



Benefit Summary

CLERMONT COUNTY

HMO Core Plan

Benefit Plan Number: D31

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: \$1000 per Member

Orthodontic Lifetime Maximum Benefit: \$0 per Eligible Member

Deductible: \$50 per Member, per Benefit Year
\$150 per Family, per Benefit Year
The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	80%	20%
Major Benefits	Yes	50%	50%

Endodontic Services are covered as Basic Benefits.

Periodontic Services are covered as Basic Benefits.

Sealants are covered as Basic Benefits.

Dependent children are eligible for coverage until age 19, or until age 25 if enrolled as full-time students.

A complete description of benefits, limitations and exclusions are available in the Summary Plan Description.

Members must receive services from a Dental Care Plus dentist.

Preventive Benefits

Preventive and Diagnostic Services

Routine Oral Examinations..... limited to two visits each year
 Prophylaxis (cleaning) limited to two each year
 Topical application of fluoride limited to two treatments each year
 to children under age 18
 Bitewing x-rays limited to one set each year
 Vertical Bitewing xrays..... limited to once every three years
 (7-8 films)
 Periapical x-rays limited to 5 films per year
 Full mouth x-rays limited to once every three years
 (complete series or panoramic)

Basic Benefits

Diagnostic Services

Emergency/limited oral examinations
 Office visit after hours for emergencies only
 Referral consultations and examinations performed by a specialist
 Extraoral x-rays
 Emergency palliative treatment

Sealants

Permanent molar teeth..... limited to children under 15 years of
 age and once every five years per tooth

Space Maintainers

Fixed band type only with prior authorization, limited
 to children under age 19

Oral Surgery (Includes local anesthesia and routine postoperative care)

Extractions
 • Simple single tooth Extractions
 • Root removal - exposed roots
 Surgical Extractions
 • Removal of an erupted tooth (uncomplicated)
 Incision and drainage of abscess
 Biopsy and examination
 General Anesthesia or intravenous
 sedation only when necessary and provided
 in connection with oral surgery

Periodontic Services (Includes local anesthesia and routine postoperative care)

Emergency treatment (periodontal abscess, acute periodontitis, etc.)
 Periodontal scaling limited to four quadrants each year,
 and root planing as a definitive treatment when pocket
 depths of at least 4mm are demonstrated
 Surgical periodontics limited to two additional recalls in the
 (including post-surgical visits) first year following complex surgery
 Gingivectomy, Osseous and muco-gingival surgery, Gingival grafting
 Guided Tissue Regeneration
 Periodontal maintenance procedure limited to two each year following a
 history of periodontal disease

Endodontic Services (Includes local anesthesia and routine postoperative care)

Root canal therapy, traditional
 Retreatment of previous root canal must be at least 3 years following
 previous root canal on same tooth
 Recalcification and Apexification

Basic Benefits

Restorative Services (Includes local anesthesia. Multiple restorations on single surface considered as a single restoration.)

Restorations (amalgam, limited to once every two years
composite and sedative fillings) per tooth (same surfaces only)

Pins - pin retention as part of restoration when used instead of gold or crown restoration

Stainless steel crowns when tooth cannot be adequately restored with filling material

Recementation of inlays, onlays, crowns, bridges, and space maintainers

Repairs to crowns and bridges

Full and Partial Denture Repairs

Repair broken, complete or partial dentures. Replacement of broken teeth on complete or partial denture. Additions to partial denture to replace extracted natural teeth.

Major Benefits

Restorative Services limited to once in five years on same tooth

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

- Inlay
- Onlays
- Crowns
- Post and Core

Oral Surgery (Includes local anesthesia and routine postoperative care)

Surgical extractions

- Removal of impacted tooth - soft tissue
- Removal of impacted tooth - partially bony
- Removal of impacted tooth - completely bony
- Removal of impacted tooth - completely bony, with complications
- Surgical removal of residual roots

Pre-prosthetic oral surgery

- Alveoloplasty and vestibuloplasty

Prosthetic Services

Fixed bridge limited to one original or replacement prosthesis every five years

Complete upper or lower denture limited to one original or replacement prosthesis every five years

Partial upper or lower denture limited to one original or replacement prosthesis every five years

Relining and rebasing limited to once every three years

***Orthodontic Benefits Refer to Plan design for Individual Lifetime Maximum**

Comprehensive Orthodontic Treatment

Other Orthodontic Treatment limited to one appliance per individual

Appliance for tooth guidance

Orthodontic retention appliance

All benefits paid toward orthodontia services by your current employers previous dental carrier(s) will be applied to the Dental Care Plus lifetime orthodontia maximum.

* May or may not apply to your specific plan. Please refer to your benefit sheet in your packet or your benefits administrator for details.