## Laurens County Cares Dental Schedule of Benefits Effective September 1, 2021

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%	JU /0		
Dentures (Full and Partial)				
Bridges (Fixed & Removable)	After Deductible	After Deductible		
Denture Rebase or Reline				
Repair of Fixed Bridges	50%	50% After Deductible		
Repair of Removable Dentures	After Deductible	Alter Deductible		
Re-cement Crowns and Bridges	After Deductible			

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 Filling  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  Arays (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  Existing Fixed & Removable (primary of the mouth).  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 of addition of teeth is required to replace one or more additional natural teeth extracted while covered of the period one or more additional natural teeth extracted while covered or additional natural teeth extracted while covered or additional natural teeth extracted while co	Type 4- Orthodontic	50%	50%		
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