

Schedule of benefits

Preferred provider organization (PPO) dental plan

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared for:

Employer:	Board of Education of Prince George's County, Maryland by Aetna Life Solely as Disbursing Agent
Contract number:	MSA-0373416
Schedule of benefits:	1A
Plan name:	PPO Dental Plan
Plan effective date:	January 1, 2026
Plan issue date:	March 3, 2026

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How to read your schedule of benefits

- When we say:
 - “In-network coverage” we mean that you get care from **in-network providers**.
 - “Out-of-network coverage” we mean that you can get care from **out-of-network providers**.
- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflects the **deductibles** and **payment percentage** amounts under your plan.
- You must pay any **deductibles** and your part of the **payment percentage**.
- The **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the **payment percentage** amount the plan pays. You are responsible for paying any remaining **payment percentage**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year maximums** and **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 **in-network providers** and **out-of-network 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 **Calendar Year deductible** and **payment percentage** 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 <https://www.aetna.com/>
- Call us at 1-877-238-6200

This schedule of benefits replaces any schedule of benefits previously in effect under the plan of benefits. Keep this schedule of benefits with your booklet.

General coverage provisions

This section explains the:

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

Calendar Year deductible

Eligible dental services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible dental services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

Individual deductible

You pay for **eligible dental services** each **Calendar 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 **Calendar Year**.

Family deductible

You pay for **eligible dental services** each **Calendar 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 **Calendar Year**. To satisfy this family **deductible** for the rest of the **Calendar 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 **Calendar Year**. When this happens in a **Calendar Year**, the individual **deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

This **Calendar Year maximum** applies to in-network and out-of-network **eligible dental services** combined.

Dental emergency services maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person for any one **dental emergency** is called the **dental emergency services maximum**.

Specific dental care lifetime maximum

This is the most this plan will pay, after you have paid any **deductible**, for specific dental care treatment expenses incurred by any one covered person during their lifetime for **eligible dental services**.

These specific dental care **lifetime maximums** apply to in-network and out-of-network **eligible dental services** combined.

Any expenses applied to satisfy a specific dental care **lifetime maximum** will not be applied to satisfy any **lifetime maximum**.

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 **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

Plan features

Calendar Year deductible

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

Deductibles	In-network coverage Amounts	Out-of-network coverage Amounts
Calendar Year deductible*	Individual \$50 Family \$100	Individual \$100 Family \$200
*Important note:	The Calendar Year deductible applies to all eligible dental services except Type A expenses.	The Calendar Year deductible applies to all eligible dental services except Type A expenses.

Payment percentage

The **payment percentage** listed below reflects the plan **payment percentage**. This is the **payment percentage** amount that the plan pays. You are responsible for paying any remaining **payment percentage**.

Expenses	In-network coverage Payment percentage	Out-of-network coverage Payment percentage
Type A expenses	100% of the negotiated charge	90% of the recognized charge
Type B expenses	100% of the negotiated charge	90% of the recognized charge
Type C expenses	60% of the negotiated charge	50% of the recognized charge

Orthodontic treatment payment percentage

Expense	In-network coverage Payment percentage	Out-of-network coverage Payment percentage
Orthodontic treatment	50% of the negotiated charge	40% of the recognized charge

Calendar Year maximum

Maximums	In-network coverage Amounts	Out-of-network coverage Amounts
Calendar Year maximum	\$4,000	\$3,000

Specific dental care lifetime maximum

Eligible dental service	In-network coverage Amounts	Out-of-network coverage Amounts
Orthodontic treatment	\$3,000	\$3,000

Dental emergency services maximum

Maximum	In-network coverage Amount	Out-of-network coverage Amount
Dental emergency services maximum	None	\$75

Eligible dental services

Type A Expenses

- Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every year)
- Problem-focused examination
- Prophylaxis (cleaning) (prophylaxis frequency is 2 per year and is combined with periodontal maintenance)
- Topical application of fluoride, (limited to one course of treatment per year and to children under age 19)
- Bitewing X-rays (limited to 2 sets per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Space Maintainers only when needed to preserve space resulting from premature loss of primary teeth.

Type B Expenses

- Extractions
- Sealants for permanent bicuspid and molars for persons under age 15 not to exceed one application in any 3 years period
- Application of hydroxyapatite regeneration medicament - per tooth (1 application every 3 years)
- Fillings
- General anesthetics given in connection with covered dental services
- Endodontic treatment (This includes root canal therapy)
- Injection of antibiotic drugs
- 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
- Full mouth debridement (1 per lifetime)
- 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)
- Recementing of crowns, inlays
- Emergency palliative treatment
- Periodontal maintenance procedures following active therapy (prophylaxis frequency is 2 per year and is combined with periodontal maintenance)
- Removal of an indirect restoration on a natural tooth

Type C Expenses

- Inlays, gold fillings, or crowns (This includes precision attachments for dentures)
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered (This includes inlays and crowns as abutments)
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework, subject to the *Replacement Rule*.
- Repair, bridgework, or dentures
- Relining of dentures
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered (This includes adjustments for the 6 month period following the date they were installed)
- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture, subject to the *Replacement Rule*.
- Treatment of diseased periodontal structures
- Implants

Important note:

The following apply:

- Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only:
 - As treatment for decay or acute traumatic **injury**.
 - When teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.
- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Additional eligible dental services

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 **Calendar 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 **Calendar Year deductible** and **payment percentage** for the additional **eligible dental services** above.

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

Expense	In-network coverage Payment Percentage	Out-of-network coverage Payment Percentage
Additional eligible dental services	100%	100%