Aetna Dental Inc.
One Prudential Circle
Sugar Land, TX 77478
1-877-238-6200

SUMMARY OF COVERAGE

CONTRACT HOLDER: Conroe Independent School District **GROUP AGREEMENT: 100087**

PLAN EFFECTIVE: September 1, 2015

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

ELIGIBILITY

You are in an Eligible Class if you are a regular full-time employee and you work, live, or reside in the Service Area.

If you elect to have coverage under any other dental plan sponsored by the Contract Holder and such coverage becomes effective, this Certificate of Coverage will no longer apply. A new description of your coverage will be issued to you. Contact the Contract Holder for information as to when your coverage under any other dental plan may be effective.

Your Eligibility Date is the date determined by the Contract Holder, but not before the later of the Effective Date of this Plan or the date you enter the Eligible Class.

DENTAL COVERAGE
FOR YOU AND YOUR DEPENDENTS

Service Area .... All Texas counties in their entirety, with the exception of the following excluded Texas counties:

Brewster*	Culberson	Jeff Davis**
Kinney	Presidio	Terrell
Val Verde		

*Only zip code 79830, 79831, 79832 & 79842 from Brewster County is included in the service area. All other zip codes in Brewster County are excluded.
**Only zip code 79734 from Jeff Davis County is included in the service area. All other zip codes in Jeff Davis County are excluded.

Dental Plan Coverage (DPC)..................... See the description of your Dental Plan Coverage on the pages that follow.

DENTAL CARE SCHEDULE

Applies to Covered Services Provided by Member Dental Providers

Covered dental services shown in the Dental Care Schedule must be given by Primary Care Dentists and Specialty Dentists; at the dental office location; except for Referral Care when approved by Aetna; or for Out-Of-Area Emergency Dental Care.

Office Visit Copayment: In addition to copayments for Covered Services shown in the following Schedule, Members are liable for an office visit copayment of $5 per visit.

The next sentence applies 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.

In that case; the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Primary Care Dentist Services

	Copayment Amount
VISITS AND EXAMS	
• Oral examination	$ 0.00
• Emergency palliative treatment	10.00
• Prophylaxis	
Adult	0.00
Child	0.00
• Topical application of fluoride (limited to covered persons under age 16)	0.00
• Oral hygiene instruction	0.00
• Sealants, per tooth (limited to permanent molars and to covered persons under age 16)	0.00
• Pulp vitality test	0.00
• Consultation	0.00
• Diagnostic casts	0.00
X-RAYS AND PATHOLOGY	
• Bitewing X-rays	0.00
• Entire series, including bitewings, or panoramic film	0.00
• Vertical bitewing X-rays	0.00
• Periapical X-ray	0.00
• Intraoral, occlusal view, maxillary or mandibular	0.00
• Extraoral upper or lower jaw	0.00
• Accession of oral tissue	0.00
SPACE MAINTAINERS - *Includes all adjustments within six months after installation.*	
• Fixed	0.00
• Removable	0.00
• Recement space maintainer	12.00
• Removal of fixed space maintainer (by dentist who did not place appliance)	12.00
ENDODONTICS	
• Pulp cap	0.00
• Pulpotomy	0.00
• Root canal therapy, including necessary X-rays	
Anterior	50.00
Bicuspid	70.00

RESTORATIONS AND REPAIRS - *(Copayments for crowns and pontic are per unit.) There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.*

- Amalgam restoration
  - 1 surface 0.00
  - 2 surfaces 0.00
  - 3 surfaces 0.00
  - 4 or more surfaces 0.00
- Resin-based composite restoration - anterior
  - 1 surface 0.00
  - 2 surfaces 0.00
  - 3 surfaces 0.00
  - 4 or more surfaces or incisal angle 40.00
- Resin-based composite crown – anterior 40.00
- Resin-based composite restoration – posterior
  - 1 surface 35.00
  - 2 surfaces 45.00
  - 3 surfaces 55.00
  - 4 or more surfaces 75.00
- Retention pins 10.00
- Stainless steel crowns, prefabricated, primary tooth 0.00
- Stainless steel crowns, prefabricated, permanent tooth 40.00
- Recementing inlays or crowns 5.00
- Recementing bridges 15.00
- Sedative filling 0.00
- Inlays Metallic* 190.00
- Crowns
  - Porcelain 225.00
  - Porcelain with metal (includes abutments)* 225.00
  - Metallic (full cast) (includes abutments)* 225.00
  - Metallic (3/4 cast)* 225.00
  - Cast post and core* 80.00
  - Prefabricated post and core 70.00
  - Core buildup including pins 60.00
- Pontics
  - Metallic (full cast)* 225.00
  - Porcelain with metal* 225.00
- Full mouth rehabilitation, per unit *(This means 6 or more covered units of crowns and/or pontics under one treatment plan.)* 125.00
- Dentures and Partials - *(Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)*
  - Complete, upper or lower 275.00
  - Partial, upper or lower
  - Resin base 275.00
  - Cast metal base 325.00
  - Immediate, upper or lower (does not include charge for reline) 325.00
  - Adjust complete denture, upper or lower 10.00
  - Adjust partial denture, upper or lower 10.00
  - Repair broken acrylic, complete denture, upper or lower 30.00
  - Replace one tooth on complete denture 35.00
  - Repair resin denture base, cast frame, broken clasp 35.00
  - Replace broken tooth, partial 35.00
  - Add tooth to existing partial denture 35.00
  - Add clasp to existing partial 40.00
  - Replace all teeth and acrylic on cast metal framework 100.00
  - Rebase, complete denture, upper or lower 100.00
  - Rebase, partial denture, upper or lower 100.00
  - Reline, complete denture, upper or lower (chairside) 40.00
  - Reline, partial denture, upper or lower (chairside) 40.00

Reline, complete denture, upper or lower (laboratory) 90.00
Reline, partial denture, upper or lower (laboratory) 90.00
Interim partial denture, upper or lower (stayplate), anterior only 90.00
Tissue conditioning for dentures 40.00

PERIODONTICS

- Scaling and root planing, per quadrant
  (limited to 4 separate quadrants every 2 rolling years) 50.00
- Scaling and root planing, 1 to 3 teeth (limited to once per site every 2 rolling years) 30.00
- Periodontal maintenance procedures following surgical therapy
  (limited to 2 per calendar year) 30.00
- Occlusal guard (for bruxism only), limited to 1 every 3 rolling years 100.00
- Full mouth debridement, once per lifetime 60.00

ORAL SURGERY *- Includes local anesthetics and routine post-operative care.*

- Extraction, erupted teeth or exposed root 0.00
- Extraction, coronal remnants - deciduous tooth uncomplicated 0.00
- Surgical removal of erupted tooth 0.00
- Surgical removal of impacted tooth (soft tissue) 0.00
- Incision and drainage of intraoral abscess 10.00
- Mobilization of erupted or malpositioned tooth to aid eruption 30.00
- Biopsy of oral tissue 50.00

Specialty Services

Copayment Amount

ENDODONTICS *- Includes local anesthetics where necessary.*

- Apicoectomy/periradicular surgery
  - Anterior .... $ 65.00
  - Bicuspid, first root 65.00
  - Molar, first root 80.00
  - Each additional root 40.00

  Retrograde filling, per root 20.00
  Root amputation, per root 60.00
  Molar root canal therapy 175.00
  Retreatment of previous root canal therapy
  - Anterior 150.00
  - Bicuspid 170.00
  - Molar 275.00

ORAL SURGERY *- Includes local anesthetics where necessary and post-operative care.*

- Surgical removal or root tip, root recovery 15.00
- Frenectomy 24.00
- Alveoloplasty in conjunction with extractions - per quadrant 18.00
- Alveoloplasty not in conjunction with extractions - per quadrant 25.00
- Surgical removal of impacted tooth
  - Partially bony 45.00
  - Completely bony 70.00
  - Completely bony with unusual surgical complications 70.00

PERIODONTICS

- Gingivectomy or gingivoplasty - per quadrant, limited to 1
  per quadrant, every 3 rolling years 100.00
- Gingivectomy or gingivoplasty - per tooth, limited to 1
  per site, every 3 rolling years 30.00
- Gingival flap procedure, including root planing - per quadrant 110.00
- Gingival flap procedure, including root planing – 1 to 3 teeth,
  limited to once per site every 3 years 66.00

- Occlusal adjustment (other than with an appliance or by restoration)
  - Limited 20.00
  - Complete 80.00
- Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 rolling years 250.00
- Osseous surgery (including flap entry and closure) – 1 to 3 teeth, limited to once per site every 3 rolling years 150.00
- Surgical revision procedure, per tooth 100.00
- Pedicle soft tissue graft 190.00
- Free soft tissue graft (including donor site surgery) 205.00
- Subepithelial connective tissue graft 115.00
- Soft tissue allograft 230.00
- Combined connective tissue and double pedicle graft 190.00

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (only when provided in conjunction with a covered surgical procedure)

- Deep sedation/General Anesthesia
  - First 30 minutes 165.00
  - Each additional 15 minutes 70.00
- Intravenous conscious sedation/analgesia
  - First 30 minutes 165.00
  - Each additional 15 minutes 70.00

ORTHODONTICS

- Orthodontic screening exam 30.00
- Orthodontic diagnostic records 150.00
- Comprehensive orthodontic treatment of adolescent or adult dentition 1945.00
- Orthodontic retention 275.00

ADJUSTMENT RULE

If for any reason an individual is entitled to a different amount of coverage, coverage will be adjusted as provided in the group contract, except that an increase is subject to the active work rule described in the Eligibility Provisions section of the Certificate of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this plan in effect prior to the date of any adjustment.

YOUR CONTRIBUTION

Your contributions toward the cost of this coverage are subject to change. Your Employer will advise you concerning the method and amount of any required contributions.

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group agreement. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The coverage described in this Certificate of Coverage will be provided under Aetna Dental Inc.'s Group Agreement.

KEEP THIS SUMMARY WITH
YOUR CERTIFICATE OF COVERAGE