

Schedule of Benefits

(GR-29N 01-01 01)

Employer: Denison University

Group Policy Number: GP-478811

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Schedule: 1A

Cert Base: 1

For: Dental Maintenance Organization (DMO) Dental (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-22-005-01)

This Schedule Applies To Covered Expenses Provided By Network Providers.

Dental Emergency Maximum: \$100

Dental Care Schedule

The following dental care schedule shows services that require a **copay**; and the **copay** amount.

Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by **network providers**, at the dental office location. The exceptions to this rule are when **Aetna** approves referral care, or for out-of-area emergency dental care.

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 professionally acceptable result, as determined by **Aetna**.

This Schedule Applies to Services Provided by Network Providers

Primary Care Dentist Services (GR-9N-S-22-010-01)

Visits and Exams	Copayment Amount
Oral examination (limited to total of 4 visits per year)	\$0
Emergency palliative treatment	\$10
Prophylaxis (cleaning), (limited to 2 treatments per year)	
Adult	\$12
Child	\$10
Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)	\$0
Oral hygiene instruction	\$0

Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)	\$10
Pulp vitality test	\$0
Consultation	\$0
Diagnostic casts	\$0
X-Rays and Pathology	
Bitewing x-rays (limited to 1 set per year)	\$0
Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years)	\$0
Vertical bitewing X-rays (limited to 1 set every 3 years)	\$0
Periapical x-ray	\$0
Intra-oral, occlusal view, maxillary or mandibular	\$0
Extra-oral upper or lower jaw	\$0
Biopsy and histopathologic examination of oral tissue	\$100
Space Maintainers - (only when needed to preserve space resulting from premature loss of primary teeth) Includes all adjustments within six months after installation	
Fixed	\$100
Removable	\$100
Recement space maintainer	\$15
Removal of fixed space maintainer (by dentist who did not place appliance)	\$15
Endodontics	
Pulp cap	\$8
Pulpotomy	\$50
Root canal therapy, including necessary x-rays	
Anterior	\$150
Bicuspid	\$195
Restorations and Repairs (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal (“gold”) when used for services shown with an asterisk.	
Amalgam restoration	
1 surface	\$22
2 surfaces	\$32
3 surfaces	\$43
4 or more surfaces	\$53
Resin-based composite restoration (other than for molars)	
1 surface	\$40
2 surfaces	\$55
3 surfaces	\$60
4 or more surfaces or incisal angle	\$70
Resin-based composite crown, anterior	\$80
Retention pins	\$15
Stainless steel crowns, prefabricated, primary tooth	\$65
Stainless steel crowns, prefabricated, permanent tooth	\$80
Recementing inlays or crowns	\$18
Recementing bridges	\$20
Sedative filling	\$15
Inlays and Onlays, metallic*	\$275
Crowns	
Porcelain	\$325
Porcelain with metal (includes abutments)*	\$325
Metallic (full cast) (includes abutments)*	\$325
Metallic (3/4 cast)*	\$300

Cast post and core*	\$95
Prefabricated post and core	\$90
Core buildup including pins	\$55
Pontics	
Metallic (full cast)*	\$325
Porcelain with metal*	\$325
Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.)	\$125
Dentures and Partial s - (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)	
Complete, upper or lower	\$375
Partial, upper or lower	
Resin base	\$375
Cast metal base	\$475
Immediate, upper or lower (does not include charge for reline)	\$400
Adjust complete denture, upper or lower	\$15
Adjust partial denture, upper or lower	\$15
Repair broken acrylic, complete denture, upper or lower	\$35
Replace one tooth on complete denture	\$25
Repair acrylic, cast frame, broken clasp	\$45
Replace broken tooth, partial	\$45
Add tooth to existing partial denture	\$45
Add clasp to existing partial	\$50
Replace all teeth and acrylic on cast metal framework	\$95
Rebase, complete denture, upper or lower	\$95
Rebase, partial denture, upper or lower	\$95
Reline, complete denture, upper or lower (chairside)	\$65
Reline, partial denture, upper or lower (chairside)	\$65
Reline, complete denture, upper or lower (laboratory)	\$110
Reline, partial denture, upper or lower (laboratory)	\$110
Interim partial denture, upper or lower (stayplate), anterior only	\$110
Tissue conditioning for dentures	\$35
Periodontics	
Scaling and root planning, per quadrant (limited to 4 separate quadrants every 2 years)	\$65
Scaling and root planning - 1 to 3 teeth per quadrant (limited to once per site every 2 years)	\$39
Periodontal maintenance procedures following surgical therapy (limited to 2 per year)	\$60
Occlusal guard (for bruxism only), limited to 1 every 3 years	\$90
Oral Surgery - Includes local anesthetics and routine post-operative care	
Extraction- exposed root or erupted tooth	\$30
Extraction- coronal remnants	\$15
Surgical removal of erupted tooth	\$60
Surgical removal of impacted tooth (soft tissue)	\$80
Incision and drainage of intraoral abscess	\$50
Surgical exposure of impacted or unerupted tooth to aid eruption	\$90
Specialty Services	
Endodontics - Includes local anesthetics where necessary	Copayment Amount
Apicoectomy/periradicular surgery	
Anterior	\$156
Bicuspid, first root	\$156

Molar, first root	\$190
Each additional root	\$130
Retrograde filling, per root	\$75
Root amputation, per root	\$100
Molar root canal therapy	\$295
Retreatment of previous root canal therapy	
Anterior	\$250
Bicuspid	\$295
Molar	\$395
Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Surgical removal of root tip, root recovery	\$55
Frenectomy	\$128
Alveoplasty in conjunction with extractions - per quadrant	\$55
Alveoplasty not in conjunction with extractions - per quadrant	\$75
Surgical removal of impacted tooth	
Partially bony	\$100
Completely bony	\$150
Completely bony with unusual surgical complications	\$150
Periodontics	
Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years	\$160
Gingivectomy or gingivoplasty - 1-3 teeth, limited to 1 per site, every 3 years	\$43
Gingival flap procedure - per quadrant	\$200
Gingival flap procedure - 1-3 teeth one per quadrant	\$120
Occlusal adjustment (other than with an appliance or restoration)	
Limited	\$25
Complete	\$90
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years	\$340
Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years	\$204
Surgical revision procedure, per tooth	\$136
Pedicle soft tissue graft	\$260
Free soft tissue graft (including donor site surgery)	\$275
Subepithelial connective tissue graft	\$310
Soft tissue allograft	\$310
Combined connective tissue and double pedicle graft	\$341
Clinical crown lengthening	\$204
Orthodontics	
Orthodontic screening exam (when no Orthodontic Procedure is performed)	\$30
Orthodontic diagnostic records	\$150
Comprehensive orthodontic treatment of adolescent and adult dentition	\$1,945
Orthodontic retention	\$275

This Schedule Applies to Covered Expenses Provided by Out-of-Network Providers.

Dental Care Schedule (GR-9N-S-22-015-01)

Out-of-Network Deductible

\$100

Copayment

The **copayment** is the amount of charges that exceeds the benefits payable under this coverage.

This dental care schedule shows services that are covered and maximum charge eligible under the plan for each service. Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by a licensed **dentist**, at the dental office location. You are responsible for any amount above the Amount Payable shown.

The next sentence applies 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**.

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.

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.