BlueDental Choice Plus

Benefit Summary

Group Name: COMMUNITY ACTION PROGRAM INC

Group Effective Date: 10/01/2016

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Deductible No Deductible for Preventive Services (or ortho if selected) Per Person Per Plan Year Per Family Per Plan Year	**In-Network** $50 $150	**Out-of-Network** $50 $150
Amounts used to satisfy the in-network deductible also satisfy the out-of-network deductible and amounts used to satisfy the out-of-network deductible also satisfy the in-network deductible.		

	We Pay*	You Pay*	We Pay**	You Pay***
Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%

Periodic Oral Evaluation (0120)	Preventive
Comprehensive Oral Evaluation (0150)	Preventive
Bitewing X-rays, two films (0272)	Preventive
Cleanings - Adult/Child (1110, 1120)	Preventive
Fluoride Treatment - Child (1203)	Preventive
Office Visits (9430)	Preventive
X-rays - Intraoral/Complete Series (0210)	Preventive
Sealant – per tooth (1351)	Preventive
Amalgam Restorations (Silver Fillings) (2140)	Basic
Resin-Based Restorations - Anterior (2330)	Basic
Extractions - Routine and Surgical (7140)	Basic
Root Canal Molar (3330)	Basic
Periodontal Scaling & Root Planing-per quad (4341)	Major
Crowns - Porcelain fused to noble metal (2752)	Major
Complete Dentures (5110, 5120)	Major
Pontic - Porcelain fused to noble metal (6242)	Major
Partial Dentures (5213, 5214)	Major
Surgical placement of implant body - endosteal implant (6010)	Major
Implant supported porcelain fused to metal crown (titanium, high noble metal) (6066)	Major
Orthodontia Services BlueDental Coverage	None N/A
Waiting Periods Major Service Benefits Orthodontia Benefits	 None N/A
Maximum Benefits Plan Year (per person) Lifetime Orthodontia (per person)	 $1,000 N/A
Dental Rollover	Opt In

The information provided above is a summary of benefits for group certificate: 50534-1103. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

Some limitations may apply.

*Percentage of fee schedule.

** Payment is based on the 80th percentile of U&C.

***The majority of dentists' fees are within our allowed charges; however, you will be responsible for any fees in excess of the allowed amount

22243-0112 (DCE)

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Benefits

* **These benefits may be covered under a different service type or a different frequency based on the plan selected by your employer.**

Preventive

* • Two (2) routine oral examinations per plan year
* • Prophylaxis (cleaning, scaling and polishing of teeth) two (2) times per plan year
• Topical application of fluoride in conjunction with prophylaxis for dependent children under fourteen (14) years of age, two (2) times per plan year
* • Bitewing x-rays, once per plan year
* • Periodontal maintenance procedures (following active therapy). Limited to two (2) times per plan year. The total benefit for all types of prophylaxis services is limited to two (2) times per plan year.

Basic

• Palliative (emergency) treatment of an acute condition requiring immediate care
• Application of desensitizing medicaments
* • Sealants for dependent children through age sixteen (16)
* • Periapical (root area) x-rays as required
* • Complete mouth x-rays or panoramic x-rays (once in any thirty-six [36] consecutive month period). Panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit
* • Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service
• Repair of broken partial or complete dentures
• Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under fourteen (14) years of age. No payment will be made for duplicate space maintainers
• Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth
• Routine extractions
* • Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment. No payment will be made for root canal therapy until treatment is completed. Treatment is considered to be completed on the date the canals are sealed
• General anesthesia given in a dentist's office, for services that are: (a) performed by a person qualified to administer general anesthesia; (b) billed by such dentist; and (c) in connection with covered dental services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. The allowance for the administration of a local infiltration or block anesthetic in connection with other covered dental services is included in the allowance for those covered dental services
• Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year
• Adjustments to the maxillary and mandibular dentures, two (2) times per plan year (six [6] months after the initial insertion of the denture)
• Recementation of space maintainers once per plan year (must be six [6] months after the initial placement date)
• Replacement of core build up, if satisfactory proof is provided that at least five (5) years have passed since the date of service when the procedure was performed
• Relining and rebasing of immediate dentures if more than six (6) months after the insertion of an initial or replacement denture (not more than one relining or rebasing in any thirty-six [36] consecutive month period)
• Repair of broken crowns, inlays, onlays or bridges
• Surgical removal of teeth
• Surgical removal of maxillary or mandibular intrabony cysts
* • Apicoectomy (dental root surgery)
* • Gingivectomy and gingivoplasty
* • Periodontal scaling, payable once per quadrant every twenty-four (24) months
* • Root amputation—per root
* • Hemisection—(including any root removal), not including root canal therapy
• Alveoloplasty—per quadrant
* • Gingival flap procedure—once per quadrant every thirty-six (36) months
* • Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis—payable once every thirty-six (36) months

Major

• Clinical crown lengthening-hard tissue only, subject to dental consultant review for approval and pricing; office notes are required for review
• Replacement of cast post and core along with prefabricated post and core procedures, if satisfactory proof is given that at least five (5) years have passed since the date of service when the procedure was performed
• Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays)
• Initial insertion of partial or complete dentures (including any adjustments during the six [6] month period following insertion)
• Replacement of an existing partial or complete denture or bridge by a new denture or by a new bridge, if satisfactory proof is given that
  - The existing denture or bridge was inserted at least five (5) years before it is replaced
  - The existing denture or bridge is not serviceable and can not be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable
• Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months
• Free soft tissue graft procedure, including donor site
• Frenulectomy
• Bone replacement graft—once per site every thirty-six (36) months
• Pedicle soft tissue graft—once per site every thirty-six (36) months
• Guided tissue regeneration—once per site every thirty-six (36) months
• Subepithelial connective tissue graft—once per site every thirty-six (36) months
• Implants

16696-1011 (DCE)

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Limitations and Exclusions

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Limitations

- Any retreatment of root canals are payable one (1) year after completion date of root canal therapy.
- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
- Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of dependent children.
- General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
- Periodontal services are limited to insureds age eighteen (18) and older.
- Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
- Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
- All fixed prosthetics are billable upon the seat/insertion date.
- All removable prosthetics are billable upon final delivery.

Exclusions

The following are excluded under this plan:

- Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to an insured's effective date of coverage, (until the insured has been covered under the contract for twelve [12] consecutive months), unless otherwise specified.
- Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
- Charges for services or supplies when billed by other than a dentist.
- Benefits for services rendered by a member of an employee's family, (his spouse and the children, brothers, sisters and parents of either the employee or his spouse).
- Services rendered primarily for cosmetic purposes.
- Charges incurred for failure to keep a dental appointment.
- Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone—lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- Experimental or investigational treatment.
- Dental services received or rendered:
  - through or in a veteran’s hospital or government facility due to a service connected disability
  - which are covered and paid under Worker’s Compensation or similar law
  - which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total expenses that are incurred
- Services for which the insured incurs no charge.
- Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
- Local anesthesia when billed separately by a dentist.
- Any services paid or payable under the insured's health insurance contract.
- Services not listed in the Benefits section of this plan.
- Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this certificate will be based on the allowance for the least costly service, procedure, or course of treatment.
- Any additional treatment required due to the insured's failure to follow instructions, or lack of cooperation with the dentist.
- Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- Services rendered before the effective date of coverage.
- Services rendered after termination of coverage, except as provided under the plan's "Extension of Benefits upon Contract Termination."
- Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
- Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by an insured.
- Services in connection with any crown, inlay or onlay restoration or for any denture or bridge if treatment began prior to the insured's coverage under this certificate.
- Duplicate or temporary denture, crown, or bridge.
- Labial veneer restorations.
- General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
- Charges for nitrous oxide.
- Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or tower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Prescribed drugs, premedication or analgesia.
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges for oral hygiene, plaque control, or diet instruction.
- Charges for orthodontia services, unless shown on the Benefit Summary.
- Charges for sterilization are included in the allowance for other covered dental procedures.
- Charges for biohazardous waste disposal are included in the allowance for other covered dental procedures.
- Charges associated with accidental injuries to sound natural teeth.

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