Laurens County Cares
Dental Schedule of Benefits
Effective September 1, 2020

Dental Coverage

Calendar Year Benefits Maximum (Per Member)	**$1,000**
Calendar Year Deductible:	
Individual-	**$50**
Family- The first three members of an enrolled family to satisfy their deductible will satisfy the Deductible for the entire family.	**$150**
Orthodontic Services Lifetime Maximum Benefits per member under age 19	**$1,500**

Benefit Highlights	Plan Pays	You Pay
Type 1- Preventive & Diagnostic		
Oral Evaluation		
Prophylaxis: Routine Cleanings	**100%**	
Dental X-Rays	**No Deductible**	
Topical Fluoride		**No Charge**
Diagnostic Casts		
Pulp Vitality Testing		
Sealants		
Space Maintainers		
Type 2- Basic		
Fillings		
Simple Extractions		
Oral Surgery		
Palliative Emergency Treatment	**80%**	**20%**
Apicoectomy	**After Deductible**	**After Deductible**
Occlusal Guards		
Impactions		
Endodontics		
Gingivectomy and Gingivoplasty		
Osseous Surgery		
Vestibuloplasty		
Periodontic Services		
Periodontal Prophylaxis		
Type 3- Major		
Inlays and Onlays		**50%**
Crowns	**50%**	
Dentures (Full and Partial)		
Bridges (Fixed & Removable)	**After Deductible**	**After Deductible**
Denture Rebase or Reline		
Repair of Fixed Bridges	**50%**	**50%**
Repair of Removable Dentures	**After Deductible**	**After Deductible**
Re-cement Crowns and Bridges	**After Deductible**	

Type 4- Orthodontic Coverage for Dependent Children under age 19 **Lifetime Benefits Maximum: $1,500**	**50%** **No Deductible**	**50%** **No Deductible**
Benefit Plan Provisions:		
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.	
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.	
Special Requirements	For new dental plans (non-replacement), Type 3 Services will not be covered for the first 12 months. For any LATE entrants to the program, Type 3 and 4 Services will not be covered for the first 12 months.	
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $350 is proposed.	
Alternate Benefit Provision	Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards, Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.	
Timely Filing	Out of network claims submitted to Core after 365 days from date of service will be denied	
Benefit Plan Provisions:		
Missing Tooth Limitation	For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.	
Oral Evaluations	2 per calendar year	
X-rays (routine) Bitewings:	2 per calendar year	
X-rays (non-routine)	Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment.	
Diagnostic Casts	Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year.	
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.	
Fluoride Application	2 per calendar year for children under age 15.	
Sealants (per tooth)	For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months).	
Space Maintainers	Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary or baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth.	
Bridges (Fixed & Removable)	Fixed and Removable **EXCEPT THAT**: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable.	
Denture and Bridge Repairs	Reviewed if more than once.	
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.	
SEE DENTAL SPD FOR DETAILED EXCLUSIONS		