# DENTAL BENEFIT PLAN SUMMARY

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|---|---|
| **Client Group #** | 54118 |
| **Client Name** | New Lexington City Schools |
| **Plan Code** | DENT |
| **Plan Description** | New Lexington City Schools Dental Plan |
| **Plan Revision Date** | 9/1/2016 |
| **Plan Year/Calendar Year** | Calendar Year |
| **Timely Filing** | One Year |
| **Dependent Age Max** | 26 (through the end of the month in which this birthday occurs) |
| **Student Age Max** | 26 (through the end of the month in which this birthday occurs) |
| **Deductible Carryover** | 3 months |
| **Coordination of Benefits** | Standard with No Savings |
| | |
| **CLAIMS MAILING ADDRESS / OTHER INFORMATION** | |
| **Claims to:** | EBMC<br>PO Box 9057<br>Dublin, OH 43017-0957 |
| **EDI number:** | |
| **Special Notes:** | |
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**NEW LEXINGTON CITY SCHOOLS DENTAL PLAN**

**DENTAL CARE BENEFIT SCHEDULE**

| **DENTAL CARE BENEFIT** | |
|---|---|
| **DENTAL CARE DEDUCTIBLE, PER CALENDAR YEAR** | |
| Per Covered Person | $50 |
| **Calendar Year Deductible applies to these classes of services: Class B Services - Basic and Class C Services - Major** | |
| **MAXIMUM BENEFIT AMOUNT** | **BENEFIT** |
| For Class A - Preventive | Limited to two examinations per Benefit Period. This benefit is not included in the annual dental maximum. |
| For Class B - Basic and Class C - Major Services<br>Per Covered Person per Calendar Year | $1,000 |
| For Class D - Orthodontia<br>(benefit available for Dependents under age 19)<br>Lifetime maximum per Covered Person | $1,000 |
| **COVERED CHARGES** | |
| **Dental Percentage Payable** | |
| Class A Services - Preventive | 100% |
| Class B Services - Basic | 80% |
| Class C Services - Major | 80% |
| Class D Services - Orthodontia | 60% |

**NON-DUPLICATION OF BENEFITS**

When dental expenses are eligible for payment under both the medical plan and dental plan, benefits for such expenses shall be paid only under the medical plan.

**COVERED DENTAL SERVICES**

**Class A Services:**
**Preventive and Diagnostic Dental Procedures**

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

**(1)** Routine oral exams, limited to two examinations per Benefit Period. This includes the cleaning and scaling of teeth.

**(2)** Bitewing x-rays, two sets per Benefit period.

**(3)** Topical fluoride treatments, limited to two per Benefit Period.

**(4)** Space maintainers for covered Dependent children under age 19.

**(5)** Emergency palliative treatment for pain, including emergency oral evaluations.

**(6)** Sealants once every 36 months per tooth, limited to eligible teeth free from decay or restorations on the occlusal surface.

**(7)** Prophylaxis, two per Benefit Period.

**(8)** Consultations and other evaluations by a Dental specialist.

**Class B Services:**
**Basic Dental Procedures**

**(1)** Dental x-rays not included in Class A.

**(2)** Full mouth or Panoramic X-rays, limited to 1 in a 36 month period

**(3)** Periodontics, including removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue.

**(4)** Endodontics, including pulpotomy, root canal treatment and apicoectomy.

**(5)** Extractions, including simple extractions and surgical extractions and impactions. This service includes local anesthesia and routine post-operative care.

**(6)** Repairs, relines and adjustments of prosthetics.

**(7)** Fillings (Amalgams or Resin based composite)

**(8)** General anesthetics, upon demonstration of Medical Necessity.

**(9)** Biopsy

**(10)** Minor oral surgery, including alveoloplasty. This service includes local anesthesia and routine post-operative care.

**(11)** IV sedation

**(12)** Laboratory tests and drug injections

**Class C Services:**
**Major Dental Procedures**

**(1)** Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

**(2)** Installation of crowns.

**(3)** Initial installation of fixed bridgework to replace one or more natural teeth, limited to once every five years per unit.

**(4)** Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36-month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture. If an appliance can be made serviceable, a replacement appliance is not covered.

**Class D Services:**
**Orthodontic Treatment and Appliances**

The Plan will pay the benefit percentage shown on the Schedule of Benefits for the initial banding fee for the orthodontic appliance for Covered Persons as soon as the treatment plan is received. Thereafter, monthly payments will be made based on the benefit percentage shown in the Schedule of Benefits of the monthly payment stipulated by the Dentist. The Plan will provide benefits for the following orthodontic services subject to the Maximum Lifetime Benefit set forth in the Schedule of Benefits:

- Oral examinations and diagnosis
- The initial and subsequent installation, if any, of orthodontic appliances, if indicated by a Dentist
- The adjustment of orthodontic appliances
- All other orthodontic treatment required by accepted orthodontic practice, including tooth extraction, if indicated by a Dentist

These services are available for covered Dependent children under age 19.

When you are already receiving active or retention treatment on your effective date, only services incurred after your effective date will be covered based on a proration of the expected months of treatment.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

**PREDETERMINATION OF BENEFITS**

Before starting a dental treatment for which the charge is expected to be $500 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

**EXCLUSIONS**

A charge for the following is not covered:

**(1)** **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

**(2)** For **appliances or restorations** needed to increase the vertical dimension or to restore or correct the occlusion.

**(3)** **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.

**(4)** **Broken appointments.** Charges for broken or missed dental appointments.

**(5)** **Cosmetic Purposes.** Including the alteration, extraction or replacement of sound natural teeth to change appearance, and bleaching of teeth. For congenital or developmental malformation or other services primarily to improve appearance.

**(6)** **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge. Services rendered by more than one Dental provider. If you change Dental providers during a course of treatment or if more than one Dental providers treats you for a procedure, additional benefits are not provided.

**(7)** **Felonious behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.

**(8)** **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

**(9)** **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

**(10)** **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

**(11)** **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

**(12)** **No listing.** Services which are not included in the list of covered dental services.

**(13)** **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

**(14)** **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.

**(15)** **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.

**(16)** **Personalization.** Personalization of dentures.

**(17)** **Plan design.** Charges excluded or limited by the Plan design as stated in this document.

**(18)** **Relative.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

**(19)** **Replacement.** Replacement of lost or stolen appliances. For the repair of a damaged space maintainers.

**(20)** **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

**(21)** **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

**(22)** **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

**(23)** **War.** Any loss that is due to a declared or undeclared act of war.