DENTAL BENEFIT PLAN SUMMARY

Client Group #	54109
Client Name	Bloom Carroll Local Schools
Plan Code	DENT
Plan Description	Bloom Carroll Local Schools Dental Plan
Plan Revision Date	1/1/2016
Plan Year/Calendar Year	Calendar Year
Timely Filing	365 days
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	N/A
Coordination of Benefits	Standard with No Savings
CLAIMS MAILING ADDRESS / OTHER INFORMATION	
Claims to:	EBMC PO Box 9057 Dublin, OH 43017-0957
EDI number:	
Special Notes:	

BLOOM CARROLL LOCAL SCHOOLS DENTAL PLAN

DENTAL BENEFITS SCHEDULE	
CALENDAR YEAR DEDUCTIBLE	
Per Covered Person	$25
Per Family Unit	$75
Calendar Year Deductible applies to: Class B Services – Basic Class C Services – Major Class D Services - Orthodontia	
MAXIMUM BENEFIT AMOUNT PER COVERED PERSON	
For Class a – Preventive, Class B – Basic, and Class C - Major	$1,250 per Calendar Year
For Class D – Orthodontia (For Dependent Children under age 25 Only)	$1,000 per Lifetime
COVERED CHARGES	
Classes of Benefits	**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.

- Bitewing X-rays – limited to two series per Calendar Year
- Desensitizing medicaments
- Emergency palliative treatment
- Fluoride treatment for children under age 19 – limited to twice per Calendar Year
- Full mouth or panorex X-rays – limited to one series every 36 consecutive months
- Initial oral exam
- Routine oral exam and prophylaxis – limited to twice per Calendar Year
- Sealants on first and second non-restored molars for covered dependents to age 19
- Space maintainers, not including orthodontic procedures and appliances, for children under age 19
- Study models

Class B Services:
Basic Dental Procedures

Restorative

- Amalgam and composite resin fillings
- Pin retention
- Relining or rebasing dentures at least 6 months after their installation. Limited to once in any 36-month period
- Repair or re-cementing of crowns, inlays, onlays, bridgework and dentures
- Sedative fillings
- Veneers (except as excluded for cosmetic purposes as noted under "Dental Limitations").

Oral Surgery and Extractions

- Alveoplasty
- Antibiotic drugs
- Complete and partial bone impactions
- Excision of hyperplastic tissue
- Extraction of teeth, simple or surgical, including local anesthesia
- Frenectomy
- General anesthesia – in connection with oral or dental surgery
- Root recovery
- Soft tissue impaction
- Surgical exposure of impacted or unerupted tooth

Endodontics

- Apicoectomy
- Pulp cap and pulpotomy
- Root canal therapy – extirpation of pulp and canal filling
- Surgical root canal treatment

Periodontics

- Gingivectomy or gingivoplasty
- Gingival curettage
- Gingival flap surgery
- Incision and drainage
- Local periodontal chemotherapy agent
- Occlusal adjustment – not in connection with restoration – limited or complete
- Osseous surgery and graft
- Periodontal prophylaxis – as subsequent follow-up visit only. Limited to four per Calendar Year
- Periodontal scaling and root planning – one per quadrant every 24 months

Class C Services:
Major Dental Procedures

Crowns and Prosthetics

- Crown buildup
- Crowns –gold, porcelain with gold, semi-precious or non-precious metal, full cast and stainless steel – limited to one per tooth in any five-year period
- Fixed bridgework – gold, porcelain with gold, non-precious or semi-precious metal, full cast

- Gold inlays and onlays
- Maryland bridge
- Temporary crown for fractured tooth

Dentures

- Full or partial dentures
- Flipper
- Adding tooth or clasp to partial denture to replace extracted tooth
- Replacing broken clasp
- Tissue conditioning

Class D Services:
Orthodontic Treatment and Appliances

The Plan will pay the benefit percentage specified in 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

Benefits are payable for monthly orthodontic treatment in progress for payments made after the Effective Date of this dental plan. No orthodontic benefits shall be payable after coverage under the dental plan terminates.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $300.00 or more, a predetermination of benefits form may be submitted.

The Dentist must itemize all recommended services and costs and include all supporting x-rays and/or charting.

EXCLUSIONS

A charge for the following is not covered:

(1) **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet o mesh); or to stabilize the teeth in their supporting structures.

(2) **Before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan, except as otherwise provided herein. **In Progress.** Prosthetic services started or in the process prior to the date of becoming effective under the Plan.

(3) **Cosmetic.** Any dental procedure performed solely for cosmetic or esthetic purposes.

(4) **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.

(5) **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.

(6) **Foreign travel.** Charges incurred outside the United States if the Covered Person traveled outside the United States for the purpose of obtaining medical care, treatment, services, or supplies.

(7) **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.

(8) **Hospitalization.** Charges for hospitalizations, including hospital visits.

(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) **Miscellaneous.** Charges precision attachments for prosthodontic appliances, temporary procedures, or appliances; or non-Dental Services, such as filling out claim forms; missed appointments; athletic mouth guards; myofunctional therapy; take home items such as toothbrushes, floss and fluoride rinse.

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

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

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

(15) **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary; or treatment that is considered Experimental/Investigational.

(16) **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.

(17) **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.

(18) **Replacement.** Replacement of lost or stolen appliances; duplicate appliances; or replacement of an existing prosthetic appliance, crown or fixed bridgework within five years of its installation unless a tooth has been extracted or surgery has been performed.

(19) **Same Arch.** Fixed bridge and removable partial denture on same arch.\

(20) **Sterilization.** Sterilization supplies and other infection-control procedures.

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

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

(23) **Workplace Clinic.** For services or supplies provided through a medical department, clinic, or other facility provided by or maintained by the Employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Covered Person.