Schedule of Benefits
(Gr-29N 01-01 01)

Applies to the Alternate Dental Coverage (Comprehensive Dental Expense Coverage)

Employer: University of Hartford

Group Policy Number: GP-724328

Issue Date: November 11, 2019
Effective Date: January 1, 2020
Schedule: 2A
Cert Base: 2

For: Freedom of Choice Passive PPO Dental (PPO Dental Plan)

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

Comprehensive Dental Plan (PPO)

Schedule of Comprehensive Dental Benefits (Gr-9N S 21-005 01)

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>Individual $75</td>
<td>Individual $75</td>
</tr>
<tr>
<td>Deductible</td>
<td>Family $225</td>
<td>Family $225</td>
</tr>
</tbody>
</table>

The Calendar Year deductible applies to all covered expenses except Type A Expenses.

(Gr-9N 21-010 02 CT)
Please refer to the listing of covered expenses and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

<table>
<thead>
<tr>
<th>PLAN COINSURANCE</th>
<th>NETWORK COINSURANCE</th>
<th>OUT-OF-NETWORK COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A Expenses</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Type B Expenses</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Type C Expenses</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Calendar Year Maximum Benefit (Gr-9N 21-010 02 CT)
Calendar Year Maximum: $2,000

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to network and out-of-network covered dental expenses combined.
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)

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

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.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.

Network Family Deductible Limit
When you incur network covered expenses that apply toward the network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the network Calendar Year family deductible limit. Your network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the network family deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur out-of-network covered expenses that apply toward the out-of-network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the out-of-network Calendar Year family deductible limit. Your out-of-network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the out-of-network family deductible limit in a Calendar Year.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.

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.

Maximum Benefit Provisions *(GR.9N.S-09.025 01)*

**Calendar Year Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

The Calendar Year maximum benefit applies to network care and out-of-network care expenses combined.

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.