

Dental Plan Exclusively for PBC Board of County Commissioners

| Dental PPO Summary of Benefits Effective | 1/1/2022 | | | |
|--|--|--------------------------------------|--|--------------------------------|
| | NON-ORT NETWORK | HODONTICS OUT-OF-NETWORK | ORTHODONTICS NETWORK OUT-OF-NETWORK | |
| Individual Annual Calendar Year Deductible | \$50 | \$100 | \$0 | \$0 |
| Family Annual Calendar Year Deductible | \$150 | \$300 | \$0 | \$0 |
| Maximum (the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits) | \$1500 per person per Calendar Year | \$1000 per person per Caleno Year | dar \$1000 per person per Lifetime | \$1000 per person per Lifetime |
| Annual deductible applies to preventive and diagnostic services | | | No (In Network) No (Out-of-Network) | |
| Solstice BenefitsBooster Included (Increasing Calendar Year Maximum Benefit) | | | Yes | |
| Preventive Waiver Saver Included (P&D Services Do Not Accumulate Towards Annual Maximum) | | | No | |
| Orthodontic eligibility requirement | | | Adults and Children | |
| COVERED SERVICES | NETWORK PLAN PAYS* | OUT-OF-NETWORK PLAN PAYS** | BENEFIT GUIDELINES | |
| PREVENTIVE & DIAGNOSTIC SERVICES | | | | |
| Periodic Oral Evaluation | 100% | 90% | Limited to two (2) times per consecutive twelve (12) months. | |
| Routine Radiographs | 100% | 90% | Bitewings: Limited to one (1) series of films per consecutive twelve (12) months. | |
| Non-Routine - Complete Series Radiographs | 100% | | Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months. | |
| Prophylaxis (Cleanings) | 100% | 90% | Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months. | |
| Fluoride Treatment | 100% | | Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months. | |
| Sealants | 100% | | Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months. | |
| Space Maintainers | 100% | 90% | Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation. | |
| Palliative Treatment | 100% | | Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit | |
| BASIC SERVICES | | | | |
| Restorations (Amalgam or Composite) | 80% | 70% | Multiple restorations on one (1) surface will be treated as a single filling. | |
| Simple Extractions | 80% | 70% | Limited to one (1) time per tooth per lifetime. | |
| MAJOR SERVICES | | | | |
| Anesthetics | 50% | | General Anesthesia: When clinically necessary or when administered in conjunction with an approved bony extraction (D7230/40/41) of a 3rd molar. | |
| Adjunctive Services | 50% | 40% | | |
| Oral Surgery (includes surgical extractions) | 50% | 40% | Extractions: Limited to one (1) time per tooth per lifetime. | |
| Periodontics - Surgical | 50% | | Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area. | |
| Periodontics - Non Surgical | 50% | 40% | Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty- four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months. | |
| Endodontics | 50% | 40% | | |
| Implants | 50% | 40% | Subject to separate Lifetime Maximum of \$2,500 | |
| Inlays/Onlays/Crowns | 50% | 40% | Limited to one (1) time per tooth per consecutive sixty (60) months. | |
| Dentures and other Removable Prosthetics | 50% | | Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments. | |
| Fixed Partial Dentures (Bridges) | 50% | 40% | Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months | |
| ORTHODONTIC SERVICES | | | | |
| Diagnose or correct misalignment of the teeth or bite | 50% | | Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment. | |

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the 80th Percentile of Usual and Customary Charge.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersed plan design features.

1.877.760.2247 www.SolsticeBenefits.com Once enrolled, visit: www.MySolstice.net

