Schedule of Benefits

(GR-29N 01-01 01)

Applies to the Managed Dental Coverage

Employer: **University of Hartford**

Group Policy Number: **GP-724328**

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Effective Date: January 1, 2019
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.