

Schedule of benefits

Managed dental expense insurance plan

If this is an ERISA plan, you have certain rights under this plan. If the **policyholder** is a church group or a government group this may not apply. Please contact the **policyholder** for additional information.

Prepared for:

Policyholder:	University of Hartford
Policyholder number:	GP-0724328-A
Schedule of benefits:	1A
Group policy effective date	January 1, 2021
Plan name:	Freedom of Choice DMO
Plan effective date:	January 1, 2021
Plan issue date:	December 6, 2022
Plan revision effective date:	January 1, 2023

Underwritten by Aetna Life Insurance Company in the state of Connecticut



Schedule of benefits

This schedule of benefits lists the **eligible dental services, deductibles, office visit copayments, coinsurance, maximums, and any 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**.
- You must pay any **deductibles** and any office visit **copayment** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects your **coinsurance** percentage. Your **coinsurance** percentage is the amount that you pay. We are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that is not a **covered benefit** or that exceed your **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. See later in this schedule of benefits for more information about limits.

Important note:

All **covered benefits** are subject to an office visit **copayment** and **coinsurance** 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 www.aetna.com
- Call us at 1-877-238-6200

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

General coverage provisions

This section explains the:

- **Calendar Year out-of-network deductible**
- **Dental emergency services maximum**

Calendar Year out-of-network deductible

You pay for out-of-network **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 out-of-network **eligible dental services** for the rest of the **Calendar Year**.

Dental emergency services maximum

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

Out-of-network orthodontic treatment lifetime maximum

The **orthodontic treatment lifetime maximum** applies to out-of-network **eligible dental services** for **orthodontic treatment**.

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-certificate.

Plan features

In-network plan features

Expenses	Copayments
Office visit	\$0 per visit

Expenses	Coinsurance	
	Primary care services	Specialty care services
Type A expenses	0%	Not applicable
Type B expenses	0%	0%
Type C expenses	40%	40%

Expenses	Copayments
Comprehensive orthodontic treatment of adolescent and adult dentition	\$2,000

Maximums	Amounts
Dental emergency services maximum	\$100

Eligible dental services

In-network coverage

This dental care schedule applies to **eligible dental services** provided by **primary care dentists (PCDs)** and other **in-network providers** upon **referral** from your **PCD**. The plan covers only the **eligible dental services** listed below.

Primary Care Services Type A expenses

Visits and exams

- Oral evaluation (4 visits per year)
- Oral hygiene instruction
- Consultation – second opinion
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth, (2 treatments per year)
- Topical application of fluoride or fluoride varnish if you are under age 18 (1 treatment per year)
- Sealants, per tooth (1 applications every 3 years for permanent molars)
- Sealant repair (for permanent molars)
- Resin infiltration of incipient smooth surface lesions for permanent teeth only (1 applications every 3 years)
- Preventive resin restoration (1 applications every 3 years for permanent molars)
- Diagnostic casts
- Emergency palliative treatment

Images and pathology

- Bitewing Images (2 sets per year)
- Entire dental series, including bitewings, or panoramic film (1 set every 3 years)
- Vertical bitewing X-rays (1 set every 3 years)
- Periapical X-rays
- Intra-oral radiographic image
- Extra-oral radiographic image
- Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
- Accession of tissue

Type B Expenses

Endodontics

- Pulp cap
- Pulpotomy
- Pulpal debridement
- Pulpal therapy
- Pulpal regeneration
- Treatment of root canal obstruction
- Internal root repair
- Incomplete endodontic surgery
- Root canal therapy and retreatment, anterior & bicuspid
- Surgical procedure for isolation of tooth with rubber dam

Restorative

- Amalgam restoration
- Resin-based composite restoration (other than for molars)
- Retention pins
- Protective restoration
- Crowns – prefabricated and stainless steel (excluding temporary crowns)
- Re-cement
- Reattachment of tooth fragment
- Interim therapeutic restoration

Periodontics

- Scaling and root planing, 1-3 teeth (1 per site every 1 years)
- Scaling and root planing, 4 or more teeth (4 separate quadrants, every 1 year)
- Periodontal maintenance procedures (limited to 2 per year)
- Unscheduled dressing change

Oral surgery – (Includes local anesthetics and routine post-operative care)

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Incision and drainage of abscess
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Removal of foreign body from soft tissue
- Surgical access of an unerupted tooth
- Suture

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

- Removal of fixed space maintainer

Type C Expenses

Restorations – Multiple restorations in 1 surface will be considered as a single restoration

- Inlays
- Onlays
- Crowns (including build-ups)
- Crown repair
- Connector bar
- Labial veneers
- Post and core
- Core build up
- Pontics

Prosthodontics – 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 with 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
- Replace missing or broken teeth, complete denture
- Adding teeth and clasps to existing partial denture
- Procedures to construct new crown under existing partial denture framework
- Repairs: bridges
- Occlusal guard for bruxism
- Adjustments, repairs or reline of occlusal guard (adjustments are not eligible within 6 months of the placement of the appliance)
- Cleaning and inspection of a removable appliance

Periodontics

- Full mouth debridement (limited to 1 per lifetime)

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

- Fixed
- Removable

**Specialty Care Services
Type B Expenses**

Endodontics – Includes local anesthetics

- Apexification/recalcification
- Apicoectomy
- Surgical repair of root resorption
- Retrograde filling
- Root amputation
- Hemisection

Oral surgery – Includes local anesthetics and post-operative care

- Surgical removal of residual tooth roots
- Closure of sinus perforation
- Orantral fistula closure
- Transplantation of tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Incisional biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Removal of foreign body from bone
- Partial ostectomy/ sequestrectomy
- Frenectomy/ frenuloplasty
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula

Periodontics

- Gingivectomy/gingivoplasty, 1 - 3 teeth per quadrant
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant
- Gingivectomy or gingivoplasty to allow access for restorative, per tooth procedure
- Gingival flap procedure, 1 - 3 teeth per quadrant
- Gingival flap procedure, 4 or more teeth per quadrant
- Apically positioned flap (limited to 1 per quadrant every 5 years)
- Occlusal adjustment

**Specialty Care Services
Type C Expenses**

Endodontics – Includes local anesthetics

- Molar root canal therapy and retreatment

Intravenous sedation and general anesthesia sedation – Only when provided in conjunction with a covered surgical procedure

- Evaluation by anesthesiologist for deep sedation or general anesthesia

Oral surgery – Includes local anesthetics and post-operative care

- Removal of impacted teeth, partially or completely bony
- Coronectomy

Periodontics

- Osseous surgery, (including flap entry and closure)
- Soft tissue graft procedure
- Surgical revision procedure
- Clinical crown lengthening – hard tissue

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

**Specialty Care Services
Type: Orthodontic Care Expenses**

- Orthodontic screening exam
- Orthodontic diagnostic records
- Orthodontic retention
- Comprehensive **orthodontic treatment** of adolescent dentition
- Post treatment stabilization
- Fixed or removable appliance therapy
- Re-cement, re-bond, or repair of fixed retainer limited **orthodontic treatment**

Out-of-network coverage

Out-of-network coverage is provided only for services shown in the list of **eligible dental services** below. The “Amount payable by **Aetna**” applies only to **eligible dental services** provided by **out-of-network providers**. The amounts shown are not **copayments**, they are the maximum amounts that we pay under your plan for the listed **eligible dental service**.

Out-of-network plan features

Plan features	Amount
Out-of-network Calendar Year deductible	\$100
Important note: The deductible does not apply to orthodontic treatment services.	

Out-of-network eligible dental services

Eligible dental services	Limitations	Amount payable by Aetna
	Crowns and pontics are per unit. There will be an additional patient charge for the actual cost of high noble metal (gold, titanium) when used for services shown	
Periodic oral evaluation - established patient	4 visits per year for all oral evaluations combined	\$12
Limited oral evaluation - problem focused		\$12
Oral evaluation for a patient under 3 years of age and counseling with primary caregiver		\$12
Comprehensive oral evaluation – new or established patient		\$12
Detailed and extensive oral evaluation – problem focused, by report		\$12
Re-evaluation - limited, problem focused		\$12
Comprehensive Periodontal Evaluation - New or Established Patient		\$12
Intraoral – complete series of radiographic images	1 set every 3 years	\$14
Intraoral – periapical first radiographic image		\$6
Intraoral - periapical each additional radiographic image		\$6
Intraoral – occlusal radiographic image		\$8
Extraoral – first radiographic image		\$12
Extra-oral posterior dental radiographic image		\$12
Bitewing - single radiographic image	2 sets every year	\$4
Bitewings - two radiographic images		\$8
Bitewings - three radiographic images		\$12
Bitewings - four radiographic images		\$16
Vertical bitewings – 7 to 8 radiographic images	1 set every 3 years	\$12

Panoramic radiographic image	1 set every 3 years	\$14
Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		\$5
Pulp vitality test		\$8
Diagnostic casts		\$20
Accession of tissue, gross examination, preparation and transmission of written report		\$27
Accession of tissue, gross and microscopic examination, preparation and transmission of written report		\$27
Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation & transmission of written report		\$27
Prophylaxis - adult	2 visits per year	\$26
Prophylaxis - child	2 visits per year	\$14
Scaling-moderate/severe inflammation – full mouth	2 treatments per year combined with prophylaxis	\$13
Topical application of fluoride varnish if you are under age 18	1 treatment per year	\$16
Topical application of fluoride- excluding varnish if you are under age 18	1 treatment per year	\$16
Oral hygiene instructions		\$12
Sealant - per tooth	1 application every 3 years for permanent molars	\$10
Preventive resin restoration in a moderate to high risk caries patient – permanent tooth	1 application every 3 years for permanent molars	\$10
Sealant repair		\$5
Interim caries arresting medicament application	1 application every 3 years for permanent molars	\$10
Resin infiltration of incipient smooth surface lesions	1 application every 3 years	\$10
Palliative (emergency) treatment of dental pain, minor procedure		\$12
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician . for second opinions only		\$12
Amalgam - 1 surface, primary or permanent		\$12
Amalgam - 2 surfaces, primary or permanent		\$16
Amalgam - 3 surfaces, primary or permanent		\$26
Amalgam - 4 or more surfaces, primary or permanent		\$26
Resin based composite – 1 surface, anterior		\$12
Resin based composite – 2 surfaces, anterior		\$16
Resin based composite – 3 surfaces, anterior		\$26

Resin based composite – 4 or more surfaces or involving incisal angle (anterior)		\$26
Resin-based composite crown, anterior		\$26
Resin-based composite - 1 surface, posterior	Other than for molars	\$12
Resin-based composite - 2 surfaces, posterior	Other than for molars	\$16
Resin-based composite - 3 surfaces, posterior	Other than for molars	\$26
Resin-based composite - four or more surfaces, posterior	Other than for molars	\$26
Re-cement inlay, onlay, or partial coverage restoration		\$16
Re-cement or re-bond indirectly fabricated or prefabricated post and core		\$8
Re-cement crown		\$16
Reattachment of tooth fragment, incisal edge or cusp		\$3
Prefabricated porcelain/ceramic crown - primary tooth		\$42
Prefabricated stainless steel crown – primary tooth		\$26
Prefabricated stainless steel crown – permanent tooth		\$26
Protective restoration		\$12
Interim therapeutic restoration - primary dentition		\$6
Pin retention - per tooth, in addition to restoration		\$14
Pulp cap – direct (excluding final restoration)		\$3
Pulp cap – indirect (excluding final restoration)		\$3
Therapeutic pulpotomy (excluding final restoration)		\$27
Pulpal debridement, primary and permanent teeth		\$12
Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		\$24
Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		\$27
Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		\$27
Endodontic therapy (root canal), anterior tooth (excluding final restoration)		\$80
Endodontic therapy (root canal), bicuspid tooth (excluding final restoration)		\$96
Treatment of root canal obstruction; non-surgical access		\$80
Incomplete endodontic therapy (root canal); inoperable, unrestorable or fractured tooth		\$48
Internal root repair of perforation defects		\$40
Retreatment of previous root canal therapy – anterior		\$80
Retreatment of previous root canal therapy – bicuspid		\$96

Periodontal scaling and root planing, four or more teeth per quadrant	4 separate quadrants every 1 year	\$40
Periodontal scaling and root planing, one to three teeth per quadrant	1 per site every 1 years	\$24
Periodontal maintenance procedures following surgical therapy	2 per year	\$40
Unscheduled dressing change (by someone other than treating dentist or their staff)		\$26
Recement implant/abutment supported crown		\$16
Recement implant/abutment supported fixed partial denture		\$16
Recement or re-bond fixed partial denture retainers		\$16
Extraction, coronal remnants - deciduous tooth		\$14
Extraction - erupted tooth or exposed root		\$27
Surgical removal of erupted tooth		\$32
Removal of impacted tooth - soft tissue		\$40
Occlusal adjustment - limited		\$20
Occlusal adjustment - complete		\$40
Inlay - metallic - 1 surface		\$60
Inlay - metallic - 2 surfaces		\$80
Inlay - metallic - 3 or more surfaces		\$80
Onlay - metallic - 2 surfaces		\$80
Onlay - metallic - 3 surfaces		\$80
Onlay - metallic – 4 or more surfaces		\$80
Inlay - porcelain/ceramic – 1 surface		\$60
Inlay - porcelain/ceramic – 2 surfaces		\$80
Inlay - porcelain/ceramic – 3 or more surfaces		\$80
Onlay - porcelain/ceramic – 2 surfaces		\$80
Onlay - porcelain/ceramic – 3 surfaces		\$80
Onlay - porcelain/ceramic – 4 or more surfaces		\$80
Inlay – resin-based composite – 1 surface		\$60
Inlay - resin-based composite – 2 surfaces		\$80
Inlay - resin-based composite – 3 surfaces		\$80
Onlay - resin-based composite – 2 surfaces		\$80
Onlay - resin-based composite – 3 surfaces		\$80
Onlay - resin-based composite – 4 or more surfaces		\$80
Crown - resin-based composite (indirect)		\$120
Crown – ¾ resin-based composite (indirect)		\$96
Crown - resin with predominantly base metal		\$120
Crown - resin with noble metal		\$120
Crown - porcelain/ceramic substrate		\$120
Crown -porcelain fused to predominantly base metal		\$120
Crown - porcelain fused to noble metal		\$120
Crown - ¾ cast predominantly base metal		\$120

Crown - ¾ cast noble metal		\$120
Crown - ¾ cast porcelain/ceramic		\$120
Crown - full cast predominantly metal		\$120
Crown - full cast noble metal		\$120
Core buildup, including any pins when required		\$27
Cast post and core in addition to crown, indirectly fabricated		\$27
Each additional indirectly fabricated post - same tooth		\$27
Prefabricated post and core, in addition to crown		\$27
Each additional prefabricated post - same tooth		\$27
Additional procedures to construct new crown under existing partial denture framework		\$18
Endodontic therapy (root canal), molar (excluding final restoration)		\$120
Retreatment of previous root canal therapy – molar		\$120
Full mouth debridement	1 per lifetime	\$26
Complete denture - maxillary	Relines/rebases/ adjustments <u>are not</u> separately eligible within 6 months of placement of the denture	\$120
Complete denture - mandibular	Relines/rebases/ adjustments <u>are not</u> separately eligible within 6 months of placement of the denture	\$120
Immediate denture - maxillary	Relines/rebases/ adjustments are separately eligible within 6 months of placement of the immediate denture	\$120
Immediate denture - mandibular	Relines/rebases/ adjustments are separately eligible within 6 months of placement of the immediate denture	\$120
Space maintainer - fixed – unilateral	Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation	\$40

Space maintainer - fixed – bilateral:	Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation	
Maxillary		\$40
Mandibular		\$40
Space maintainer - removable - unilateral	Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation	\$32
Space maintainer - removable – bilateral:	Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation.	
Maxillary		\$32
Mandibular		\$32
Distal shoe space maintainer – fixed – unilateral		\$44
Re-cementation or re-bond of space maintainer		\$16
Removal of fixed space maintainer		\$16
Maxillary partial denture - resin base	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$120
Mandibular partial denture - resin base	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$120
Maxillary partial denture - cast metal framework with resin denture bases	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$120
Mandibular partial denture - cast metal framework with resin denture bases	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$120
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Includes limited follow-up care only; does not include future rebasing	\$138

Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Includes limited follow-up care only; does not include future rebasing	\$138
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Includes limited follow-up care only; does not include future rebasing	\$138
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Includes limited follow-up care only; does not include future rebasing	\$138
Maxillary partial denture – flexible base	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$144
Mandibular partial denture – flexible base	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	\$144
Removable unilateral partial denture – one piece cast metal, including clasps and teeth:	Relines/rebases/ adjustments are not separately eligible within 6 months of placement of the denture	
Maxillary		\$120
Mandibular		\$120
Adjust complete denture – maxillary	Adjustment is not separately eligible within 6 months of placement of the denture	\$20
Adjust complete denture - mandibular	Adjustment is not separately eligible within 6 months of placement of the denture	\$20
Adjust Partial Denture - maxillary	Adjustment is not separately eligible within 6 months of placement of the denture	\$20
Adjust partial denture – mandibular	Adjustment is not separately eligible within 6 months of placement of the denture	\$20
Repair broken complete denture base		\$27
Replace missing or broken teeth, complete denture (each tooth)		\$40
Repair resin denture base		\$27
Repair cast framework		\$27
Repair or replace broken clasp		\$40
Replace broken teeth – per tooth		\$40
Add tooth to existing partial denture		\$40

Add Clasp to Existing Partial Denture		\$40
Replace all teeth and acrylic on cast metal framework (maxillary)		\$40
Replace all teeth and acrylic on cast metal framework (mandibular)		\$40
Rebase complete maxillary denture	Rebase is not separately eligible within 6 months of placement of the denture	\$40
Rebase complete mandibular denture	Rebase is not separately eligible within 6 months of placement of the denture	\$40
Rebase maxillary partial denture	Rebase is not separately eligible within 6 months of placement of the denture	\$40
Rebase mandibular partial denture	Rebase is not separately eligible within 6 months of placement of the denture	\$40
Reline complete maxillary denture (chairside)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline complete mandibular denture (chairside)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline maxillary partial denture (chairside)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline mandibular partial denture (chairside)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline complete maxillary denture (laboratory)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline complete mandibular denture (laboratory)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline maxillary partial denture (laboratory)	Reline is not separately eligible within 6 months of placement of the denture	\$40
Reline mandibular partial denture (laboratory)	Reline is not separately eligible within 6 months of placement of the denture	\$40

Interim partial denture - (maxillary)	Eligible when replacing anterior teeth	\$40
Interim partial denture - (mandibular) when replacing anterior teeth	Eligible when replacing anterior teeth only	\$40
Tissue conditioning, maxillary	Tissue conditioning is not separately eligible within 6 months of placement of the denture	\$26
Tissue conditioning, mandibular	Tissue conditioning is not separately eligible within 6 months of placement of the denture	\$26
Abutment supported porcelain/ceramic crown		\$120
Abutment supported porcelain fused to metal crown (predominantly base metal)		\$120
Abutment supported porcelain fused to metal crown (noble metal)		\$120
Abutment supported cast metal crown (predominantly base metal)		\$120
Abutment supported cast metal crown (noble metal)		\$120
Implant supported porcelain/ceramic crown		\$120
Abutment supported retainer for porcelain/ceramic fixed partial denture		\$120
Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)		\$120
Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)		\$120
Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)		\$120
Abutment supported retainer for cast metal fixed partial denture (noble metal)		\$120
Implant supported retainer for ceramic fixed partial denture		\$120
Implant/abutment supported removable denture for completely edentulous arch – mandibular		\$138
Implant/abutment supported removable denture for completely edentulous arch – maxillary		\$138
Implant/abutment supported removable denture for partially edentulous arch – maxillary		\$132
Implant/abutment supported removable denture for partially edentulous arch – mandibular		\$132
Implant/abutment supported fixed denture for completely edentulous arch - maxillary		\$120
Implant/abutment supported fixed denture for completely edentulous arch – mandibular		\$120

Implant/abutment supported fixed denture for partially edentulous arch – maxillary		\$120
Implant/abutment supported fixed denture for partially edentulous arch - mandibular		\$120
Pontic - indirect resin based composite		\$20
Pontic - cast Predominantly base metal		\$20
Pontic - cast noble metal		\$20
Pontic - porcelain fused to predominantly base metal		\$20
Pontic - porcelain fused to noble metal		\$20
Pontic - porcelain/ceramic		\$20
Pontic - resin with predominantly base metal		\$20
Pontic - resin with noble metal		\$20
Retainer - cast metal for resin bonded fixed prosthesis		\$80
Retainer - porcelain/ceramic for resin bonded fixed prosthesis		\$80
Resin retainer – for resin bonded fixed prosthesis		\$60
Pediatric partial denture, fixed		\$40
Cleaning and inspection of removable complete denture, maxillary		\$7
Cleaning and inspection of removable complete denture, mandibular		\$7
Cleaning and inspection of removable partial denture, maxillary		\$7
Cleaning and inspection of removable partial denture, mandibular		\$7
Occlusal guards for bruxism, by report		
Hard appliance, full arch		\$46
Hard appliance, partial arch		\$24
Soft appliance, full arch		\$40
Repair and/or reline of occlusal guard	Not eligible within 6 months of the placement of the appliance	\$20
Occlusal guard adjustment	Not separately eligible within 6 months of the placement of the appliance	\$5
Apicoectomy – anterior		\$60
Apicoectomy - bicuspid (first root)		\$60
Apicoectomy (each additional root)		\$40
Periradicular surgery without apicoectomy		\$45
Retrograde filling – per root		\$14
Root amputation - per root		\$27
Gingivectomy/gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant		\$40

Gingivectomy/gingivoplasty, 1 - 3 contiguous teeth or tooth bounded spaces per quadrant		\$20
Gingivectomy or gingivoplasty to allow access for restorative, per tooth procedure		\$8
Gingival flap procedure including root planing, 4 or more contiguous teeth or tooth bounded spaces per quadrant		\$60
Gingival flap procedure, including root planing - 1 - 3 contiguous teeth or tooth bounded spaces per quadrant		\$36
Apically positioned flap	1 per quadrant every 5 years	\$60
Surgical removal of residual tooth roots (cutting procedure)		\$27
Exposure of an unerupted tooth		\$27
Mobilization of erupted or malpositioned tooth to aid eruption		\$27
Placement of device to facilitate eruption of impacted tooth		\$5
Incisional biopsy of oral tissue-hard (bone/tooth)		\$27
Incisional biopsy of oral tissue-soft		\$27
Exfoliative cytological sample collection		\$14
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		\$27
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		\$14
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		\$40
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		\$20
Incision and drainage of abscess - intraoral soft tissue		\$20
Incision and drainage of abscess - intraoral soft tissue, complicated		\$22
Frenulectomy		\$40
Frenuloplasty		\$42
Apicoectomy - molar (first root)		\$60
Clinical crown lengthening - hard tissue		\$40
Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		\$80
Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		\$48
Surgical revision procedure, per tooth		\$32
Pedicle soft tissue graft procedure		\$40

Free soft tissue graft procedure (including donor site surgery)		\$60
Free soft tissue graft procedure (including donor site surgery), each additional site		\$60
Subepithelial connective tissue graft procedures, per tooth		\$75
Soft tissue allograft		\$75
Combined connective tissue and double pedicle graft – per tooth		\$83
Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		\$41
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		\$41
Removal of impacted tooth - partially bony		\$53
Removal of impacted tooth - completely bony		\$60
Removal of impacted tooth - completely bony, with unusual surgical complications		\$64
Coronectomy – intentional partial tooth removal		\$30
Evaluation for deep sedation or general anesthesia		\$9
Deep sedation / general anesthesia - each 15 minutes		\$20
Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment		\$20
Add metal substructure to acrylic full denture, per arch		\$27
Prefabricated resin crown		\$60
Prefabricated stainless steel crown with resin window		\$26
Prefabricated aesthetic coated stainless steel crown-primary tooth		\$26
Crown repair necessitated by restorative material failure		\$27
Apexification/recalcification – initial visit		\$32
Apexification/recalcification- interim medication replacement		\$32
Apexification/recalcification-final visit		\$32
Hemisection		\$27
Inlay Repair necessitated by restorative material failure		\$22
Onlay Repair necessitated by restorative material failure		\$22

Veneer Repair necessitated by restorative material failure		\$22
Labial veneer (lamine) - chairside, refers to labial/facial direct resin bonded veneers.		\$60
Labial veneer (resin laminate) - laboratory, refers to labial/facial indirect resin bonded veneers.		\$24
Labial veneer (porcelain laminate) - laboratory, refers also to facial veneers that extend interproximally and/or cover the incisal edge. Porcelain/ceramic veneers presently include all ceramic, porcelain, and polymer-reinforced porcelain veneers.		\$80
Fixed partial denture repair		\$27
Fixed partial denture sectioning		\$14
Repair implant supported prosthesis, by report		\$27
Stress breaker		\$40
Oroantral fistula closure		\$48
Primary closure of a sinus perforation		\$48
Tooth transplantation		\$48
Removal of lateral exostosis		\$60
Removal of torus palatinus		\$60
Removal of torus mandibularis		\$60
Surgical reduction of osseous tuberosity		\$60
Excision of hyperplastic tissue, per arch		\$32
Excision of pericoronal gingiva		\$40
Surgical reduction of fibrous tuberosity		\$16
Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		\$20
Removal of reaction-producing foreign bodies, musculoskeletal system		\$20
Partial ostectomy/sequestrectomy for removal of non-vital bone		\$20
Suture of recent small wounds up to 5 cm		\$20
Complicated suture - up to 5 cm		\$20
Complicated suture - greater than 5 cm		\$20

Out-of-network coverage	Limitations
Type Orthodontic treatment expenses	
Comprehensive orthodontic treatment of adolescent and adult dentition	Subject to lifetime maximum below
Post treatment stabilization	Subject to lifetime maximum below
Lifetime maximum	\$400

Important note:

The following apply:

- **Copayment** amounts for crowns and pontics are per unit.
- Fees for dentures and partial dentures include relines, rebases, and adjustments within 12 months after installation. Fees for relines and rebases include adjustments within 12 months after installation. Specialized techniques and characterizations are not eligible.
- 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.

(Limited to 1 per tooth every 5 years. See the *Replacement rule*.)

- **Restorative services:** Multiple restorations on 1 surface are considered as a single restoration. (Limited to 1 per teeth every 5 years.)
- 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 out-of-network **Calendar Year deductible** and **coinsurance** for the additional **eligible dental services** above.

Your **coinsurance** applied to the additional **eligible dental services** will be:

Expense	In-network coverage Coinsurance	Out-of-network coverage Coinsurance
Additional eligible dental services	0%	0%