Henry County Medical Center
Dental and Vision Coverage 2020

Dental Coverage

Single $2.01 PP Family $8.96 PP

Maximum benefit per calendar year for Class 1, 2 and 3 Services	**$1,000**
Maximum Lifetime benefit for Class 4 Services	**$1,000**

Covered Dental Expenses:	Benefits
Class 1 Services (Preventive Care)	80%
Class 2 Services (Repair and Restoration)	70%
Class 3 Services (Major Dental Repair)	70%
Class 4 Services (Orthodontics)	50%
Charges are limited to Usual and Customary Fees.	

Class 1 Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than twice per calendar year;
2. All Medically Necessary x-rays;
3. Periapical x-rays, as required, and bitewing x-rays twice per calendar year;
4. Full mouth x-rays or panoramic x-rays, but not more than once in any period of 36 consecutive months;
5. Topical application of fluoride for Dependent Children under age 18, but not more than twice in a calendar year;
6. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 18. No payment will be made for duplicate space maintainers;
7. Palliative Emergency treatment of an acute condition requiring immediate care; and
8. Topical application of sealants.

Class 2 Services (Repair and Restoration)

1. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
2. Simple extractions;
3. Crowns;
4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;

5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
6. Periodontal scaling;
7. Stainless steel crowns;
8. Simple extractions and oral surgery;
9. Periodontal examinations, treatment and surgery; and
10. Consultations.

Class 3 Services (Major Dental Repair)
Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
4. Re-lines;
5. Re-basing once per 36 month period; and
6. Post and core.

Class 4 Services (Orthodontics)

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
2. Interceptive, interventive or preventive orthodontic services;
3. Fixed and removable appliance placement, and active treatment per month after the first month; and
4. Extractions in connection with orthodontic services.

Vision Coverage

Single $2.01 PP Family $5.64 PP

Covered Vision Expenses:	Benefits
Eye exam	Covered 100% up to a maximum of $50 per calendar year
Frame-type lenses (any kind) Frames Contact Lenses	All lenses and frames covered 100% up to a combined maximum of $150 per calendar year

Covered expenses - Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses; and