The Dental Care
PLUS GROUP
A DentaQuest Company

Benefit Summary

BROWN COUNTY SCHOOL CONSORTIUM

Product: DHMO

Network: Dental Care Plus

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $2500 per Member

Orthodontic Lifetime Maximum Benefit: $1500 per Eligible Member
Limited to eligible subscriber, spouse and dependent children under age 25

Deductible: $25 per Member, per Benefit Year
$50 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	80%	20%
Major Benefits	Yes	60%	40%
Orthodontic Benefits	No	60% Limited to eligible subscriber, spouse and dependent children under age 25	40%

Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Preventive Benefits.

Dependent children are eligible for coverage until age 23, or until age 25 if enrolled as full-time students.

A complete description of benefits, limitations and exclusions are available in the Summary Plan Description.
Members must receive services from a Dental Care Plus dentist.

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Benefit Summary

BROWN COUNTY SCHOOL CONSORTIUM

Product: Indemnity

Network: None

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $2500 per Member

Orthodontic Lifetime Maximum Benefit: $1500 per Eligible Member
Limited to eligible subscriber, spouse and dependent children under age 25

Deductible: $25 per Member, per Benefit Year
$50 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	80%	20%
Major Benefits	Yes	60%	40%
Orthodontic Benefits	No	60% Limited to eligible subscriber, spouse and dependent children under age 25	40%

Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Preventive Benefits.

Dependent children are eligible for coverage until age 23, or until age 25 if enrolled as full-time students.

A complete description of benefits, limitations and exclusions are available in the Summary Plan Description.
Members who receive services under the Indemnity plan may be subject to balance billing.

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Benefit Summary

BROWN COUNTY SCHOOL CONSORTIUM

Product: DPPO

Network: DentaSelect Plus

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $2500 per Member

Orthodontic Lifetime Maximum Benefit: $1500 per Eligible Member
Limited to eligible subscriber, spouse and dependent children under age 25

Deductible: Deductible for services provided by an In-Network Provider

$25 per Member, per Benefit Year
$50 per Family, per Benefit Year

Deductible for services provided by an Out-of-Network Provider

$25 per Member, per Benefit Year
$50 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only
Any deductible amount that is satisfied will be applied toward both the In-Network and Out-of-Network deductibles

Covered Dental Services	Deductible Applied	In Network		Out-of Network	
		Percentage of Allowable Expense Paid by the Plan	*Member Copayment*	*Percentage of Allowable Expense Paid by the Plan*	*Member Copayment*
Preventive Benefits	No	100%	None	100%	None
Basic Benefits	Yes	80%	20%	80%	20%
Major Benefits	Yes	60%	40%	60%	40%
Orthodontic Benefits	No	60% Limited to eligible subscriber, spouse and dependent children under age 25	40%	60% Limited to eligible subscriber, spouse and dependent children under age 25	40%

Out of network claims are reimbursed at the Advantage 900 level.

Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Preventive Benefits.

Dependent children are eligible for coverage until age 23, or until age 25 if enrolled as full-time students.

A complete description of benefits, limitations and exclusions are available in the Summary Plan Description.
Members must receive services from a Dental Care Plus dentist.

COVERED SERVICES

This is a summary only. A complete description of covered services, limitations and exclusions is available in the member handbook or certificate of insurance.

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PREVENTIVE AND DIAGNOSTIC SERVICES

Routine oral examinations: limited to two visits each year
Prophylaxis (cleaning): limited to two each year
Topical application of fluoride: limited to two treatments each year to children under age 18
Bitewing X-Rays: limited to one set each year
Vertical bitewing X-Rays: limited to once every three years (7-8 films)
Periapical X-Rays: limited to five films per year
Full-mouth X-Rays (complete series or panoramic): limited to once every three years
Extraoral X-Rays
Referral consultations and examinations performed by a specialist

EMERGENCY SERVICES

Emergency/limited oral examinations
Office visit after hours: for emergencies only
Emergency palliative treatment

SEALANTS & PREVENTIVE RESIN RESTORATIONS

Permanent molar teeth only: limited to children under 15 years of age and once every five years per tooth

SPACE MAINTAINERS

Space maintainer – fixed, unilateral: limited to children under 19 years of age
Distal shoe space maintainer – fixed, unilateral: limited to children under 8 years of age

ORAL SURGERY

Extractions

- Simple single-tooth extractions
- Root removal – exposed roots

Surgical Extractions

- Removal of an erupted tooth (uncomplicated)
- Removal of impacted tooth – soft tissue
- Removal of impacted tooth – partially bony
- Removal of impacted tooth – completely bony
- Removal of impacted tooth – completely bony, with complications
- Surgical removal of residual roots

Alveoloplasty and vestibuloplasty
Incision and drainage of abscess
Biopsy and examination
General anesthesia or intravenous sedation: only when necessary and provided in connection with oral surgery

ENDODONTIC SERVICES

Root canal therapy, traditional
Retreatment of previous root canal: must be at least three years following previous root canal treatment on the same tooth
Recalcification and apexification

PERIODONTIC SERVICES

Emergency treatment (periodontal abscess, acute periodontitis, etc.)
Periodontal scaling and root planing: limited to four quadrants once per 12 months as a definitive treatment when pocket depths of at least 4mm are demonstrated
Scaling in presence of generalized moderate or severe gingival inflammation: limited to once in a 24 month period when clinical documentation demonstrates that 30% or more of teeth are involved.
Surgical periodontics (including post-surgical visits): limited to two additional recalls in the first year following complex surgery
Gingivectomy, osseous and muco-gingival surgery, gingival grafting
Guided tissue regeneration
Periodontal maintenance procedure: limited to two each year following a history of periodontal disease

RESTORATIVE SERVICES

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.
Amalgam, composite and sedative fillings: limited to once every two years per tooth (same surfaces only)
Inlays, Onlays, Crowns, Post and Core: limited to once every five years on same tooth
Pins: pin retention as part of restoration when used instead of gold or crown restoration
Stainless-steel crowns: when tooth cannot be adequately restored with filling material
Recementation of inlays, onlays, crowns, bridges, and space maintainers
Repairs to crowns and bridges

PROSTHODONTIC SERVICES

Fixed bridge: limited to one original or replacement prosthesis every five years
Complete upper or lower denture: limited to one original or replacement prosthesis every five years
Partial upper or lower denture: limited to one original or replacement prosthesis every five years
Relining and rebasing: limited to once every three years
Full and partial denture repairs

ORTHODONTIC SERVICES*

Orthodontic benefits refer to plan design for individual lifetime maximum.
Comprehensive orthodontic treatment
Other orthodontic treatment: limited to one appliance per individual
Appliance for tooth guidance
Orthodontic retention appliance
All benefits paid toward orthodontia services by your current employer's previous dental carrier(s) will be applied to the Dental Care Plus lifetime orthodontia maximum.

Call us at **800-367-9466** or visit our website at **DentalCarePlus.com** with any questions you have about service or coverage.

Coverage of services vary from Preventive, Basic and Major categories. Refer to your Member Handbook or Summary Plan Description for a detailed benefit description and waiting periods. *May or may not apply to your specific plan. Please refer to your benefit summary in your packet or your benefits administrator for details.
Dental insurance plans are issued by Dental Care Plus, Inc., located at 100 Crowne Point Place, Cincinnati, OH 45241. Domicile: Ohio. NAIC No. 96265.

The Dental Care PLUS GROUP
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Dental Care Plus, Inc.
100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466

☐ DHMO
☐ INDEMNITY
☐ DPPO-DENTASELECT

ENROLLMENT FORM

ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

DENTAL GROUP NUMBER				EFFECTIVE DATE		
SOCIAL SECURITY NUMBER – –	**EMPLOYER AND LOCATION**					
EMPLOYEE LAST NAME	FIRST NAME	MI	EMPLOYEE'S HOME PHONE			
			EMPLOYEE'S EMAIL ADDRESS			
HOME ADDRESS		APT#	GENDER		DATE OF BIRTH	
CITY	STATE	ZIP CODE		COUNTY IN WHICH YOU RESIDE		
MARITAL STATUS: ☐ SINGLE (01) ☐ MARRIED (02)			EMPLOYMENT DATE			

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	GENDER	BIRTH DATE	PLAN DENTAL
	SPOUSE			

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _______________ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:____

REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE

I DECLINE ALL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL: ____

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Policy/Contract issued to my employer by Dental Care Plus, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Policy/Contract and any changes provided for therein. I understand that certain services may require copayment or deductible, payable by me (or my dependents) directly to the provider of such services. I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the provider-patient privilege and authorize any provider of dental or vision services to give Dental Care Plus, Inc., its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

To the best of my knowledge, the above information is complete, true, and correct. In the absence of fraud, however, all statements made by applicants or by an insured person shall be deemed representations and not warranties.

PLEASE SIGN WHETHER YOU ARE ACCEPTING OR DECLINING COVERAGE

EMPLOYEE SIGNATURE ____ **DATE** ______________________________

Fraud Notice – Michigan and Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Notice – Kentucky Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Fraud Notice – Indiana Residents Only: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

Fraud Notice – Tennessee Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.