

## 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:

<b>Policyholder:</b>	Truist Financial Corporation
<b>Policyholder</b> number:	GP-0141938-NJSD
Schedule of benefits:	2A
<b>Group policy</b> effective date:	January 1, 2024
Plan name:	Dental Maintenance Organization – New Jersey Specialty Care Dentist Services
Plan effective date:	January 1, 2024
Plan issue date:	December 21, 2023

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



## Schedule of benefits

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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](http://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

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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

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## Orthodontic treatment copayment

Expenses	Copayments
Comprehensive <b>orthodontic treatment</b> of adolescent and adult dentition	\$2,800

## Eligible dental services

Eligible Dental Services	Limitations	Copayment Amounts
Endodontic therapy, molar tooth (excluding final restoration)		\$175
Retreatment of previous root canal therapy – anterior		\$150
Retreatment of previous root canal therapy – premolar		\$170
Retreatment of previous root canal therapy – molar		\$275
Apicoectomy – anterior		\$65
Apicoectomy – premolar (first root)		\$65
Apicoectomy – molar (first root)		\$80
Apicoectomy – each additional root		\$40
Retrograde filling – per root		\$20
Root amputation – per root		\$60
Surgical repair of root resorption - anterior		\$29
Surgical repair of root resorption – premolar		\$39
Surgical repair of root resorption – molar		\$49
Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		\$54
Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		\$72
Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		\$90
Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$100
Gingivectomy or gingivoplasty – 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$30
Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	1 per quadrant every 3 years	\$12
Gingival flap procedure, including root planing – 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$110
Gingival flap procedure, including root planing – 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$66
Apically positioned flap		\$90

Clinical crown lengthening – hard tissue		\$150
Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$250
Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$150
Surgical revision procedure, per tooth		\$100
Pedicle soft tissue graft procedure		\$190
Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position		\$115
Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft		\$230
Combined connective tissue and pedicle graft, per tooth		\$190
Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		\$82
Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site		\$41
Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		\$63
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		\$127
Add metal substructure to acrylic full denture (per arch)		\$30
Removal of impacted tooth – partially bony		\$45
Removal of impacted tooth – completely bony		\$70
Removal of impacted tooth – completely bony, with unusual surgical complications		\$70
Removal of residual tooth roots (cutting procedure)		\$15
Coronectomy - intentional partial tooth removal, impacted teeth only		\$35

Exposure of an unerupted tooth		\$26
Mobilization of erupted or malpositioned tooth to aid eruption		\$30
Placement of device to facilitate eruption of impacted tooth		\$6
Excisional biopsy of minor salivary glands		\$75
Incisional biopsy of oral tissue – hard (bone, tooth)		\$50
Incisional biopsy of oral tissue – soft		\$50
Exfoliative cytological sample collection		\$25
Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces, per quadrant		\$18
Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant		\$9
Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces, per quadrant		\$25
Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant		\$13
Incision and drainage of abscess – intraoral soft tissue		\$10
Incision and drainage of abscess – intraoral soft tissue - complicated		\$11
Buccal/labial frenectomy (frenulectomy)		\$24
Lingual frenectomy (frenulectomy)		\$24
Frenuloplasty		\$25
Deep sedation/general anesthesia – first 15 minutes		\$104
Deep sedation/general anesthesia – each subsequent 15 minute increment		\$83
Intravenous moderate (conscious) sedation/analgesia – first 15 minutes		\$104
Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		\$83
Occlusal adjustment – limited	Not covered when performed in conjunction with a restoration, root canal therapy or appliance	\$20
Occlusal adjustment – complete		\$80

## **Additional eligible dental services**

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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.