

Schedule of Benefits

(GR-9N S-01-001-01)

Employer: Roman Catholic Diocese Of Dallas
Group Policy Number: GP-870560-WI
Issue Date: February 9, 2015
Effective Date: January 1, 2015
Schedule: 7A
Cert Base: 7

For: DMO

Managed Dental Plan

Schedule of Managed Dental Benefits (GR-9N-22-005-02 WI)

This Schedule Applies to Covered Expenses Provided by Network Providers.

Office Visit Copayment \$5 per visit.

Dental Emergency Maximum: \$100

Dental Care Schedule

The following dental care schedule shows services that require a **copay**; and the **copay** amount.

Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by **network providers**, at the dental office location. The exceptions to this rule are when **Aetna** approves referral care, or for out-of-area emergency dental care.

In addition to **copays** for **covered expenses** shown in the following schedule, you will also be responsible for an office visit **copay** as shown above.

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, then the charge will be considered to have been made for a service that would have produced professionally acceptable result, as determined by **Aetna**.

This Schedule Applies to Services Provided by Network Providers

Primary Care Dentist Services (GR-9N-S-22-010-01)

Visits and Exams	Copayment Amount
Oral examination (limited to total of 4 visits per year)	\$0
Emergency palliative treatment	\$10
Prophylaxis (cleaning), (limited to 2 treatments per year)	
Adult	\$0
Child	\$0

Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)	\$0
Oral hygiene instruction	\$0
Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)	\$0
Pulp vitality test	\$0
Consultation	\$0
Diagnostic casts	\$0
X-Rays and Pathology	
Bitewing x-rays (limited to 1 set per year)	\$0
Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years)	\$0
Vertical bitewing X-rays (limited to 1 set every 3 years)	\$0
Periapical x-ray	\$0
Intra-oral, occlusal view, maxillary or mandibular	\$0
Extra-oral upper or lower jaw	\$0
Accession of oral tissue	\$0
Space Maintainers - (only when needed to preserve space resulting from premature loss of primary teeth) Includes all adjustments within six months after installation	
Fixed	\$75
Removable	\$70
Recement space maintainer	\$12
Remove fixed space maintainer (by dentist who did not place appliance)	\$12
Endodontics	
Pulp cap	\$4
Pulpotomy	\$22
Root canal therapy, including necessary x-rays	
Anterior	\$70
Bicuspid	\$109
Restorations and Repairs (Copayments for crowns and pontics 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	\$10
2 surfaces	\$12
3 surfaces	\$16
4 or more surfaces	\$18
Resin-based composite restoration (anterior)	
1 surface	\$15
2 surfaces	\$21
3 surfaces	\$25
4 or more surfaces or incisal angle	\$45
Resin-based composite crown, anterior	\$50
Resin-based composite restoration (posterior)	
1 surface	\$35
2 surfaces	\$50
3 surfaces	\$60
4 or more surfaces	\$90
Retention pins	\$10
Stainless steel crowns, prefabricated, primary tooth	\$40
Stainless steel crowns, prefabricated, permanent tooth	\$50
Recementing inlays or crowns	\$10

Recementing bridges	\$15
Sedative filling	\$3
Inlays metallic*	\$195
Crowns	
Porcelain	\$255
Porcelain with metal (includes abutments)*	\$255
Metallic (full cast) (includes abutments)*	\$255
Metallic (3/4 cast)*	\$255
Cast post and core*	\$112
Prefabricated post and core	\$74
Core buildup including pins	\$80
Pontics	
Metallic (full cast)*	\$255
Porcelain with metal*	\$255
Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.)	\$125
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
Partial, upper or lower	
Resin base	\$275
Cast metal base	\$350
Immediate, upper or lower (does not include charge for reline)	\$315
Adjust complete denture, upper or lower	\$10
Adjust partial denture, upper or lower	\$10
Repair broken acrylic, complete denture, upper or lower	\$30
Replace one tooth on complete denture	\$20
Repair resin denture base, cast frame, broken clasp	\$35
Replace broken tooth, partial	\$35
Add tooth to existing partial denture	\$35
Add clasp to existing partial	\$40
Replace all teeth and acrylic on cast metal framework	\$100
Rebase, complete denture, upper or lower	\$100
Rebase, partial denture, upper or lower	\$100
Reline, complete denture, upper or lower (chairside)	\$45
Reline, partial denture, upper or lower (chairside)	\$45
Reline, complete denture, upper or lower (laboratory)	\$102
Reline, partial denture, upper or lower (laboratory)	\$102
Interim partial denture, upper or lower (stayplate), anterior only	\$90
Tissue conditioning for dentures	\$40
Periodontics	
Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years)	\$51
Scaling and root planing -1 to 3 teeth per quadrant (limited to once per site every 2 years)	\$31
Periodontal maintenance procedures following surgical therapy (limited to 2 per year)	\$45
Occlusal guard (for bruxism only), limited to 1 every 3 years	\$100
Full mouth debridement once per lifetime	\$60
Oral Surgery - Includes local anesthetics and routine post-operative care	
Extraction - exposed root or erupted tooth	\$11
Extraction - coronal remnants - deciduous tooth uncomplicated	\$4
Surgical removal of erupted tooth	\$28
Surgical removal of impacted tooth (soft tissue)	\$46

Incision and drainage of intraoral abscess	\$20
Mobilization of erupted or malpositioned tooth to aid eruption.	\$30
Biopsy of oral tissue	\$75

Specialty Services

	Copayment Amount
Endodontics - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	\$92
Bicuspid, first root	\$92
Molar, first root	\$90
Each additional root	\$55
Retrograde filling, per root	\$40
Root amputation, per root	\$70
Molar root canal therapy	\$280
Retreatment of previous root canal therapy	
Anterior	\$170
Bicuspid	\$209
Molar	\$380
Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Surgical removal of residual tooth roots	\$25
Frenectomy	\$34
Alveoplasty in conjunction with extractions - per quadrant	\$25
Alveoplasty not in conjunction with extractions - per quadrant	\$40
Surgical removal of impacted tooth	
Partially bony	\$58
Completely bony	\$117
Completely bony with unusual surgical complications	\$117
Periodontics	
Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years	\$133
Gingivectomy or gingivoplasty - 1-3 teeth, limited to 1 per site, every 3 years	\$57
Gingival flap procedure - per quadrant	\$134
Gingival flap procedure - 1-3 teeth one per quadrant	\$80
Occlusal adjustment (other than with an appliance or restoration)	
Limited	\$20
Complete	\$80
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years	\$300
Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years	\$180
Surgical revision procedure, per tooth	\$120
Pedicle soft tissue graft	\$230
Free soft tissue graft (including donor site surgery)	\$245
Subepithelial connective tissue graft	\$138
Soft tissue allograft	\$275
Combined connective tissue and double pedicle graft	\$227
Clinical crown lengthening - hard tissue	\$180
Orthodontics	
Orthodontic screening exam (when no Orthodontic Procedure is performed)	\$30
Orthodontic diagnostic records	\$150
Comprehensive orthodontic treatment of adolescent and adult dentition	\$1,545
Orthodontic retention	\$275

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

Deep sedation/General Anesthesia

First 30 minutes	\$165
each additional 15 minutes	\$70

Intravenous conscious sedation/analgesia

First 30 minutes	\$165
each additional 15 minutes	\$70

Expense Provisions (GR-9N S-09-05 01)

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*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Copayments and Benefit Deductible Provisions (GR-9N-09-015-01 WT)

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

General (GR-9N S-28-01 01)

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.