Schedule of Benefits

Employer:	**Conroe Independent School District**
ASA:	100087
Control Number:	737387
Issue Date:	February 2, 2016
Effective Date:	September 1, 2015
Schedule:	3A
Booklet Base:	3

For: PPO/PDN Dental High Option Plan

Comprehensive Dental Plan (PPO/PDN)

Schedule of Comprehensive Dental Benefits *(GR-9N-S-21-005-01)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Year Deductible	Individual $50 Family $150	Individual $50 Family $150

The Plan Year **deductible** applies to all covered expenses except Type A Expenses.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN PAYMENT PERCENTAGE	NETWORK PAYMENT PERCENTAGE	OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%
Orthodontic Treatment	50%	50%

Plan Year Maximum Benefit
Plan Year Maximum: $1,200

The most the plan will pay for **covered expenses** incurred by any one covered person in a Plan Year is called the Plan Year Maximum Benefit.

The Plan Year maximum benefit applies to network and out-of-network covered dental expenses combined.

Expense Provisions

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*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits.*

You and each of your covered dependents have separate Plan Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Plan Year **deductibles**.

Network Provider Plan Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Plan Year from a **network provider** for which no benefits will be paid. This individual Plan Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Plan Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Plan Year.

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

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

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Plan Year **deductibles** must reach this family **deductible** limit in a Plan Year.

When this occurs in a Plan Year, the individual Plan Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Plan Year.

Out-of-Network Provider Plan Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Plan Year from an **out-of-network provider** for which no benefits will be paid. This individual Plan Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Plan Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Plan Year.

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

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

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Plan Year **deductibles** must reach this family **deductible** limit in a Plan Year.

When this occurs in a Plan Year, the individual Plan Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Plan Year.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Benefit Provisions

Plan Year Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person in a Plan Year is called the Plan Year maximum benefit.

The Plan Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

General

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 and should be kept with your Booklet.