## Laurens County Cares Dental Schedule of Benefits Effective September 1, 2023

Dental Coverage				
Calendar Year Benefits Maximum (Per Member)	\$1,000			
Calendar Year Deductible:				
Individual-	\$50			
<b>Family-</b> 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	After Deductible		
Re-cement Crowns and Bridges	After Deductible			

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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 deductions 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 any LATE entrants to the program, Type 3 and 4 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  Alternate Benefit Provision  Alternate Benefit Provision  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 (nout-noutine)  Rediographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months), it also includes not not thin was supplementary bleewing A-rays witce per condition requiring thealment.  Payable only in conjunction with orthodonic workup. Pulp Vitality Testing- one per calendar year.  Cleanings  2 per calendar year for children under age 15.  For permanent teeth (imited to covered dependent children between the ages of 6 and 18 years of 350 period one per tooth every 36 months).  Space Maintainers  Bridges (Fixed & Removable)  Fixed and Removable are found that in the member is covered under this Plan, and, the proposed and popular to the months.  Provision than the member is covered under this Plan, and, the replacement or addition of teeth is required to concerd dependent children between the ages o		No Deductible	No Deductible		
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