BENEFIT OUTLINE

For

COUNTY OF ONONDAGA

ONONDAGA COUNTY DENTAL BENEFITS PLAN

Dental Claims Administration By

POMCO

EFFECTIVE: JANUARY 1, 2010

This benefit outline is not a Summary Plan Description and should not be used as a source to confirm or deny Plan coverage or benefits.

ONONDAGA COUNTY DENTAL BENEFITS PLAN
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EFFECTIVE JANUARY 1, 2010

This outline for the **ONONDAGA COUNTY DENTAL BENEFITS PLAN** has been prepared to provide a brief description of Plan features **in effect as of January 1, 2010.** This outline is not a Summary Plan Description and should not be used as a source to confirm or deny Plan coverage or benefits**.** For details of Plan provisions and exclusions, refer to the Plan SPD. Plan benefits **are available only for Covered Persons (eligible and enrolled Onondaga County Employees and their eligible and enrolled dependents and Participants under the Plan's COBRA Continuation of Coverage Provision).**

ONONDAGA COUNTY DENTAL BENEFITS PLAN

All benefits described in this schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Dentally Necessary and that charges are Usual and Reasonable. **The meanings of these capitalized terms are in the Defined Terms section of the Plan's Summary Plan Description document.**

Allowed Charge. The Usual and Reasonable Charges as determined by the Claims Administrator for covered dental services rendered and billed by a covered non-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. The Plan will not pay charges that exceed the Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Coordination of Benefits. When services and supplies are rendered and billed by a Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision, all benefits will still apply.

Deductible - This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits. **Family Unit Limit.** When the dollar amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Benefit Payment. Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

Maximum Benefit Amount. The Maximum dental benefit amount is shown in the Schedule of Benefits.

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The following shows the dental services covered by the Plan, and benefits available. The Plan provides benefits for the following grouping of dental services when covered according to Plan provisions and limitations.

DEDUCTIBLE	
Annual Deductible for all expenses except Diagnostic and Preventive Procedures	$50 Individual $150 Family
Annual Maximum Benefit per Person, per Calendar Year	$2,000

DIAGNOSTIC AND PREVENTIVE PROCEDURES Covered Charges are not subject to the deductible. The limits shown are for each Covered Person.		
Percentage Coinsurance	**Network**	**Out-of-Network**
	100% of Allowed Charges	80% of Allowed Charges
Covered Dental Services	**Limits**	
Routine oral examinations	Limited to 2 per Calendar Year.	
Prophylaxis (scaling and cleaning of teeth and gums)	Limited to 2 per Calendar Year.	
Full-mouth X-rays (complete series or Panoramic)	Limited to once every 3 years.	
Bitewing X-rays	Limited to 2 sets per Calendar Year.	
Other X-rays	As needed for dental treatment.	
Fluoride treatment (Covered Persons under age 19)	Limited to 2 per Calendar Year. Not a benefit for Covered Persons over age 19.	
Space maintainer (Covered Persons under age 14)	Limited to 1 appliance every 36 months for non-orthodontic treatment, when used in place of prematurely lost teeth.	
Sealants (Covered Persons under age 14)	Limited to once per tooth per 36 months on unfilled permanent first and second molars. Not a benefit for Covered Persons age 14 and older.	

BASIC DENTAL PROCEDURES Covered Charges are subject to the deductible. **Pretreatment Estimate is recommended for services over $300.**		
Percentage Coinsurance	**Network**	**Out-of-Network**
	100% of Allowed Charges	80% of Allowed Charges
Covered Dental Services	**Limits**	
Emergency exams or palliative care	Plan allowance includes local anesthetic, analgesic, and routine follow-up care. Sometimes, a service will be considered part of another procedure. Separate benefits will not be payable for inclusive procedures.	
Tests and laboratory examinations		
Basic restorations silver amalgam or composite resin fillings		
Endodontics		
Periodontics		
Oral surgery		
Repair crowns and dentures		
General anesthesia		

MAJOR DENTAL PROCEDURES Covered Charges are subject to the deductible. **Pretreatment Estimate is recommended for services over $300.**		
Percentage Coinsurance	**Network**	**Out-of-Network**
	80% of Allowed Charges	60% of Allowed Charges
Covered Dental Services	**Limits**	
Crowns	Plan allowance includes local anesthetic, analgesic, and routine follow-up care. Sometimes, a service will be considered part of another procedure. Separate benefits will not be payable for inclusive procedures.	
Inlays		
Onlays		
Dentures and bridgework		

TMJ REVERSIBLE PROCEDURES Covered Charges are subject to the deductible. **Pretreatment Estimate is recommended for services over $300.**		
Percentage Coinsurance	**Network**	**Out-of-Network**
	50% of Allowed Charges	50% of Allowed Charges
Covered Dental Services	**Limits**	
Reversible procedures for treatment of TMJ dysfunctions	Appliances only. Surgery or implants are not covered.	

COVERED DENTAL SERVICES

Preventive and Diagnostic Dental Procedures

The limits on these services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams and/or emergency exams. This includes the cleaning and scaling of teeth. Limit of two per Covered Person each Calendar Year.

(2) Two bitewing x-ray series every Calendar Year (maximum of four bitewings per Calendar Year).

(3) One full mouth x-ray (complete series or panoramic) every three years.

(4) Other dental x-rays, as needed.

(5) Fluoride treatments for covered dependent children under age 19, limited to two per Calendar Year.

(6) Space maintainers for covered dependent children under age 14 to replace primary teeth.

(7) Emergency palliative treatment for pain.

(8) Sealants on the occlusal surface of a permanent posterior tooth for dependent children under age 14, once per tooth in any 36 month period on unfilled permanent first and second molars.

Basic Dental Procedures

(1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(2) Periodontics (gum treatments).

(3) Endodontics (root canals).

(4) Extractions. This service includes local anesthesia and routine post-operative care.

(5) Recementing bridges, crowns, or inlays.

(6) Fillings, other than gold.

(7) General anesthetics with oral surgery of one or more simple extractions and/or with surgical extractions for patients under age 19; and with three or more simple extractions and/or surgical extractions for patients age 19 and older.

Major Dental Procedures

(1) Gold restorations, including inlays and onlays. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns.

(3) Installing precision attachments for removable dentures.

(4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during the six months following the installation.

(5) Addition of clasp or rest to existing partial removable dentures.

(6) Initial installation of fixed bridgework to replace one or more natural teeth.

(7) Repair of crowns, bridgework and removable dentures.

(8) Rebasing or relining of removable dentures.

(9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within six months from the date the temporary denture was installed.

TMJ Reversible Procedures

A TMJ Reversible Procedure is treatment that is conservative, but that does not involve tissues of the face, jaw, or joint and does not include surgery. Permanent changes in the structure or position of the jaw or teeth are not considered reversible procedures. Covered services include stabilization splints (an oral appliance or a bite guard). Irreversible treatments, such as surgery or implants, are not covered.

PRETREATMENT ESTIMATE

Before starting a dental treatment for which the charge is expected to be $300 or more, a pretreatment estimate may be submitted.

A regular dental claim form is used for the pretreatment estimate. The Covered Employee fills out the Employee section of the form and then gives the form to the Dentist. The Dentist must itemize all recommended services and costs and attach all supporting X-rays to the form. The Dentist should send the form to the Claims Administrator (POMCO, 2425 James Street, Syracuse, New York 13206).

The Claims Administrator will notify the Dentist of the benefits payable under the Plan, per the pretreatment estimate submitted. Pretreatment estimates will help to make informed decisions concerning dental costs and availability of Plan benefits.

The pretreatment estimate is not a guarantee of benefits. Plan benefits will be payable at the time of claim submission based on Plan limitations and exclusions in effect at the time services were Incurred.

ALTERNATE BENEFITS/STANDARD PROCEDURES

Coverage will be based on the most appropriate standard procedures needed to adequately correct or treat the dental condition. If the Dentist and/or the patient selects personalized restoration, prosthetics or to employ special techniques as opposed to standard procedures, the benefits provided will be limited to the allowance for the standard procedure as decided by the Claims Administrator. There may be occasions when differences of opinion regarding the dental care arise. In these situations, the Plan Administrator will rely on the findings of the Claims Administrator and/or their dental consultant.

SERVICES BY MORE THAN ONE PROVIDER

The covered services or supplies will be used to decide the Plan benefits, not the number of Providers doing the services. If dental care is transferred from one Dentist or Physician to another Provider during treatment, total Plan payment will not be more than the Plan would have been paid had one Provider given the covered service.

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CLAIMS ADMINISTRATORS

Dental Benefits
POMCO P.O. Box 6329 Syracuse, NY 13217 1-866-543-0277 Website: www.pomcogroup.com

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