# Preferred Provider Organization (PPO)
# Dental Plan

## Schedule of benefits

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 exclusively for:**

| | |
|---|---|
| **Policyholder**: | HSP Southern Healthcare, LLC |
| **Policyholder** number: | 141582-B |
| | Schedule of Benefits 1A |
| **Group policy** effective date: | August 1, 2019 |
| Plan effective date: | August 1, 2019 |
| Plan issue date: | July 25, 2020 |
| Plan revision effective date: | August 1, 2020 |

## Underwritten by Aetna Life Insurance Company in the state of Florida.

# Schedule of benefits

This schedule of benefits lists the **eligible dental services**, **deductibles**, **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**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year** or **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.

**Important note:**
All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

## How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at www.aetna.com.
- Call Member Services at 1-877-238-6200.

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:

- **Deductibles**
- **Coinsurance**
- Maximums

## Calendar Year deductible

**Eligible dental services** applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible dental services** applied to the **in-network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

**Individual deductible**

This is the amount you pay for in-network and out-of-network **eligible dental services** each **Calendar Year** before the plan begins to pay. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. Once you have reached the **Calendar Year deductible**, this plan will begin to pay for **eligible dental services** for the rest of the **Calendar Year**.

**Family deductible**

When you and each of your covered dependents incur **eligible dental services** that apply towards the individual **Calendar Year deductibles,** these expenses will also count toward a family **deductible**.

To satisfy this family **deductible** for the rest of the **Calendar Year**, the following must happen:

- The combined **eligible dental services** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** in a **Calendar Year**.

When this happens in a **Calendar Year**, the individual **Calendar Year deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

## Coinsurance

Once any applicable **deductibles** have been met, the specific **coinsurance** percentage the plan pays for **eligible dental services** is listed below.

## Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

The **Calendar Year maximum** applies to in-network and out-of-network **eligible dental services** combined.

## Dental emergency services maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person for any one **dental emergency** is called the **dental emergency services** maximum.

## Orthodontic lifetime maximum

The most the plan will pay for orthodontic expenses incurred by any one covered person during their lifetime is called the orthodontic **lifetime maximum**.

The orthodontic **lifetime maximum** applies to covered in-network and out-of-network **eligible orthodontic treatment** combined.

## 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

## Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

| | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Calendar Year deductible** | Individual $50<br>Family $150 | Individual $50<br>Family $150 |
| | | |
| The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses. | | |

## Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

| | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Type A expenses** | 100% of the **negotiated charge** | 80% of the **recognized charge** |
| **Type B expenses** | 80% of the **negotiated charge** | 80% of the **recognized charge** |
| **Type C expenses** | 50% of the **negotiated charge** | 50% of the **recognized charge** |
| | | |

## Orthodontic treatment coinsurance

| | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Orthodontic treatment coinsurance** | 50% of the **negotiated charge** | 50% of the **recognized charge** |

## Dental emergency services maximum

| | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Dental emergency services maximum** | N/A | $75 |

## Coinsurance incentives and Calendar Year maximum incentive

| **Plan coinsurance in-network coverage** | | | | **Calendar Year maximum incentive*** |
|---|---|---|---|---|
| | **Type A expenses** | **Type B expenses** | **Type C expenses** | |
| **During the first Calendar Year**: | 100% of the **negotiated charge** | 80% of the **negotiated charge** | 50% of the **negotiated charge** | $1,750 |
| **During the second Calendar Year**: | 100% of the **negotiated charge** | 80% of the **negotiated charge** | 50% of the **negotiated charge** | $2,000 |
| **During the third Calendar Year**: | 100% of the **negotiated charge** | 80% of the **negotiated charge** | 50% of the **negotiated charge** | $2,250 |
| **During the fourth and subsequent Calendar Years**: | 100% of the **negotiated charge** | 80% of the **negotiated charge** | 50% of the **negotiated charge** | $2,500 |
| * The **Calendar Year maximum** applies to all **eligible dental services**. | | | | |
| **Coinsurance out-of-network** | | | | **Calendar Year maximum incentive*** |
| | **Type A expenses** | **Type B expenses** | **Type C expenses** | |
| **During the first Calendar Year**: | 80% of the **recognized charge** | 80% of the **recognized charge** | 50% of the **recognized charge** | $1,750 |
| **During the second Calendar Year**: | 80% of the **recognized charge** | 80% of the **recognized charge** | 50% of the **recognized charge** | $2,000 |
| **During the third Calendar Year**: | 80% of the **recognized charge** | 80% of the **recognized charge** | 50% of the **recognized charge** | $2,250 |

| | | | | |
|---|---|---|---|---|
| **During the fourth and subsequent Calendar Years**: | 80% of the **recognized charge** | 80% of the **recognized charge** | 50% of the **recognized charge** | $2,500 |
| *The **Calendar Year maximum** applies to all **eligible dental services**. | | | | |

## Orthodontic lifetime maximum

| | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Orthodontic lifetime maximum** | $1,500 | $1,500 |

# Eligible dental services

## Type A expenses: Diagnostic & preventive care

### Visits and exams

- Office visit during regular office hours for oral examination, (2 visits per year or 2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 application per year)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)

**Space maintainers -** Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

### Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

## Type B expenses: Basic restorative care

### Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit

### Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

**Restorative** - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (excluding temporary crowns)
- Recementation

**Oral surgery**

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth - Soft tissue
- Removal of impacted tooth – Partially bony
- Removal of impacted tooth – Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- 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
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Coronectomy

**Periodontics**

- Periodontal maintenance (following active therapy, 2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)

- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Clinical crown lengthening, hard tissue
- Full mouth debridement (Limited to 1 per lifetime)

**Endodontics**
- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid
  - Molar
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation

**General anesthesia and intravenous sedation**
- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

## Type C expenses: Major restorative care

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic **injury**, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 years. (See the *Replacement rule*.)
- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown
- Core buildup, including any pins

**Prosthodontics** - The 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 8 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 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
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance
- Implant

## Type: Orthodontics care expenses

- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**
- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Appliance therapy to control harmful habits
- Orthodontic retention
- Repair of orthodontic appliance

## Additional eligible dental services

We will provide additional **eligible dental services** if you and your covered dependent have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

**Additional eligible dental services**:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant (one additional per **Calendar Year**)
- Scaling and root planing (limited to 1-3 teeth), per quadrant (one additional per **Calendar Year**)
- Full mouth debridement (one additional per **Calendar Year**)
- Periodontal maintenance (one additional per **Calendar Year**)

**Payment of benefits**

We will waive the **Calendar Year deductible** for the additional **eligible dental services** above. The **coinsurance** applied to the additional **eligible dental services** will be 100% for in-network coverage and 100% for out-of-network coverage. These additional benefits will not be subject to any frequency limits except as shown above, or to any **Calendar Year** maximum.