Schedule of benefits

Comprehensive dental expense 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:	Outten & Golden, LLP
Policyholder number:	GP-0149284-E
Schedule of benefits:	1A
Group policy effective date:	January 1, 2022
Plan name:	DMO - New Jersey Specialty Care Dentist Services
Plan effective date:	January 1, 2022
Plan issue date:	November 10, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey

Schedule of benefits

This schedule of benefits lists the **eligible dental services**, **copayment**, and any limits that apply to the services you get under this plan.

How to read your schedule of benefits

- The **copayment** listed in the schedule of benefits below reflects the **copayment** amounts under your plan.
- You must pay any office visit **copayment** and your part of the **copayment** listed in the schedule of benefits.
- You must pay the full amount of any dental care services you get that is not a **covered benefit**.
- 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 a **copayment** 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 the number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- **Copayment**

Copay, copayments

The specific dollar amount you have to pay for **eligible dental services**.

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

Orthodontic treatment copayment

Expenses	Copayments
Comprehensive **orthodontic treatment** of adolescent and adult dentition	$2,800

Eligible dental services

Eligible Dental Services	Limitations	Copayment Amounts
Endodontic therapy, molar (excluding final restoration)		$333
Retreatment of previous root canal therapy – anterior		$242
Retreatment of previous root canal therapy – premolar		$308
Retreatment of previous root canal therapy – molar		$435
Apicoectomy – anterior		$148
Apicoectomy – bicuspid (first root)		$148
Apicoectomy – molar (first root)		$158
Apicoectomy – each additional root		$99
Surgical repair of root resorption - anterior		$67
Surgical repair of root resorption - premolar		$89
Surgical repair of root resorption - molar		$111
Retrograde filling – per root		$80
Root amputation – per root		$88
Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior		$88
Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar		$118
Surgical exposure of root surface without apicoectomy or repair of root resorption - molar		$147
Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$168
Gingivectomy or gingivoplasty, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$78
Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		$26
Gingival flap procedure, including root planing, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$180

Gingival flap procedure, including root planing, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$108
Apically positioned flap		$147
Clinical crown lengthening – hard tissue		$205
Osseous surgery (including elevation of a full thickness flap and closure),4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$341
Osseous surgery (including elevation of a full thickness flap and closure), 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$205
Surgical revision procedure, per tooth		$137
Pedicle soft tissue graft procedure		$263
Autogenous connective tissue graft procedure (including donor and recipient surgical sites), first tooth, implant or edentulous tooth position		$158
Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant, or edentulous tooth position in graft		$347
Combined connective tissue and pedicle graft, per tooth		$260
Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft		$111
Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site		$56
Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site		$87
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		$191
Add metal substructure to acrylic full denture (per arch)		$40
Removal of impacted tooth – partially bony		$85

Removal of impacted tooth – completely bony		$155
Removal of impacted tooth – completely bony, with unusual surgical complications		$155
Removal of residual tooth roots -cutting procedure		$37
Coronectomy - intentional partial tooth removal		$70
Exposure of an unerupted tooth		$63
Mobilization of erupted or malpositioned tooth to aid eruption		$77
Placement of device to facilitate eruption of impacted tooth		$15
Incisional biopsy of oral tissue – hard (bone, tooth)		$195
Incisional biopsy of oral tissue – soft		$195
Exfoliative cytological sample collection		$110
Alveoloplasty in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant		$39
Alveoloplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant		$20
Alveoloplasty not in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant		$66
Alveoloplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant		$33
Incision and drainage of abscess – intraoral soft tissue		$33
Incision and drainage of abscess – intraoral soft tissue - complicated		$36
Buccal/ labial frenectomy (frenulectomy)		$99
Lingual frenectomy (frenulectomy)		$99
Frenuloplasty		$105
Evaluation for deep sedation or general anesthesia		$0
Deep sedation/general anesthesia, first 15 minutes		$109
Deep sedation/general anesthesia – each 15 minute increment		$87
Intravenous moderate (conscious) sedation/analgesia, first 15 minutes		$109
Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment		$87

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service		$0
Occlusal adjustment – limited		$53
Occlusal adjustment – complete		$120

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 **coinsurance** for the additional **eligible dental services** above. The **coinsurance** applied to the additional **eligible dental services** will be 100%. These additional benefits will not be subject to any frequency limits except as shown above.