (full cast) | $20 |
| Noble metal (full cast) | $20 |
| Porcelain with noble metal | $20 |
| Porcelain with base metal | $20 |
| Resin with noble metal | $20 |
| Resin with base metal | $20 |

**Dentures and Partials** - (includes relines; rebases and adjustments within six months after installation)

| | |
|---|---|
| Complete (Upper or Lower) | $120 |
| Partial | $120 |
| Stress breakers (per unit) | $40 |
| Interim partial denture; (stayplates); anterior only | $40 |
| Crown and bridge repairs | $27 |
| Adding teeth to an existing denture | $40 |
| Full and partial denture repairs | $27 |
| Relining/rebasing dentures (includes adjustments with six months after installation) | $40 |
| Occlusal guard (for bruxism only) | $40 |

**Space maintainers - Includes all adjustments within six months after installation.**

| | |
|---|---|
| Fixed; band type | $40 |
| Removable acrylic with round wire clasp | $32 |
| Recement space maintainer | $10 |
| Removal of fixed space maintainer (by dentist who did not place appliance) | $10 |

**Specialty Care Dental Services**

**Type B Services**

**Endodontics** - Includes local anesthetics where necessary.

| | |
|---|---|
| Apexification/recalcification - per visit | $32 |
| Apicoectomy | |
| First root | $60 |
| Each additional root | $40 |
| Retrograde Filling | $14 |
| Root Amputation | $27 |
| Hemisection | $27 |

**Oral Surgery** - Includes local anesthetics where necessary and post-operative care.

| | |
|---|---|
| Removal of residual root | $27 |
| Removal of odontogenic cyst | $40 |
| Closure of oral fistula | $48 |
| Removal of foreign body from bone | $20 |
| Sequestrectomy | $20 |
| Frenectomy | $40 |
| Transplantation of tooth or tooth bud | $48 |
| Alveoplasty in conjunction with extractions - per quadrant | $27 |
| Alveoplasty not in conjunction with extractions - per quadrant | $40 |
| Removal of exostosis | $60 |
| Sialolithotomy; removal of salivary calculus | $36 |
| Closure of salivary fistula | $36 |

**Periodontics**

| | |
|---|---|
| Gingivectomy or gingivoplasty - per quadrant | $40 |
| Gingivectomy or gingivoplasty, 1 to 3 teeth - per quardrant | $20 |
| Gingival flap procedure - per quadrant | $60 |
| Occlusal adjustment (other than with an appliance or by restoration) | |
| Limited | $20 |
| Entire Mouth | $40 |

### Type C Services

**Endodontics** - Includes local anesthetics where necessary.

| | |
|---|---|
| Complex Molar Root Canal Therapy | $120 |

**Intravenous Sedation and General Anesthesia**

| | |
|---|---|
| - per 15-minute segment. | $20 |

**Oral Surgery** - Includes local anesthetics where necessary and post-operative care.

| | |
|---|---|
| Surgical removal of impacted tooth | |
| Partially bony | $53 |
| Completely bony | $60 |
| Completely bony with unusual surgical complications | $64 |

**Periodontics**

| | |
|---|---|
| Osseous surgery (including flap entry and closure) - per quadrant | $80 |
| Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant | $40 |
| Clinical crown lengthening - hard tissue | $40 |

**Orthodontics**

| | |
|---|---|
| Comprehensive orthodontic treatment | |
| Post Treatment Stabilization | |
| Interceptive orthodontic treatment | |
| Limited orthodontic treatment | |
| Lifetime Maximum: | $400 |

## Expense Provisions *(GR-9N S-09-05 01)*

**The following provisions apply to your health expense plan.**
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

**Keep This Schedule of Benefits With Your Booklet-Certificate.**

### Deductible Provisions *(GR-9N S-09-05 01)*

**Out-of-Network Calendar Year Deductible**
This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

### Copayments and Benefit Deductible Provisions *(GR-9N-09-015-01 CT)*

**Copayment, Copay**
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

### Coinsurance Provisions *(GR-9N S-09-020 01)*

**Coinsurance**
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

## General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.