

Schedule of Benefits

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

Employer: Board of Franklin County Commissioners Aka- Franklin County Cooperative Dental Plan

Group Policy Number: GP-659146

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Schedule: 1A

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For: Dental Maintenance Organization - DMO (Managed Dental Plan)

Managed Dental Plan

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

This Schedule Applies To Covered Expenses Provided By Network Providers.

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.

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	\$8
Child	\$7
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)	\$8

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	\$80
Removable	\$80
Recement space maintainer	\$15
Remove fixed space maintainer (by dentist who did not place appliance)	\$15
Endodontics	
Pulp cap	\$6
Pulpotomy	\$55
Root canal therapy, including necessary x-rays	
Anterior	\$120
Bicuspid	\$180
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	\$16
2 surfaces	\$24
3 surfaces	\$32
4 or more surfaces	\$40
Resin-based composite restoration (anterior)	
1 surface	\$25
2 surfaces	\$35
3 surfaces	\$35
4 or more surfaces or incisal angle	\$60
Resin-based composite crown, anterior	\$60
Resin-based composite restoration (posterior)	
1 surface	\$45
2 surfaces	\$60
3 surfaces	\$85
4 or more surfaces	\$90
Retention pins	\$10
Stainless steel crowns, prefabricated, primary tooth	\$50
Stainless steel crowns, prefabricated, permanent tooth	\$60
Recementing inlays or crowns	\$15
Recementing bridges	\$20
Sedative filling	\$8
Inlays metallic*	\$225
Crowns	
Porcelain	\$315
Porcelain with metal (includes abutments)*	\$315

Metallic (full cast) (includes abutments)*	\$315
Metallic (3/4 cast)*	\$315
Cast post and core*	\$128
Prefabricated post and core	\$83
Core buildup including pins	\$90
Pontics	
Metallic (full cast)*	\$315
Porcelain with metal*	\$315
Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.)	\$125
Dentures and Partial s - (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)	
Complete, upper or lower	\$300
Partial, upper or lower	
Resin base	\$300
Cast metal base	\$400
Immediate, upper or lower (does not include charge for reline)	\$330
Adjust complete denture, upper or lower	\$10
Adjust partial denture, upper or lower	\$10
Repair broken acrylic, complete denture, upper or lower	\$36
Replace one tooth on complete denture	\$25
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	\$45
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)	\$50
Reline, partial denture, upper or lower (chairside)	\$50
Reline, complete denture, upper or lower (laboratory)	\$114
Reline, partial denture, upper or lower (laboratory)	\$114
Interim partial denture, upper or lower (stayplate), anterior only	\$143
Tissue conditioning for dentures	\$50
Periodontics	
Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years)	\$56
Scaling and root planing -1 to 3 teeth per quadrant (limited to once per site every 2 years)	\$34
Periodontal maintenance procedures following surgical therapy (limited to 2 per year)	\$60
Occlusal guard (for bruxism only), limited to 1 every 3 years	\$130
Full mouth debridement, once per lifetime	\$60
Oral Surgery - Includes local anesthetics and routine post-operative care	
Extraction - exposed root or erupted tooth	\$15
Extraction - coronal remnants - deciduous tooth uncomplicated	\$6
Surgical removal of erupted tooth	\$36
Surgical removal of impacted tooth (soft tissue)	\$60
Incision and drainage of intraoral abscess	\$30
Mobilization of erupted or malpositioned tooth to aid eruption.	\$70
Biopsy of oral tissue	\$100

Specialty Services

	Copayment Amount
Endodontics - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	\$141
Bicuspid, first root	\$141
Molar, first root	\$150
Each additional root	\$90
Retrograde filling, per root	\$65
Root amputation, per root	\$80
Molar root canal therapy	\$303
Retreatment of previous root canal therapy	
Anterior	\$220
Bicuspid	\$280
Molar	\$403
Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Surgical removal of residual tooth roots	\$35
Frenectomy	\$90
Alveoloplasty in conjunction with extractions - per quadrant	\$35
Alveoloplasty not in conjunction with extractions - per quadrant	\$60
Surgical removal of impacted tooth	
Partially bony	\$72
Completely bony	\$128
Completely bony with unusual surgical complications	\$128
Periodontics	
Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years	\$160
Gingivectomy or gingivoplasty - 1-3 teeth, limited to 1 per site, every 3 years	\$60
Gingival flap procedure - per quadrant	\$171
Gingival flap procedure - 1-3 teeth one per quadrant	\$103
Occlusal adjustment (other than with an appliance or restoration)	
Limited	\$30
Complete	\$100
Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years	\$325
Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years	\$195
Surgical revision procedure, per tooth	\$130
Pedicle soft tissue graft	\$250
Free soft tissue graft (including donor site surgery)	\$265
Subepithelial connective tissue graft	\$150
Soft tissue allograft	\$300
Combined connective tissue and double pedicle graft	\$248
Clinical crown lengthening - hard tissue	\$195
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

This Schedule Applies to Covered Expenses Provided by Out-of-Network Providers.

Dental Care Schedule (GR-9N-S-22-015-01)

Out-of-Network Deductible

\$100

Copayment

The **copayment** is the amount of charges that exceeds the benefits payable under this coverage.

This dental care schedule shows services that are covered and maximum charge eligible under the plan for each service. Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by a licensed **dentist**, at the dental office location. You are responsible for any amount above the Amount Payable shown.

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,

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

Primary Care Services

Schedule (GR-9N-S-23-010-01)

Type A Services

Visits and Exams

	Out-of-Network maximum Amount Payable by Aetna
Office visit for oral examination (limited to 4 visits per year)	\$12
Emergency palliative treatment	\$12
Prophylaxis (cleaning) (limited to 2 treatments per year)	
Adult	\$26
Child	\$14
Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)	\$16
Oral hygiene instruction	\$12
Sealants; per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)	\$10
Pulp vitality test	\$8
Consultation	\$12
Diagnostic casts	\$20
X-Ray and Pathology	
Bitewing x-rays (limited to 1 set per year)	\$8
Entire series; including bitewings; or panoramic film (limited to 1 set every 3 years)	\$14
Vertical bitewing x-rays (limited to 1 set every 3 years)	\$12
Periapical x-rays	\$6

Intra-oral; occlusal view; maxillary or mandibular	\$8
Extra-oral upper or lower jaw	\$12
Biopsy and histopathologic examination of oral tissue	\$27

Space Maintainers - Includes all adjustments within six months after installation.

Fixed; band type	\$40
Removable acrylic with round wire clasp	\$32
Recement space maintainer	\$10
Removal of fixed space maintainer (by dentist who did not place appliance)	\$10

Type B Services

Endodontics

Pulp cap	\$3
Pulpotomy	\$27
Root canal therapy; including necessary x-rays	
Anterior	\$80
Bicuspid	\$96

Restorations and Repairs

Amalgam restoration	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$24
4 or more surfaces	\$26
Resin restoration (other than for molars)	
1 surface	\$12
2 surfaces	\$16
3 surfaces	\$26
4 or more surfaces or incisal angle	\$30
Retention pins	\$14
Sedative filling	\$12
Stainless steel crowns	\$26
Prefabricated resin crowns (excluding temporary crowns)	\$60
Recementing inlays or crowns	\$16
Recementing bridges	\$16
Tissue conditioning for dentures	\$26

Periodontics

Emergency treatment (abscess; acute periodontitis; etc.)	\$26
Subgingival curettage (limited to 4 separate quadrants; every 2 years)	\$40
Scaling and root planning (limited to 4 separate quadrants every 2 years)	\$40
Periodontal maintenance procedures following surgical therapy (limited to 2 per year)	\$40
Full mouth debridement, once per lifetime	\$60

Oral Surgery - Includes local anesthetics and routine post-operative care.

Extraction, coronal remnants	\$14
Extraction - exposed root or erupted tooth	\$27
Surgical removal of erupted tooth	\$32
Surgical removal of impacted tooth (soft tissue)	\$40
Excision of hyperplastic tissue	\$32
Excision of pericoronal gingival	\$40
Incision and drainage of abscess	\$20
Crown exposure to aid eruption	\$26

Removal of foreign body from soft tissue	\$20
Suture of soft tissue injury	\$20

Type C Services

Restorations

Inlays

1 surface	\$60
2 or more surfaces	\$80

Onlays

2 surfaces	\$80
3 or more surfaces	\$80

Crowns (including build-ups when necessary)

Resin	\$120
Resin with noble metal	\$120
Resin with base metal	\$120
Porcelain	\$120
Porcelain with noble metal	\$120
Porcelain with base metal	\$120
Base metal (full cast)	\$120
Noble metal (full cast)	\$120
Metallic (3/4 cast)	\$120
Post and core	\$27

Pontics

Base metal (full cast)	\$20
Noble metal (full cast)	\$20
Porcelain with noble metal	\$20
Porcelain with base metal	\$20
Resin with noble metal	\$20
Resin with base metal	\$20

Dentures and Partial - (includes relines; rebases and adjustments within six months after installation)

Full (Upper or Lower)	\$120
Partial	\$120
Stress breakers (per unit)	\$40
Interim partial denture; (stayplates); anterior only	\$40
Crown and bridge repairs	\$27
Adding teeth to an existing denture	\$40
Full and partial denture repairs	\$27
Relining/rebasing dentures (includes adjustments with six months after installation)	\$40
Occlusal guard (for bruxism only); (limited to 1 every 3 years)	\$40

Specialty Care Dental Services

Type B Services

Endodontics - Includes local anesthetics where necessary.

Apexification/recalcification - per visit	\$32
Apicoectomy	
First root	\$60
Each additional root	\$40
Retrograde Filling	\$14
Root Amputation	\$27
Hemisection	\$27

Oral Surgery - Includes local anesthetics where necessary and post-operative care.	
Removal of residual root	\$27
Removal of odontogenic cyst	\$40
Closure of oral fistula	\$48
Removal of foreign body from bone	\$20
Sequestrectomy	\$20
Frenectomy	\$40
Transplantation of tooth or tooth bud	\$48
Alveoplasty in conjunction with extractions - per quadrant	\$27
Alveoplasty not in conjunction with extractions - per quadrant	\$40
Removal of exostosis	\$60
Sialolithotomy; removal of salivary calculus	\$36
Closure of salivary fistula	\$36

Periodontics

Gingivectomy or gingivoplasty - per quadrant (limited to 1 quadrant; every 3 years)	\$40
Gingivectomy or gingivoplasty - per tooth (limited to 1 per site; every 3 years)	\$20
Gingival flap procedure - per quadrant	\$60
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	\$20
Entire Mouth	\$40

Type C Services

Endodontics - Includes local anesthetics where necessary.

Complex Molar Root Canal Therapy	\$120
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Intravenous Sedation and General Anesthesia

- per 15-minute segment.	\$20
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Oral Surgery - Includes local anesthetics where necessary and post-operative care.

Surgical removal of impacted tooth	
Partially bony	\$53
Completely bony	\$60
Completely bony with unusual surgical complications	\$64

Periodontics

Osseous surgery (including flap entry and closure) - per quadrant (limited to 1 per quadrant; every 3 years)	\$80
Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)	\$40
Clinical crown lengthening - hard tissue	\$40

Orthodontics

Comprehensive orthodontic treatment of adolescent dentition	
Comprehensive orthodontic treatment of adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	\$400

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 OH)

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.

Deductible Provisions (GR-9N-S-09-05-01 OH)

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

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

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-28-01-01-OH)

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.