Basic Dental

Schedule of Benefits

Dental Option II (No Orthodontia) – Calendar or Plan Year as applicable

Important Note
The Municipal Insurance Trust of North Carolina benefits are administered by the North Carolina League of Municipalities and MedCost Benefit Services.

Quality Service Is Part of Quality Care
Service is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need in order to manage your dental health.

Visit **www.medcost.com** and for access to information 24/7, go to Member login to visit your personalized member website. You will need your ID card with your Member and Group ID numbers to create an account.
If you have questions about dental claim status, dental benefits, or other general questions, you may contact MedCost Benefit Services Customer Service department at (800) 795-1023 or **mbscs@medcost.com**. Please include your Member ID number in the body of the email.

Preventive and Diagnostic Care
Our goal is to help keep you healthy. Preventive and diagnostic dental coverage (Type A expenses) help to uncover potential problems before they affect your dental health.

It's Your Choice
There is no network of providers for dental services. You can use any dentist. Depending upon the dental office you select, you may have to pay for services as received and file a claim for reimbursement.

Send dental claims to:
MedCost Benefit Services
PO Box 25987
EDI 56205
Winston-Salem, NC 27114-5987
Or by email to **mbswebmail@medcost.com.**

SCHEDULE OF BENEFITS
Dental Option II (No Orthodontia)
2017

For access to information 24/7, go to **www.medcost.com** and go to Member Login to visit the personalized website; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or **mbscs@medcost.com**; please include Member ID in body of email.

This Schedule of Benefits is an outline of benefits of the Employee Benefit Plan provided by your Employer. The basis of payment of the benefits described herein will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the Summary Plan Description.

Send dental claims to:
MedCost Benefit Services
PO Box 25987
EDI 56205
Winston-Salem, NC 27114-5987
Or by email to **mbswebmail@medcost.com.**

See also Master Summary Plan Description for details of the Plan.

Waiting Period	Effective on date deemed by the governmental unit
Spousal Definition	If Spousal coverage is offered by the governmental unit: The term "Spouse" means the person of the opposite gender or same gender who is legally recognized as the husband or wife under the laws of the state where the marriage took place. The Employer may require documentation proving a legal marital relationship.
Dependent Children	Coverage for Dependent children is extended to the end of the month during which the 26th birthday occurs.
Retirees / Board Members	See Master Summary Plan Description / governmental unit for details.
Open Enrollment	Benefit choices made during Open Enrollment are effective on July 1st unless otherwise specified by governmental unit's Human Resources department.
Leave of Absence	FMLA. See Master Summary Plan Description. Other than FMLA. See Master Summary Plan Description.
Pre-Existing Conditions	Not applicable to Dental Only coverage.

Plan Deductible		
Plan Deductible	Individual	$50
	Family	$100
Carryover Deductible		Yes. See Master Summary Plan Description.

Maximum – Types A, B and C	
Maximum per Calendar Year or Plan Year, as applicable	$1,000 per person (Type A, B and C Expenses combined)

Type A Preventive and Diagnostic Care	
Coverage	100%, no Plan Deductible
Clinical oral examination	2 per person per calendar or plan year, as applicable
Prophylaxis (Cleaning)	2 per person per calendar or plan year, as applicable
Periodontal Prophylaxis (Cleaning)	
Full Mouth X-rays	One full mouth X-ray every 3 calendar or plan years, as applicable
	Full mouth X-rays - a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.
Bitewing X-rays	2 bitewing X-ray series each calendar or plan year, as applicable.
Panoramic X-ray or Diagnostic service	As needed to determine necessary care
Fluoride application	1 per calendar or plan year, as applicable, to age 15
Space maintainer	Limited to non-orthodontic treatment
Sealant	Limited to permanent posterior teeth to age 14
Emergency care to relieve pain	As needed

Type B BASIC Restorative Care	
Coverage	80% after Plan Deductible
Fillings	
Root canal	
Osseous surgery	
Periodontal services, non-surgical	Includes treatment plan, local anesthetics and postoperative care: • Periodontal root planing and cleaning – as necessary for substantial bone and attachment loss. • Occlusal adjustment – allowable only when done in conjunction with periodontal surgery.
Denture adjustment / repair	adjustment / repair of a denture within 6 months of installation
Extraction	(Local anesthetic / analgesia / routine postoperative care for extractions - not separately reimbursed - considered part of submitted fee for global surgical procedure)*
General Anesthesia	Paid as separate benefit only when Medically or Dentally Necessary, as determined by MedCost Benefit Services and when administered in conjunction with complex oral surgical procedures covered under this plan.
Oral surgery	*Note above
Type C MAJOR Restorative Care	
Coverage	50% after Plan Deductible
Crowns	See Alternate Treatment paragraph in Summary Plan Description.
Dentures	
Bridges	
Implants	
Missing Tooth Provision – Waiting Period for Services	
First 24 months of coverage	Covered at 50%
Waiting Period for Services - Not applied to Type A	
If Employee / dependent NOT added when first eligible:	Covered at 50% for the first 12 months of continuous coverage
Predetermination of Benefits	
Voluntary	Before starting a dental treatment for which the charge is expected to exceed $1,000

Dental Plan Exclusions

- Cosmetic dentistry (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontal involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services, including:
  - Removal of wisdom teeth.[1]
  - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
  - Emergency repair due to Injury to sound natural teeth.
  - Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - Excision of benign bony growths of the jaw and hard palate.
  - External incision and drainage of cellulitis.
  - Incision of sensory sinuses, salivary glands or ducts.

- Reduction of dislocations and excision of temporomandibular joints (TMJs).
- Medically necessary replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment.
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, even when:
  - The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - Orthognathic surgery is medically necessary as a result of tumor, trauma, disease; or
  - Orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
- Repeat or subsequent orthognathic surgeries for the same condition.

[1]If you have elected "Dental Only" coverage with the MIT Plan, removal of wisdom teeth will be covered.

- Services and supplies received from a Hospital;
- Type D - orthodontic treatment UNLESS applicable to the specific governmental unit's selected Option;
- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- Experimental or investigational. Services or supplies that do not meet accepted standards of dental practice, or are not necessary according to those standards, including charges for services or supplies that are experimental or investigational in nature, and charges not yet approved by the Council on Scientific Affairs / Dental Therapeutics of the American Dental Association.
- Foreign travel where care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining dental services.
- Labial veneers.

Please refer to Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions. In the event of discrepancy between this Schedule and the Summary Plan Description (booklet), the approved Summary Plan Description (booklet) will govern.