Dental Benefits for
Bay County BOCC
2019 Plan Year

Financial Features	High Option				Mid Option				Low Option			
	In-Network		Out-of-Network		In-Network		Out-of-Network		In-Network		Out-of-Network	
Deductible (Basic & Major Services Only) Per Person Per Calendar Year Per Family Per Calendar Year *In-Network deductible credits apply to Out-of-Network deductible and Out-of-Network deductible credits apply to In-Network deductible.*	$50 $150		$50 $150		$50 $150		$50 $150		$50 $150		$50 $150	
Coinsurance *	**We Pay**	**You Pay**	**We Pay**	**You Pay**	**We Pay**	**You Pay**	**We Pay**	**You Pay**	**We Pay**	**You Pay**	**We Pay**	**You Pay**
PREVENTIVE **	100%	0%	80%	20%	100%	0%	80%	20%	100%	0%	80%	20%
BASIC **	60%	40%	60%	40%	60%	40%	60%	40%	60%	40%	60%	40%
MAJOR **	50%	50%	40%	60%	50%	50%	40%	60%	0%	100%	0%	100%
Service Highlights												
Oral Evaluations (Exams)	Preventive				Preventive				Preventive			
Bitewing X-ray	Preventive				Preventive				Preventive			
Prophylaxis (Cleanings) – Adult/Child	Preventive				Preventive				Preventive			
Fluoride Treatment (Child Only)	Preventive				Preventive				Preventive			
Office Visits	Preventive				Preventive				Preventive			
	Preventive				Preventive				Preventive			
X-rays – Intraoral/Complete Series/Panoramic	Basic				Basic				Basic			
Sealants	Basic				Basic				Basic			
Amalgam Restorations (Silver Fillings)	Basic				Basic				Basic			
Resin-Based Restorations (Anterior and Posterior)	Basic				Basic				Basic			
Extractions (Routine & Surgical)	Major				Major				Not Covered			
Root Canal Therapy	Major				Major				Not Covered			
Periodontal Treatment	Major				Major				Not Covered			
Crowns	Major				Major				Not Covered			
Osseous Surgery	Major				Major				Not Covered			
Complete Dentures	Major				Major				Not Covered			
Partial Dentures	Major				Major				Not Covered			
Fixed Partial Dentures (Bridges)	Major				Major				Not Covered			
Orthodontia Services (all insureds)												
Orthodontia Lifetime Maximum	$1,250				Not Covered				Not Covered			
BlueDental Pays	50%				N/A				N/A			
Benefit Waiting Period	N/A				N/A				N/A			
Waiting Period: (Major Services)	0 Months				0 Months				Major Services Not Covered			
Calendar Year Maximum Per Person	$1,250				$500				$750			
Procedures Performed By Specialist	Covered				Covered				Covered			
TYPE OF COVERAGE	MONTHLY PREMIUM AMOUNT											
Employee Only	**$27.48**				**$19.19**				**$14.71**			
Employee Plus 1	**$56.97**				**$34.90**				**$26.75**			
Employee Family	**$90.92**				**$58.36**				**$44.73**			

The information provided above is a summary of benefits for the group Choice certificate. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as a part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

* Percentage of fee schedule
** Some limitations may apply

Rvsd 09-2017

Limitations and Exclusions

Limitations

- Any retreatment of root canals are payable one (1) year after completion date of root canal therapy.
- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
- Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of dependent children.
- General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
- Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.
- Periodontal services are limited to insureds age eighteen (18) and older.
- Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
- Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.

- **Exclusions**
- The following are excluded under this plan:
- Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to an insured's effective date of coverage, (until the insured has been covered under the contract for twelve [12] consecutive months), unless otherwise specified.
- Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
- Charges for services or supplies when billed by other than a dentist.
- Benefits for services rendered by a member of an employee's family, (his spouse and the children, brothers, sisters and parents of either the employee or his spouse).
- Services rendered primarily for cosmetic purposes.
- Charges incurred for failure to keep a dental appointment.
- Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone—lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- Experimental or investigational treatment.
- Dental services received or rendered:
- -through or in a veteran's hospital or government facility due to a service connected disability
- -which are covered and paid underWorker's Compensation or similar law
- -which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount
- -payable under both plans exceeds 100% of the total expenses that are incurred
- Services for which the insured incurs no charge.
- Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
- Local anesthesia when billed separately by a dentist.
- Any services paid or payable under the insured's health insurance contract.
- Services not listed in the Benefits section of this plan.
- Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this certificate will be based on the allowance for the least costly service, procedure, or course of treatment.
- Any additional treatment required due to the insured's failure to follow instructions, or lack of cooperation with the dentist.
- Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- Services rendered before the effective date of coverage.
- Services rendered after termination of coverage, except as provided under the plan's "Extension of Benefits upon Contract Termination."
- Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
- Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by an insured.
- Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the insured's coverage under this certificate.
- Duplicate or temporary denture, crown, or bridge.
- Labial veneer restorations.
- General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
- Charges for nitrous oxide.
- Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or tower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Prescribed drugs, premedication or analgesia.
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges for oral hygiene, plaque control, or diet instruction.
- Charges for orthodontia services, unless shown on the Group Dental Benefit Summary page