

**Preferred Provider Organization (PPO)
Dental Expense Plan**

Schedule of benefits

Prepared exclusively for:

Employer:	Conroe Independent School District
Contract number:	ASA-100087
	Schedule of Benefits 1A
Plan effective date:	September 1, 2020
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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits lists the **eligible dental services, deductibles, payment percentage**, 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 **payment percentage** listed in the schedule of benefits below reflects the **deductibles** and **payment percentage** amounts under your plan.
- You must pay any **deductibles** and your part of the **payment percentage**.
- The **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the **payment percentage** amount the plan pays. You are responsible for paying any remaining **payment percentage**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Plan 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 **Plan Year deductible** and **payment percentage** 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 the Customer's group plan. This schedule of benefits replaces any schedule of benefits previously in effect under the plan of benefits. Keep this schedule of benefits with your booklet.

General coverage provisions

This section explains the:

- **Deductibles**
- **Payment percentage**
- **Maximums**

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

Family deductible

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

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

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

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

Payment percentage

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

Plan Year maximum

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

The **Plan Year maximum** applies to in-network and out-of-network **eligible dental services** 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 **Plan Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

Plan features

Plan Year deductible

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

	In-network coverage	Out-of-network coverage
Plan Year deductible	Individual \$50 Family \$150	Individual \$50 Family \$150
The Plan Year deductible applies to all eligible dental services except Type A expenses.		

Payment percentage

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

	In-network coverage	Out-of-network coverage
Type A expenses	100% of the negotiated charge	100% 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 payment percentage

	In-network coverage	Out-of-network coverage
Orthodontic treatment payment percentage	50% of the negotiated charge	50% of the recognized charge

Plan Year maximum

	In-network coverage	Out-of-network coverage
Plan Year maximum	\$1,200	\$1,200

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 (1 application every 3 years 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
- 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

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)

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification

- Apicoectomy
- Root canal therapy and retreatment
 - Anterior
 - Bicuspid
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation

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.

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown
- Core build up, including any pins

Endodontics

- Root canal therapy and retreatment
 - Molar

Periodontics

- 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)

Prosthodontics -

- 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

Oral surgery

- Removal of impacted tooth
 - Partially bony
 - Completely bony
- Coronectomy

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

Payment of benefits

We will waive the **Plan Year deductible** for the additional **eligible dental services** above. The **payment percentage** 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 Plan Year maximum.