Schedule of Benefits

Employer: The George Washington University
Group Policy Number: GP-622758
Issue Date: January 27, 2020
Effective Date: January 1, 2020
Schedule: 1A
Cert Base: 1

For: Dental Maintenance Organization

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

This Schedule Applies to Covered Expenses Provided by Network Providers.

Office Visit Copayment $5 per visit.
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.

In addition to copays for covered expenses shown in the following schedule, you will also be responsible for an office visit copay as shown above.

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-22010101)**

<table>
<thead>
<tr>
<th>Services</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visits and Exams</strong></td>
<td></td>
</tr>
<tr>
<td>Oral examination (limited to total of 4 visits per year)</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency palliative treatment</td>
<td>$10</td>
</tr>
<tr>
<td>Prophylaxis (cleaning), (limited to 2 treatments per year)</td>
<td></td>
</tr>
<tr>
<td>- Adult</td>
<td>$0</td>
</tr>
<tr>
<td>- Child</td>
<td>$0</td>
</tr>
<tr>
<td>Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)</td>
<td>$0</td>
</tr>
<tr>
<td>- Oral hygiene instruction</td>
<td>$0</td>
</tr>
<tr>
<td>- Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)</td>
<td>$10</td>
</tr>
<tr>
<td>- Pulp vitality test</td>
<td>$0</td>
</tr>
<tr>
<td>- Consultation</td>
<td>$0</td>
</tr>
<tr>
<td>- Diagnostic casts</td>
<td>$0</td>
</tr>
<tr>
<td><strong>X-Rays and Pathology</strong></td>
<td></td>
</tr>
<tr>
<td>Bitewing x-rays (limited to 1 set per year)</td>
<td>$0</td>
</tr>
<tr>
<td>Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years)</td>
<td>$0</td>
</tr>
<tr>
<td>Vertical bitewing X-rays (limited to 1 set every 3 years)</td>
<td>$0</td>
</tr>
<tr>
<td>Periapical x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>Intra-oral, occlusal view, maxillary or mandibular</td>
<td>$0</td>
</tr>
<tr>
<td>Extra-oral upper or lower jaw</td>
<td>$0</td>
</tr>
<tr>
<td>Accession of oral tissue</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Space Maintainers</strong> - (only when needed to preserve space resulting from premature loss of primary teeth) Includes all adjustments within six months after installation</td>
<td></td>
</tr>
<tr>
<td>- Fixed</td>
<td>$80</td>
</tr>
<tr>
<td>- Removable</td>
<td>$80</td>
</tr>
<tr>
<td>- Recement space maintainer</td>
<td>$15</td>
</tr>
<tr>
<td>- Remove fixed space maintainer (by dentist who did not place appliance)</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Pulp cap</td>
<td>$0</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>$55</td>
</tr>
<tr>
<td>Root canal therapy, including necessary x-rays</td>
<td></td>
</tr>
<tr>
<td>- Anterior</td>
<td>$120</td>
</tr>
<tr>
<td>- Bicuspid</td>
<td>$180</td>
</tr>
<tr>
<td><strong>Restorations and Repairs</strong> (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal (&quot;gold&quot;) when used for services shown with an asterisk.</td>
<td></td>
</tr>
<tr>
<td>Amalgam restoration</td>
<td></td>
</tr>
<tr>
<td>- 1 surface</td>
<td>$0</td>
</tr>
<tr>
<td>- 2 surfaces</td>
<td>$0</td>
</tr>
<tr>
<td>- 3 surfaces</td>
<td>$0</td>
</tr>
<tr>
<td>- 4 or more surfaces</td>
<td>$0</td>
</tr>
<tr>
<td>Resin-based composite restoration (anterior)</td>
<td></td>
</tr>
<tr>
<td>- 1 surface</td>
<td>$0</td>
</tr>
<tr>
<td>- 2 surfaces</td>
<td>$0</td>
</tr>
</tbody>
</table>

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### Surfaces and Composites
- **3 surfaces**
- **4 or more surfaces or incisal angle**
- **Resin-based composite crown, anterior**
- **Resin-based composite restoration (posterior)**
  - 1 surface
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- **Retention pins**
- **Stainless steel crowns, prefabricated, primary tooth**
- **Stainless steel crowns, prefabricated, permanent tooth**
- **Recementing inlays or crowns**
- **Recementing bridges**
- **Sedative filling**
- **Inlays metallic***

### Crowns
- **Porcelain**
- **Porcelain with metal (includes abutments)**
- **Metallic (full cast)**
- **Metallic (3/4 cast)**
- **Cast post and core**
- **Prefabricated post and core**
- **Core buildup including pins**

### Pontics
- **Metallic (full cast)**
- **Porcelain with metal***

### 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 - (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)
- **Complete, upper or lower**
- **Partial, upper or lower**
  - **Resin base**
  - **Cast metal base**
- **Immediate, upper or lower (does not include charge for reline)**
- **Adjust complete denture, upper or lower**
- **Adjust partial denture, upper or lower**
- **Repair broken acrylic, complete denture, upper or lower**
- **Replace one tooth on complete denture**
- **Repair resin denture base, cast frame, broken clasp**
- **Replace broken tooth, partial**
- **Add tooth to existing partial denture**
- **Add clasp to existing partial**
- **Replace all teeth and acrylic on cast metal framework**
- **Rebase, complete denture, upper or lower**
- **Rebase, partial denture, upper or lower**
- **Reline, complete denture, upper or lower (chairside)**
- **Reline, partial denture, upper or lower (chairside)**
- **Reline, complete denture, upper or lower (laboratory)**
- **Reline, partial denture, upper or lower (laboratory)**
- **Interim partial denture, upper or lower (stayplate), anterior only**
- **Tissue conditioning for dentures**
**Periodontics**
Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years) $60
Scaling and root planing -1 to 3 teeth per quadrant (limited to once per site every 2 years) $36
Periodontal maintenance procedures following surgical therapy (limited to 2 per year) $40
Occlusal guard (for bruxism only), limited to 1 every 3 years $130

**Oral Surgery** - Includes local anesthetics and routine post-operative care
- Extraction - exposed root or erupted tooth $0
- Extraction - coronal remnants - deciduous tooth uncomplicated $0
- Surgical removal of erupted tooth $50
- Surgical removal of impacted tooth (soft tissue) $60
- Incision and drainage of intraoral abscess $30
- Mobilization of erupted or malpositioned tooth to aid eruption $70
- Biopsy of oral tissue $80

**Specialty Services**

**Endodontics** - Includes local anesthetics where necessary
Apicoectomy/periradicular surgery
- Anterior $170
- Bicuspid, first root $170
- Molar, first root $170
- Each additional root $100
- Retrograde filling, per root $65
- Root amputation, per root $80
- Molar root canal therapy $300
- Retreatment of previous root canal therapy
  - Anterior $220
  - Bicuspid $280
  - Molar $400

**Oral Surgery** - Includes local anesthetics where necessary and post-operative care
- Surgical removal of residual tooth roots $55
- Frenectomy $90
- Alveoloplasty in conjunction with extractions - per quadrant $60
- Alveoloplasty not in conjunction with extractions - per quadrant $75
- Surgical removal of impacted tooth
  - Partially bony $80
  - Completely bony $120
  - Completely bony with unusual surgical complications $120

**Periodontics**
- Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years $125
- Gingivectomy or gingivoplasty - 1-3 teeth, limited to 1 per site, every 3 years $55
- Gingival flap procedure - per quadrant $155
- Gingival flap procedure - 1-3 teeth one per quadrant $93
- Occlusal adjustment (other than with an appliance or restoration)
  - Limited $30
  - Complete $100
- Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years $375
- Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years $225
- Surgical revision procedure, per tooth $150
Pedicle soft tissue graft $285
Free soft tissue graft (including donor site surgery) $305
Subepithelial connective tissue graft $173
Soft tissue allograft $345
Combined connective tissue and double pedicle graft $285
Clinical crown lengthening - hard tissue $225

Orthodontics
Orthodontic screening exam (when no Orthodontic Procedure is performed) $30
Orthodontic diagnostic records $150
Comprehensive orthodontic treatment of adolescent and adult dentition $1,845
Orthodontic retention $275

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.

Copayments and Benefit Deductible Provisions (GR-9N S-09-15 01)

Copayment, Copay
This is a specified dollar amount or percentage, shown in the Schedule of Benefits, you are required to pay for covered expenses.

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.