

## Schedule of benefits

### Comprehensive dental expense insurance plan

**Prepared for:**

<b>Policyholder:</b>	Conroe Independent School District
<b>Policyholder</b> number:	GP-0100087
<b>Control</b> number:	CN-737387
Schedule of benefits:	2A
<b>Group policy</b> effective date:	September 1, 2021
Plan name:	Comprehensive Dental Plan - Low Option
Plan effective date:	September 1, 2021
Plan issue date:	September 7, 2021

Underwritten by Aetna Life Insurance Company in the state of Texas



## Schedule of benefits

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This schedule of benefits lists the **eligible dental services, deductibles, coinsurance**, maximums, and other limits that apply to the services you get under this plan.

### How to read your schedule of benefits

- When we say:
  - “**Contracting dental provider coverage**” we mean that you get care from **contracting dental providers**.
  - “**Non-contracting dental provider coverage**” we mean that you can get care from **non-contracting dental providers**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects 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 **Plan Year** or **lifetime maximums**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate limits for **contracting dental providers** and **non-contracting dental providers** unless we state otherwise. See later in this schedule of benefits for information about limits.

#### Important note:

All **covered benefits** are subject to a **Plan 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:

- Register and log onto our self-service website available 24/7 at [www.aetna.com](http://www.aetna.com)
- Call us 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

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This section explains the:

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

### Plan Year deductible

**Eligible dental services** applied to the **non-contracting dental provider deductibles** will be applied to satisfy the **contracting dental provider deductibles**. **Eligible dental services** applied to the **contracting dental provider deductibles** will be applied to satisfy the **non-contracting dental provider deductibles**.

### Individual deductible

You pay for **eligible dental services** each **Plan Year** before this plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Plan Year**.

### Family deductible

You pay for **eligible dental services** each **Plan Year** before this plan begins to pay. After the amount paid for **eligible dental services** reaches this family **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Plan Year**. To satisfy this family **deductible** for the rest of the **Plan Year**, the combined **eligible dental services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a **Plan Year**. When this happens in a **Plan Year**, the individual **deductibles** for you and your covered dependents are met for the rest of the **Plan Year**.

### 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**.

This **Plan Year maximum** applies to **eligible dental services** provided by **contracting dental providers** and **non-contracting dental providers** 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-certificate.

## Plan features

### Plan Year deductible

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

Deductibles	Contracting dental provider coverage Amounts	Non-contracting dental provider coverage Amounts
Plan Year deductible*	Individual \$50 Family \$150	Individual \$50 Family \$150
*Important note:	The <b>Plan Year deductible</b> applies to all <b>eligible dental services</b> except Type A expenses.	The <b>Plan Year deductible</b> applies to all <b>eligible dental services</b> 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**.

### About contracting and non-contracting dental providers

Your benefits, cost-sharing, and maximums are the same for **contracting dental providers** and **non-contracting dental providers**. However, you might pay more when you use a **non-contracting dental provider**. **Non-contracting dental providers** do not have to accept the **negotiated charge** that the **contracting dental providers** have agreed to be paid. We pay **non-contracting dental providers** based on the **recognized charge**, and they may balance bill you for charges over our **recognized charge**.

### Coinsurance

Expenses	Contracting dental provider coverage Coinsurance	Non-contracting dental provider coverage Coinsurance
Type A expenses	100% of the <b>negotiated charge</b>	100% of the <b>recognized charge</b>
Type B expenses	80% of the <b>negotiated charge</b>	80% of the <b>recognized charge</b>
Type C expenses	50% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>

### Orthodontic treatment coinsurance

Expense	Contracting dental provider coverage Coinsurance	Non-contracting dental provider coverage Coinsurance
Orthodontic treatment	50% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>

### Plan Year maximum

Maximums	Contracting dental provider coverage Amounts	Non-contracting dental provider coverage Amounts
Plan Year maximum	\$800	\$800

## Eligible dental services

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### **Type A expenses: Diagnostic & preventive care**

#### **Visits and exams**

- Oral evaluations, (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)
- Scaling – moderate/severe inflammation, full mouth (2 treatments per year, frequency combined with prophylaxis)

**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 (primary teeth only, excludes 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
- 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 once 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 relines 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

### **Dental care services and anesthesia in a hospital or surgery center**

**Eligible dental services** include dental care and anesthesia in a hospital or surgery center only if your **provider** tells us you:

- Have a physical, mental, or medical condition that requires you be treated in a hospital or surgery center
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

**Infiltration of a sustained release therapeutic when provided as part of an eligible dental service** - Only for impacted wisdom teeth procedure

### **Type: Orthodontics treatment 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

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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 **Plan 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 **Plan Year deductible** for the additional **eligible dental services** above.

The plan **coinsurance** applied to the additional **eligible dental services** will be:

<b>Expense</b>	<b>Contracting dental provider coverage Coinsurance</b>	<b>Non-contracting dental provider coverage Coinsurance</b>
Additional <b>eligible dental services</b>	100%	100%