Manatee Your Choice Dental Plan

Who is the Plan Sponsor?
The Plan Sponsor is Manatee County Government's Board of County Commissioners. The Dental Plan is administered by Aetna using the Aetna Dental PPO/PDN Network.

How Is the Manatee Choice Dental Plan Funded?
An employee of Manatee County Government who desires individual, and/or family coverage must contribute through Payroll Deduction. **The Plan is self-insured, and the Employees pay 100% of the cost.**

Upon reasonable notice (60 days), the Plan Administrator may change the enrollment rate or premium equivalent, and may change the Employee's payroll deduction to the appropriate enrollment rate or premium.

What Are the Dental Plan's Benefits?
The following are the Rules and Regulations, Guidelines, and Benefit Allowances for the Your Choice Dental Plan. This is not a legal document, but rather a guide to assist you in deciding whether or not to participate in the Dental Program.

IMPORTANT:
Are There Any Special Limitations and Exclusions Rules That an Employee Should Be Familiar with Prior to Enrolling in the Dental Plan?
Yes. There are Limitations and Exclusions that Members should be aware of prior to obtaining dental care. It is important to read the Dental Section - Summary Plan Description prior to receiving Major Dental Procedure treatment (Crowns, Dentures, and Bridges, etc.). Two significant rules to be aware of are:

- **Procedural Waiting Period**: Major Dental Procedures are **not** covered during the first 12 months from the Effective Date of Coverage.

- **Re-entry Rule**: An employee who cancels an individual, family, or dependent membership must wait 24 months in order to rejoin the Plan. There will be a new Pre-existing Condition Period, Limitations, and Exclusion for the employee, and/or dependent re-enrolling in the Plan.

Waiting Period
New Employee:
A new employee will become eligible to join the Plan on the first day of the month following **60** days continuous active employment.

Open Enrollment :
An employee who is not a member of the Plan under the rules of a "New Employee" will be offered the opportunity to join the Plan on the first day of January, or such time the Plan Administrator declares "Open Enrollment". Thirty (30) days prior notice will be given to all employees on the "Open Enrollment" period.

Deductibles
Certain covered dental charges are subject to a deductible. The deductible **i**s the amount of covered charges each covered person must incur before benefits are payable. The deductible must be satisfied each calendar year. Each individual enrollee has their own separate dental deductible and preferred and non-preferred deductibles are combined.

Coinsurance
Certain covered dental charges are subject to coinsurance once the deductible has been met. A coinsurance is a percentage of the negotiated rate that the member is responsible for. Coinsurance only applies to Type B and Type C procedures. There is no coinsurance for preventative or diagnostic.

Deductible Per Calendar Year – Applies to Type B-Basic Restorative and Type C-Major Restorative Procedures:

Per Person	$ 50.00/year

Dental Cost Sharing	**Plan Pays**
Diagnostic and Preventative	100% of the contracted rate
Basic Restorative	80% of the contracted rate
Major Restorative	50% of the contracted rate

Choice of Dentists
A Member selects the dentist of their choice to perform all services. Dentists listed in the **Aetna Dental PPO/PDN Network** have agreed to contracted rates for dental services and agree to not bill the member for the difference between the contracted rate and their billed charge. Non-network Dentists will be reimbursed at the Aetna PPO/PDN contracted rate by the Plan, however members are subject to additional charges by that provider as a non-network Dentist.

Maximum Annual Benefit
Calendar Year Maximum Per Person $2,000.00

What Is the Maximum Benefit Allowance?
The Maximum Benefit Allowance is the maximum dollar amount that the plan will cover in a plan year for covered dental services: preventative, basic and major.

Covered Dental Charges
Covered Dental Charges are charges which are: (1) prescribed, performed, or ordered by a dentist; and (2) Reasonable and Customary charges; and (3) incurred while you, and your dependents are covered under this Plan; and (4) not excluded by other provisions of the Plan that apply to the procedures described below.

Preventative Services	Plan Responsibility
Oral Examination (2 per calendar year)	100%
Cleanings (2 per calendar year)	100%
Fluoride (1 application/year under age 16)	100%
Sealants (1 treatment every 3 rolling years on permanent molars only for children to age 13)	100%
Bitewing X-rays (1 set per calendar year)	100%
Full Mouth Series (1 set every 24 months)	100%
Space Maintainers (covered to age 13 for premature loss of primary teeth only. Includes adjustment w/in 6 months of installation)	100%
Basic Services	**Plan Responsibility**
Root canal therapy (anterior teeth/Bicuspid teeth)	80%
Scaling and root planing (4 separate quads every 2 rolling years)	80%
Gingivectomy (once per quad/site every 3 rolling years)	80%
Amalgam (silver) fillings	80%
Composite fillings (anterior teeth only)	80%
Stainless steel crowns	80%
Incision and drainage of abscess	80%
Uncomplicated extractions	80%
Surgical removal of erupted tooth	80%
Surgical removal of impacted tooth (soft tissue)	80%
Major Services	**Plan Responsibility**
Root canal therapy, molar teeth	50%
Osseous surgery (Once per quadrant every 3 rolling years)	50%
Surgical removal of impacted tooth (partial bony/full bony)	50%
General anesthesia/intravenous sedation*	50%
Crown Lengthening	50%
Inlays	50%
Onlays	50%
Crowns	50%
Full and Partial dentures	50%
Pontics	50%
Denture repairs	50%
Crown Build-ups	50%
*Covered under dental if not covered in whole or part under medical	

Does the Plan Cover Orthodontic?
No. It is suggested that an employee use their Health Care Spending Account to obtain maximum tax savings.

Second Opinion
The Plan will pay in full for an Office Consultation and X-rays if a member of the Plan desires a Second Opinion on Dental Services in excess of $500.00.

Coordination of Benefits
The Plan coordinates benefits with any other Plan covering the individual, and/or members of the Plan. No members of the Plan shall receive more than 100% of the charges covered by the Dental Plan, and any other Plan.

Predetermination Review
If the charges for a course of treatment will total more than $350, the Provider is recommended to complete a predetermination review to Aetna. A predetermination for any dental treatment plan does not constitute treatment started.

Predetermination review is not necessary for emergency care that would be required on an immediate basis because any delay would cause physical discomfort, or aggravate the condition for which these services are required.

Dental for Retirees
A Retiree enrolled in the Dental Plan on the Effective Date of his/her retirement is allowed to continue coverage. Enrollment is not available to Retirees not enrolled in the Dental Plan after the Retiree's date of retirement. Once a Retiree terminates coverage, the Retiree is not permitted to re-enroll in the Plan.

Termination of Coverage
No benefits will be available for eligible charges incurred after a covered person's benefits end except for crowns, fixed bridges, dentures and root canals that were initiated when the member was covered and will be finished within 30 days after the covered person's coverage ends.

Emergency Dental Care
If emergency dental care is needed for pain relief or stabilization of a dental emergency and member use a participating dentist, the coinsurance amount will be based on the negotiated fee schedule. When emergency services are provided by a non-participating dentist, members will be responsible for the difference between the plan payment and the dentist's usual charge. Out of area emergency dental care may be reviewed by the plan's dental consultants to verify appropriateness of treatment.