Benefit Summary
For
Haywood County Dental Plan

Amended and Restated: 01/01/2020

Administered by:

Plan Sponsor and Administrator

Haywood County
215 N Main Street
Waynesville, NC 28786

Plan Year

The Plan Year is January 1 through December 31

Deductible and Out of Pocket Year

January 1 – December 31

Dental Plan Claims Administrator/Dental COBRA Administrator

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Your Dental Benefits

The Plan provides dental benefits that cover services you receive from a licensed dentist. The Summary of Dental Benefits chart below shows the covered services under the Plan.

A dental charge is incurred on the date the service or supply is performed or furnished. However, there are times when one overall charge may be made for all or part of a treatment. In this case, the total charge will be apportioned to each separate visit or treatment. The pro-rata charge will be considered incurred as each visit or treatment is completed.

Coinsurance

The Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. Your coinsurance is determined by the type of service you receive as shown in the chart below.

Maximum Benefit

The maximum annual benefit is $1,000 per person per calendar year. There is also a separate individual maximum benefit of $1,000 per lifetime per member for orthodontia treatment. Orthodontia benefits are only available for covered dependents under the age of 19.

Covered Services

In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.

A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the claims administrator shown on your ID card.

Orthodontic Benefits

All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. The maximum orthodontia lifetime benefit is $1000 per covered person. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in accordance with the approved treatment plan over a period of up to 8 calendar quarters.

Summary of Dental Benefits

Annual Maximum Benefit (per calendar year)	$1,000 per person
Orthodontia Maximum Benefit (per lifetime)	$1,000

Diagnostic and Preventive Care (Class A) Services	**Plan Pays**
Oral exams (limited to 2 per calendar year)	100%
Bite-wing X-Rays (limited to 2 per calendar year)	100%
Full mouth x-rays (limited to 1 per 3 year period)	100%
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per calendar year)	100%
Topical fluoride applications (limited to 1 per calendar year) (limited to dependent children under age 19)	100%
Topical application of sealants on permanent molars (limited to 1 per calendar year) (limited to dependent children age 5 - 15)	100%
Space maintainers and their fitting (limited to 1 per calendar year) (limited to dependent children under age 19)	100%
Emergency palliative treatment to relieve pain	100%

Therapeutic and Restorative (Class B) Services	**Plan Pays**
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Extraction of teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw (but excluding charges for removal of stitches or post-operative exams)	80%
Periodontics (treatment of the gums and support structures of the teeth)	80%
Root canals and other endodontic treatments	80%
General anesthetics and their administration in connection with oral surgery, Periodontics, fractures, and dislocations	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Recementing of inlays, crowns, and bridges	80%
Consultations with a specialist	80%

Major and Prosthodontic (Class C) Services	**Plan Pays**
Relining of full or partial dentures if done more than one year after initial installation	50%
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	50%
Repair of crowns, bridgework, and removable dentures	50%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture,	50%

Major and Prosthodontic (Class C) Services	Plan Pays
or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	50%
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old	50%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old	50%

Orthodontia Benefits	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	50% up to a lifetime maximum of $1000

Dental Exclusions

The following list includes some common dental charges which are not covered under the Plan:

- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;
- Charges in excess of the maximum amount payable under the Plan (see “Maximum Allowed Amount”);
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse’s parent, child, brother, or sister;

- Correction of congenital conditions;
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist;
- Expenses for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics;
- Expenses for facings on pontics or crowns posterior to the second bicuspid;
- Occlusal analysis, occlusal adjustments, mouth guards or occulusal guards, or any similar take home item;
- Replacement of a lost, missing, or stolen prosthetic device or other dental appliance;
- Retreatment or additional treatment necessary to correct or relieve results of a previous treatment;
- Services or supplies which are covered by any County's liability laws;
- Services or supplies which are covered by any workers' compensation or occupational disease laws;
- Services that do not meet the standards of dental practices, accepted by the American Dental Association;
- Treatment which is considered to be experimental by the dental profession;
- Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
- Treatment received before becoming covered under the Plan or after coverage terminates.

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the claims administrator at the number listed on the back of your dental ID card.