ALLEGAN COUNTY
EMPLOYEE HANDBOOK

Category:	**Employee Benefit Policy**
Number:	**502**
Approved:	**January 27, 2005, supersedes prior policy**
Revised:	**December 27, 2007**
Subject:	**HEALTH / HEARING / DENTAL / VISION INSURANCE IRS 125 PLAN**

1. Employees

1.1 **Plan Descriptions.** Allegan County will provide healthcare coverage under the Allegan County Medical, Hearing, Dental and Vision Plan for the employee, spouse and children (one-person, two-person, and family) under the following conditions and with the following benefit options:

PPO Plan – Community Blue PPO Plan 1 (Prescription Co-Pays $10 / $15 / $20)

POS Plan – Blue Choice POS Plan 4 (Prescription Co-Pays $10 / $15 / $20)

New Traditional Plan – Blue Managed Traditional Comprehensive Major Medical Plan – Plan 2 (Prescription Co-Pays $10 / $40)

See Appendix A for the Benefits-at-a-Glance summary sheets for each of the plans.

1.2 **Eligibility.**
Newly hired employees will become eligible to participate in the plan on the first day of the calendar month following their first day of work. Employee deductions for premiums will start on their first payroll. Employees changing addresses or adding or deleting dependents must do so within 30 days of the event. Employees may change plans only during the open enrollment period each year.

Employee eligibility for the plan ends on the final day of the calendar month within which that employee terminates employment. Employee deductions for premiums will continue through their final paycheck. Employees eligible for COBRA continuation will be notified.

When the County employs more than one family member, there will be no duplicate coverage under medical plans.

1.3 **Contributions.** Unless otherwise stated in a collective bargaining agreement, employees who elect the PPO or POS plans will pay 20% of the required premiums and the Employer will pay the remaining 80%. All employees who elect the New Traditional Plan will pay 5% of the required premiums and the Employer will pay the remaining 95%.

1.4 **Opt Out.** The County shall pay employees an incentive of $3,000 per year for those employees who opt out of the County's medical / dental / vision program. An employee must work at least through the 15th of a month to receive a month's credit. The incentive shall be accrued on a calendar year basis and paid no later than February 28 following the end of the calendar year in which the incentive was earned, unless otherwise specified in a collective bargaining agreement. Employees who choose to opt out must provide proof of other coverage and can only re-enroll during the open enrollment period, unless there is a family qualifying event for coverage under COBRA. The incentive is not available to spouses of County employees when both spouses are County employees.

1.5 **Active Duty.** When County employees are called to active duty by the United States Armed Forces, the County will pay 100% of the medical plan premiums for the employee and dependents until the employee is released from duty. The plan coverage shall continue for a period of thirty (30) days from the date of release.

2. Retirees

2.1 **Eligibility.** Unless otherwise specified in a collective bargaining agreement, employees taking a normal retirement under an Allegan County sponsored retirement plan may be eligible to enroll in the Allegan County Medical Plan for Retirees. Eligibility is determined as follows:

2.1.1 Employees going from active employment with the County to retired status, at the time of their initial retirement, are eligible for participation in the medical plan.

2.1.2 Employees not participating in the employee medical plan prior to retirement are not eligible for participation in the retiree medical plan.

2.1.3 Retirees eligible for health care coverage through a spouse, other full time employment or another retirement plan, are not eligible for participation in the retiree health plan.

Eligible retirees can choose from those medical plans offered by the County at the time of retirement and then during the open enrollment period each year. Retirees can cancel their coverage any time during a plan year, but will not be eligible for reenrollment.

Retirees are responsible for payment of the full premium, unless stated differently under a collective bargaining agreement. If, at any time a retiree fails to make a payment on a timely basis the County will attempt to contact that retiree, prior to cancellation of coverage. If the retiree is incapacitated, medical plan coverage will be continued for 30 days and payment must be resumed on a current basis. Any retiree cancelled for non-payment of premiums is not eligible for reenrollment.

Plan participation is limited to the retiree, spouse and eligible dependents at the time of retirement. Surviving dependents will be offered COBRA continuation and/or conversion coverage.

3. **Changes in Plans or Carriers.** Health care benefits for employees and retirees are provided according to the master plan(s) and / or group insurance contract(s). Each participant will receive information regarding summary descriptions of the benefits, eligibility rules and required employee contributions. The County reserves the right to change or terminate these benefits, and to select the insurance carrier or implement self insurance, at any time in the sole discretion of the Board of Commissioners. In any situation where insurance or other benefits are provided, the terms of the insurance policy or benefit plan control regardless of any statement contained in this handbook.

4. **IRS Section 125 Plan**

Allegan County will make Section IRS 125 Plans available to employees for premium payment, medical reimbursement, and dependent care reimbursement. Administrative fees will be paid by the County.

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Community Blue^SM PPO
Benefits-at-a-Glance
Plan 1 13125-025

	In-Network	Out-of-Network
Preventive Services – Limited to $250 per calendar year		
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%, one per calendar year	Not covered
Annual Gynecological Exam	Covered – 100%, one per calendar year	Not covered
Pap Smear Screening – laboratory services only	Covered – 100%, one per calendar year	Not covered
Well-Baby and Child Care	Covered – 100% • Up to 6 visits per year, through age 1 • Up to 2 visits per year, age 2 through 3 • 1 visit per year, age 4 through 15	Not covered
Immunizations	Covered – 100%, up through age 16	Not covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not covered
Mammography		
Mammography Screening	Covered – 100%	Covered – 80% after deductible
	One per calendar year, no age restrictions	
Physician Office Services		
Office Visits	Covered – $20 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office Consultations	Covered – $20 copay	Covered – 80% after deductible, must be medically necessary
Urgent Care Visits	Covered – $20 copay	Covered – 80% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 100%	Covered – 100%
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100%	Covered – 80% after deductible
Diagnostic Tests and X-rays	Covered – 100%	Covered – 80% after deductible
Radiation Therapy	Covered – 100%	Covered – 80% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – 80% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital	Unlimited days	
Inpatient Consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

	In-Network	Out-of-Network
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 100%	Covered – 100%
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to lifetime dollar maximum which is adjusted periodically	
Home Health Care	Covered – 100%	Covered – 100%
	Unlimited visits	
Surgical Services		
Surgery – includes related surgical services	Covered – 100%	Covered – 80% after deductible
Voluntary Sterilization	Covered – 100%	Covered – 80% after deductible
Human Organ Transplants		
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – in designated facilities **on**
	Up to $1 million maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 100%	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100%	Covered – 80% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	Covered – 50%	Covered – 50% after deductible
	Unlimited days	
Inpatient Substance Abuse Treatment	Covered – 50%	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient Mental Health Care		
• Facility and Clinic	Covered – 50%	Covered – 50%
• Physician's Office	Covered – 50%	Covered – 50% after deductible
Outpatient Substance Abuse Treatment – in approved facilities	Covered – 50%	Covered – 50%
	Up to the state-dollar amount which is adjusted annually	
Other Services		
Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic	Covered – 100%	Covered – 100%
• Physician's Office – **excludes speech and occupational therapy**	Covered – 100%	Covered – 80% after deductible
	A combined 60-visit maximum per calendar year for physical therapy in t outpatient department of a hospital as well as in the physician's office	
Durable Medical Equipment	Covered – 100%	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 100%
Private Duty Nursing	Covered – 50%	Covered – 50%
Prescription Drugs	Covered - $10/$15/$20 with contraceptives and MOPD	Covered – 75% less $10/$15/$20 wi contraceptives and MOPD

Deductible, Copays and Dollar Maximums

Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-Network	Out-of-Network
Deductible	None	$250 per member, $500 family per c year
Copays		
• Fixed Dollar Copays	$20 for office visits and $50 for emergency room visits	$50 for emergency room visits
• Percent Copays	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% fo mental health care, substance abuse treatment and private duty nursing **Note**: Services without a network ar covered at the in-network level.

Copay Dollar Maximums		
• Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	Not applicable	$2,000 per member, $4,000 family p calendar year
Dollar Maximums	$1 million lifetime per covered specified human organ transplant type and a separa million lifetime per member for all other covered services and as noted above for individual services	

Optional Riders

Rider CI, Contraceptive Injections, **Rider PCD,** Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive dev such as diaphragms and IUDs, and prescription oral or injectable contraceptive medications. **Note**: These riders are available only with prescription drug coverage.
Rider HC, Hearing Care	Adds specific hearing care benefits, including one hearing aid, when provided by participating providers.

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

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Blue Choice® POS Plan 4 Benefits-at-a-Glance

25539-010

	In-Network	Out-of-Network
Preventive Services		
Health Maintenance Exam	Covered – $20 copay	Not covered
Annual Gynecological Exam	Covered – $20 copay	Covered – 80% after deductible, plus $20 copay
Certain Routine Laboratory and Radiology Services	Covered – 100%	Covered – 80% after deductible
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 80% after deductible
	One every 12 months	
Well-Baby and Child Care	Covered – $20 copay	Not covered
Immunizations	Covered – 100%	Not covered
Proctoscopic Exam	Covered – 100%	Covered – 80% after deductible
	One every 3 years at age 40 and older	
Prostate Specific Antigen (PSA) Screening	Covered – 100%	Covered – 80% after deductible
	One per calendar year	
Mammography		
Mammography Screening	Covered – 100%	Covered – 80% after deductible
	One baseline for ages 35-40, one annually after age 40	
Physician Office Services		
Office Visits	Covered – $20 copay	Covered – 80% after deductible, plus $20 copay
Outpatient and Home Visits	Covered – $20 copay	Covered – 80% after deductible, plus $20 copay
Office Consultations	Covered – $20 copay	Covered – 80% after deductible, plus $20 copay
Urgent Care Visits	Covered – $20 copay	Covered – 80% after deductible, plus $20 copay
Emergency Medical Care		
Hospital Emergency Room	Covered – $25 copay	Covered – $25 copay
Ambulance Services – medically necessary	Covered – 100%, ground service, and air service required for **emergency** transportation	Covered – 100%, ground service, and air service required for **emergency** transportation
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100%	Covered – 80% after deductible for major services
Diagnostic Tests and X-rays	Covered – 100%	Covered – 80% after deductible for major services
Radiation Therapy	Covered – 100%	Covered – 80% after deductible for major services
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – 80% after deductible, requires predetermination
Note: Nonemergency services must be rendered in a **participating** hospital	Unlimited days	
Inpatient Consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

	In-Network	Out-of-Network
Skilled Nursing Care	Covered – 100%	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 80% after deductible
	Limited to lifetime dollar maximum which is adjusted periodically	
Home Health Care	Covered – 100%	Covered – 80% after deductible
	Unlimited visits	

Surgical Services

Service	In-Network	Out-of-Network
Surgery – includes related surgical services	Covered – 100%	Covered – 80% after deductible
Voluntary Sterilization	Covered – 100%	Covered – 80% after deductible

Human Organ Transplants

Service	In-Network	Out-of-Network
Specified Organ Transplants – in designated facilities only, when coordinated through Blue Choice POS network manager (248-223-5545)	Covered – 100%	Not covered
Bone Marrow – when coordinated through Blue Choice POS network manager (248-223-5545); specific criteria applies	Covered – 100%	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100%	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Note: Mental health and substance abuse services must be coordinated by the Behavioral Health Manager to be considered in-network.

Service	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Abuse Treatment	Covered – 100%	Covered – 80% after deductible
	Up to 45 days per calendar year	
Outpatient Mental Health Care	Covered – 100%	Covered – 80% after deductible
Outpatient Substance Abuse Treatment	Covered – 100%	Covered – 80% after deductible
	Up to the state-dollar amount which is adjusted annually	

Other Services

Service	In-Network	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy Testing	Covered – $20 copay	Covered – 80% after deductible, plus $20 co
Chiropractic Spinal Manipulation	Covered – $20 copay	Covered – 80% after deductible, plus $20 co
	Up to 20 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%	Covered – 80% after deductible
	Up to 60 visits per condition per calendar year	
Durable Medical Equipment	Covered – 100%	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 80% after deductible
Private Duty Nursing	Covered – 100%	Not covered
Prescription Drugs	Covered - $10/15/20 with contraceptives and MOPD	Covered – 75% less $10/15/20 with contrac and MOPD

Deductible, Copays and Dollar Maximums

Item	In-Network	Out-of-Network
Deductible	None	$100 per member, $200 family per calendar
Copays • Fixed Dollar Copays	$20 for office visits and $25 for emergency room visits	$20 for office visits and $25 for emergency r visits
• Percent Copays	None	20%
Copay Dollar Maximums • Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	Not applicable	$1,000 per member, $2,000 family per calen year
Dollar Maximums	None except as noted above for individual services	$1 million lifetime per member and as noted for individual services

Optional Riders

Rider	Description
Rider CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices s as diaphragms and IUDs, and federal legend oral or injectable contraceptive medications **Note**: These riders are available only with prescription drug coverage.
Rider HC, Hearing Care	Adds specific hearing care benefits, including one hearing aid, when provided by partici providers.

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Blue Managed Traditional Comprehensive Major Medical Plan– Plan 2

Benefits-at-a-Glance 13128-007

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Preventive Care Services

Health Maintenance Exam	Covered – 80% after deductible, one every 12 months
Gynecological Exam	Covered – 80% after deductible, one every 12 months
Pap Smear Screening – laboratory and pathology services	Covered – 80% after deductible, one every 12 months (from the date of any previous pap
Well-Baby and Child Care	Covered – $20 copay, up to age 1
Immunizations	Covered – $20 copay, up to and including age 6
Proctoscopic Exam	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 80% after deductible

Mammography

Mammography Screening	Covered – 80% after deductible, one baseline for ages 35-40, one annually at age 40 and o

Physician Office Services

Office Visits	Covered – $20 copay
Outpatient and Home Visits	Covered – $20 copay
Office Consultations	Covered – $20 copay
Urgent Care Visits	Covered – $20 copay

Emergency Medical Care

Hospital Emergency Room	Covered – 80% after deductible
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Services	Covered – 80% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible
Therapeutic Radiology	Covered – 80% after deductible

Maternity Services Provided by a Physician

Prenatal and Postnatal Care	Covered – 80% after deductible, includes care provided by a certified nurse midwife
Delivery and Nursery Care	Covered – 80% after deductible, includes delivery provided by a certified nurse midwife

Hospital Care

Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies **Note**: Nonemergency services must be rendered in a **participating** hospital	Covered – 80% after deductible, unlimited days
Inpatient Consultations	Covered – 80% after deductible
Chemotherapy	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Not covered
Hospice Care	Covered – 100%, limited to dollar maximum which is adjusted periodically
Home Health Care	Covered – 80% after deductible, unlimited visits

Surgical Services

Surgery – includes related surgical services	Covered – 80% after deductible
Voluntary Sterilization	Covered – 80% after deductible

Human Organ Transplants

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%, up to $1 million maximum per transplant type
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 50% after deductible
Inpatient Substance Abuse Treatment	Covered – 50% after deductible, up to $15,000 annual, $30,000 lifetime maximum
Outpatient Mental Health Care	Covered – 50% after deductible
Outpatient Substance Abuse Treatment – in approved facilities only	Covered – 50% after deductible, up to the state-dollar amount which is adjusted annually

Other Services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – $20 copay
Chiropractic Spinal Manipulation	Covered – 80% after deductible, up to 38 medically necessary visits per calendar year
Outpatient Physical, Speech and Occupational Therapy	Covered – 80% after deductible, unlimited treatment
Durable Medical Equipment	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible
Private Duty Nursing	Covered – 50% after deductible
Prescription Drugs	Covered - $10 Generic/$40 Brand Charge with contraceptives and MOPD2X

Deductible, Copays and Dollar Maximums

Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Deductible	$250 per member, $500 per family per calendar year
Copays	20% for general services and 50% for mental health care, substance abuse treatment and pr duty nursing
Copay Dollar Maximums – excludes mental health care, substance abuse treatment and private duty nursing copays	$1,000 contract per calendar year
Dollar Maximums	$1 million lifetime per covered specified human organ transplant type and a separate $5 mi lifetime per member for all other covered services and as noted above for individual servic

Riders

Rider AP-2, Annual Physical Exam	Adds benefits for one routine annual physical or gynecological exam and the following scr procedures: chemical profile, complete blood count, fecal occult blood screening and urina Member is responsible for applicable deductible and copays.
Rider CMM-OPS $20, Office and Outpatient Physician Services	Adds well baby care (up to age 1) and immunizations (up to and including age 6), subject t $20 copay. It also removes the deductible and changes the percent copay to a $20 copay pe service for office, outpatient and home medical care visits (excludes routine medical care), allergy testing and therapy. The $20 copay will not be applied to the annual copay maximu
Rider CI, Contraceptive Injections, **Rider PCD,** Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices suc diaphragms and IUDs, and federal legend oral or injectable contraceptive medications. **Note**: These riders are available only as a package with prescription drug coverage.
Rider PSA, Prostate Specific Antigen Screening	Covers one PSA screening test per member, per calendar year, for members age 40 and ove Member's regular deductibles and copays for lab tests apply. PSA tests must be provided b independent laboratory, or in an inpatient or outpatient hospital setting.
Rider XVA, Excludes Voluntary Abortions	Excludes benefits for voluntary abortions.
Rider CMM-MHP, Mental Health Parity	Eliminates annual and lifetime maximums for mental health care. **Note**: The separate annu and lifetime maximums still apply to inpatient substance abuse treatment.

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Traditional Plus Dental Coverage Plan 3

Benefits-at-a-Glance

For Community Blue, Point of Service & New Traditional Medical Coverage

Class I Services

Oral Exams	Covered – 100%, twice per calendar year
Bitewing X-rays	Covered – 100%, twice per calendar year
Full-mouth and Panoramic X-rays	Covered – 100%, once every 60 months
Prophylaxis (Teeth Cleaning)	Covered – 100%, twice per calendar year
Fluoride Treatment	Covered – 100%, twice per calendar year
Space Maintainers	Covered – 100%, once per quadrant per lifetime, up to age 19

Class II Services

Fillings - permanent teeth	Covered – 75%, once every 24 months
Fillings - primary teeth	Covered – 75%, once every 12 months
Inlays, Onlays, Crowns and Gold Fillings – permanent teeth	Covered – 75%, once every 60 months, payable for members age 12 ar older
Recementing of Inlays, Onlays, Crowns and Bridges	Covered – 75%, three per calendar year
Root Canal Therapy	Covered – 75%, once every 12 months for teeth with one or more cana
Periodontal Scaling and Planning	Covered – 75%, once every 24 months
Occlusal Adjustment	Covered – 75%, up to five times a 60-month period
Periodontic Appliances or Biteguards	Covered – 75%, once every 12 months
General Anesthesia or IV Sedation	Covered – 75%, when medically necessary and performed with oral or dental surgery
Oral Surgery including extractions	Covered – 75%
Relining or Rebasing of Partials or Dentures	Covered – 75%, once every 36 months per arch
Tissue Conditioning	Covered – 75%, once every 36 months per arch
Repairs to Existing Partials or Dentures	Covered – 75%, up to one-half the approved amount for a new denture any 12-month period
Palliative Emergency Treatment	Covered – 75%

Class III Services

Removable Dentures and Partials	Covered – 50%, once every 60 months
Fixed Bridges	Covered – 50%, once every 60 months, payable for members age 16 ar older

Class IV Services – Orthodontic services for dependents under age 19

Habit Breaking Appliances	Covered – 50%
Minor Tooth Guidance Appliances	Covered – 50%
Full-Banding Treatment	Covered – 50%
Monthly, Active Treatment Visits	Covered – 50%

Copays and Dollar Maximums

Copays	25% for class II services and 50% for class III and IV services
Dollar Maximums	
• Annual Maximum	$1,000 per member for covered class I, II and III services
• Lifetime Maximum	$1,000 per member for covered class IV services