Schedule of benefits

Managed dental expense insurance plan

Prepared for:

Policyholder:	City of Berwyn, Illinois
Policyholder number:	GP-0876576
Schedule of benefits:	1A
Group policy effective date	May 1, 2021
Plan name:	Freedom of Choice Dental Maintenance Organization
Plan effective date:	May 1, 2021
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Underwritten by Aetna Life Insurance Company in the state of Illinois

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**
- Lifetime out-of-network **orthodontic treatment deductible**

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**.

Lifetime out-of-network orthodontic treatment deductible

This is the amount you owe for **eligible dental services** provided by **out-of-network providers** for **orthodontic treatment** during your lifetime before the plan begins to pay.

Charges that you incur for out-of-network **eligible dental services** for **orthodontic treatment** will not be applied to satisfy the plan's **Calendar Year** out-of-network **deductible**.

This lifetime **orthodontic treatment deductible** is separate from any other **deductible** for the plan and applies to you and each of your covered dependents.

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	$5 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	Coinsurance
Comprehensive **orthodontic treatment** of adolescent and adult dentition	40%

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, (6 treatments per year)
- Topical application of fluoride or fluoride varnish if you are under age 19 (1 treatment per year)
- Sealants per tooth, if you are under age 16 (1 application every 3 years for permanent molars)
- Sealant repair (for permanent molars if you are under age 16)
- Resin infiltration of incipient smooth surface lesions for permanent teeth only, if you are under age 16, (1 application every 3 years)
- Preventive resin restoration if you are under age 16 (1 application 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 sets every 3 years)
- Vertical bitewing X-rays (1 sets 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 2 years)
- Scaling and root planing, 4 or more teeth (4 separate quadrants, every year)
- Periodontal maintenance procedures following surgical therapy (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

- 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
- Adjustment to denture more than 6 months after installation
- 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 Includes all adjustments within 6 months after installation and to children under age 19

- 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
- Alveoloplasty
- 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, (1 per quadrant every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (limited to 1 per quadrant every 3 years)
- Apically positioned flap (limited to 1 per quadrant every 5 years)
- Occlusal adjustment
- Soft tissue graft procedure

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 port-operative care

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

Periodontics

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

Implants (limited to 2 teeth per year)

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service

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

When services shown in the preceding schedule of **eligible dental services** are provided by **out-of-network providers**, you pay the **coinsurance** percentage after the **Calendar Year deductible** or lifetime **deductible** shown below for **eligible dental services**.

Out-of-network plan features

Deductible	**Amount**
Out-of-network Calendar Year deductible	$500
Important note: This **deductible** does not apply to **orthodontic treatment services** and out-of-area **dental emergency services** care.	

Expenses	
Primary care services	**Coinsurance**
Type A expenses	30%
Type B expenses	50%
Type C expenses	50%
Specialty care services	**Coinsurance**
Type B expenses	50%
Type C expenses	50%

Expenses	
Orthodontic treatment expenses	**Amounts**
Lifetime **deductible**	1,000
Coinsurance	50%

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%