SELECTHEALTH NETWORK

MEMBER PAYMENT SUMMARY	IN-NETWORK When using in-network providers, you are responsible to pay the amounts in this column.	OUT-OF-NETWORK When using out-of-network providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar year	
Maximum Annual Out-of-Network Payment - (per calendar year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar year		
Deductible	$5,000	$7,000
Out-of-Pocket Maximum	$7,000	$14,000
Family Coverage, 2 or more enrolled - per calendar year		
Deductible - per person/family	$5000/$10000	$7000/$14000
Out-of-Pocket Maximum - per person/family	$7000/$14000	$14000/$28000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per calendar year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$30	40% after deductible
Secondary Care Provider (SCP)[1]	$30	40% after deductible
Allergy Tests	See Office Visits Above	50% after deductible
Allergy Treatment and Serum	20%	50% after deductible
Major Surgery	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	50% after deductible
Secondary Care Provider (SCP)[1]	Covered 100%	50% after deductible
Adult and Pediatric Immunizations	Covered 100%	50% after deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after deductible
Diagnostic Tests: Minor	Covered 100%	50% after deductible
Other Preventive Services	Covered 100%	50% after deductible
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	50% after deductible
All Other Eye Exams	$30	40% after deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$100 then 20% after deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$100 then 20% after deductible	See In-Network Benefit
Urgent Care Facilities	$30	40% after deductible
Intermountain Connect Care®/Virtual Visits	Covered 100%	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100%	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$30 after deductible	40% after deductible

See other side for additional benefits

SELECTHEALTH NETWORK

MEMBER PAYMENT SUMMARY	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity[4]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[4] *One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.*	See Professional, Inpatient or Outpatient	50% after deductible
Infertility - *Select Services* *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	*50% after deductible	*50% after deductible
Donor Fees for Covered Organ Transplants	20% after deductible	50% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after deductible
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$30	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic	$30	*50% after deductible
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)* [4]	See Professional, Inpatient or Outpatient	50% after deductible

PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per calendar year	$750
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]	
Tier 1	$15
Tier 2	$30 after pharmacy deductible
Tier 3	$50 after pharmacy deductible
Tier 4	$100 after pharmacy deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90 ®)-selected drugs* [4]	
Tier 1	$15
Tier 2	$60 after pharmacy deductible
Tier 3	$150 after pharmacy deductible
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with out-of-network providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

* Not applied to Medical out-of-pocket maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc. ℠ *(domiciled in Utah).*

SELECTHEALTH NETWORK / HEALTHSAVE PRODUCT

MEMBER PAYMENT SUMMARY	IN-NETWORK When using in-network providers, you are responsible to pay the amounts in this column.	OUT-OF-NETWORK When using out-of-network providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar year	
Maximum Annual Out-of-Network Payment - (per calendar year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar year		
Deductible	$5,000	$6,500
Out-of-Pocket Maximum	$6,000	$9,000
Family Coverage, 2 or more enrolled - per calendar year		
Deductible	$10,000	$13,000
Out-of-Pocket Maximum - per person/family	$6000/$12000	$9000/$18000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per calendar year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$15 after deductible	40% after deductible
Secondary Care Provider (SCP)[1]	$25 after deductible	40% after deductible
Allergy Tests	See Office Visits Above	50% after deductible
Allergy Treatment and Serum	20% after deductible	50% after deductible
Major Surgery	20% after deductible	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	50% after deductible
Secondary Care Provider (SCP)[1]	Covered 100%	50% after deductible
Adult and Pediatric Immunizations	Covered 100%	50% after deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after deductible
Diagnostic Tests: Minor	Covered 100%	50% after deductible
Other Preventive Services	Covered 100%	50% after deductible
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	50% after deductible
All Other Eye Exams	$25 after deductible	40% after deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$75 after deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$75 after deductible	See In-Network Benefit
Urgent Care Facilities	$35 after deductible	40% after deductible
Intermountain Connect Care®/Virtual Visits	Covered 100% after deductible	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100% after deductible	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$25 after deductible	40% after deductible

See other side for additional benefits

SELECTHEALTH NETWORK / HEALTHSAVE PRODUCT

MEMBER PAYMENT SUMMARY	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity[4]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[4] *One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.*	See Professional, Inpatient or Outpatient	50% after deductible
Infertility - *Select Services* *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	50% after deductible	50% after deductible
Donor Fees for Covered Organ Transplants[4]	20% after deductible	50% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after deductible
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4] *(combined benefits)*		
Office Visits	$15 after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic	20% after deductible	40% after deductible
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	40% after deductible

PRESCRIPTION DRUGS	
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]	
Tier 1	$7 after in-network deductible
Tier 2	$21 after in-network deductible
Tier 3	$42 after in-network deductible
Tier 4	$100 after in-network deductible
Maintenance Drugs-*90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]	
Tier 1	$7 after in-network deductible
Tier 2	$42 after in-network deductible
Tier 3	$126 after in-network deductible
Preventive Prescription Drugs[3]-*Up to 30 Day Supply of Covered Medications*[4]	
Tier 1	$7
Tier 2	$21
Tier 3	$42
Tier 4	$100
Preventive Maintenance Drugs[3]-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]	
Tier 1	$7
Tier 2	$42
Tier 3	$126
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with out-of-network providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc. SM (domiciled in Utah).

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Twin Falls County
Group Number: 1299
Contract Effective Date: 10/01/2020

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	$50	$50	$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	$150	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,250	$1,000	$1,000
Maximum Benefit Rollover	$3,050*	$2,500*	$0
Services	**You pay the % below**		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	20%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	30%	30%
Major Services Crowns, implants, onlays, bridges, dentures Late enrollee waiting period is 12 months	50%	60%	60%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a PPO or Premier participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

* See back page for benefits and limitations

Delta Dental of Idaho
555 E Parkcenter Blvd
Boise, ID 83706

Customer Service
(208) 489-3580
(800) 356-7586

Benefits and Limitations

Class I Preventive and Diagnostic Services
Examinations once every 6 months.
Cleanings once every 6 months (restricts against periodontal maintenance within the same time period).
Fluoride two times in any 12 consecutive month period for dependent children under age 19.
Full mouth series or panoramic X-rays once every 5 years.
Bitewing X-rays once every 12 months.
Class II Basic Services
Periodontal maintenance is allowed 4 times in 12 months if patient has had previously treated periodontal disease.
Scaling and root planing covered once per quadrant every 24 months. Periodontal surgery is payable once per quadrant in any 3 year period.
Fillings restricted to same tooth/surface once every 24 months.
Class III Major Restorative Services
Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years.
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years.
Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $1,200 or the plan's annual maximum, whichever is less (Ages 19 and over).
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
   a. Full dentures or partial dentures: On the date the final impression is taken.
   b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
   c. Root canal therapy: On the date the root canal is initiated.

3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

Rollover Maximum

To be eligible for the rollover benefit, you must receive a preventive service (such as a dental cleaning or exam) within the calendar year. If ALL services are performed by a PPO dentist, the rollover amount is $300 when less than $600 of the maximum benefit is used each year, up to a $3050 maximum. If ANY service is performed by a Premier dentist, the rollover amount is $250 when less than $500 of the maximum benefit is used each year, up to a $2500 maximum. If ANY service is performed by a non-participating dentist, there is no rollover accrued.

The maximum rollover amount is available each calendar year with the annual maximum dollars used first. If paid dental claims exceed the annual maximum, the remaining amount will be deducted from the accrued rollover amount. The maximum rollover amount does not apply to any service with a lifetime maximum (such as orthodontia). There is no time limit for using the accrued maximum rollover amount as long as you have continuous coverage and your employer continues to offer a Rollover Max dental plan. You will lose your rollover balance if your employer drops their benefit plan coverage.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Services for cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of

Benefits (EOB).

16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.
17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.
22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your plan's benefits or would like to submit a predetermination before services are performed, please call Delta Dental of Idaho customer service advisors at (208) 489-3580 or toll-free at (800) 356-7586. You may also log onto our website, www.deltadentalid.com, for benefit and eligibility information or up-to-date claim status.

Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

Dental Blue Connect

Summary of Benefits Twin Falls County Effective Date: October 1, 2020	Dental Blue Connect Contracting Providers* Supported by Willamette Dental Group
Individual Deductible	No Deductible
Annual Maximum	No Annual Maximum
General Office Visit	You pay a $15 copayment per visit
Diagnostic and Preventive Services	
Routine and Emergency Exams	You pay nothing after applicable Office Visit copayment
All X-rays	
Teeth Cleaning	
Fluoride Treatment	
Sealants	
Head and Neck Cancer Screening	
Oral Hygiene Instruction	
Periodontal Charting	
Periodontal Evaluation	
Restorative Dentistry	
Filings	You pay nothing after applicable Office Visit copayment
Porcelain-Metal Crown	You pay a $200 copayment.
Prosthodontics	
Complete Upper or Lower Denture	You pay a $250 copayment
Bridge (per Tooth)	You pay a $200 copayment
Endodontics and Periodontics	
Root Canal Therapy — Anterior	You pay a $75 copayment
Root Canal Therapy — Bicuspid	You pay a $100 copayment
Root Canal Therapy — Molar	You pay a $150 copayment
Osseous Surgery (per Quadrant)	You pay a $150 copayment
Root Planing (per Quadrant)	You pay a $65 copayment
Oral Surgery	
Routine Extraction (Single Tooth)	You pay a $15 copayment
Surgical Extraction	You pay a $100 copayment
Orthodontic Services	
Pre-Orthodontic Service	You pay a $150 copayment
Comprehensive Orthodontic Service	You pay a $2,000 copayment
Miscellaneous	
Local Anesthesia	You pay nothing after applicable Office Visit copayment
Dental Lab Fees	
Nitrous Oxide	You pay a $40 copayment
Specialty Office Visit	You pay a $30 copayment
Emergency Office Visit	You pay a $15 copayment
Out of Area Emergency Care Reimbursement up to $100	

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Policy apply to this program.

Supported by Willamette Dental Group – 1.855.4DENTAL (1-855-433-6825)

ATTACHMENT C - Dental Implant Surgery

I. Benefits.

a. The Dental Implant services described in this Attachment C are covered for Members if all of the following requirements are met:

1) A Contracting Provider determines that Dental Implants are dentally appropriate for the Member.
2) A Contracting Provider prepares the treatment plan for Dental Implants prior to initiating any implant treatment.
3) All Dental Implant services are provided by a Contracting Provider or under a referral from a Contracting Dentist.
4) The Member follows the treatment plan prescribed by the Contracting Provider.
5) The Member makes payment of amounts due.
6) The Dental Implant service is listed as covered in this Dental Implant Section and is not otherwise limited or excluded.

b. **Services After Termination of Benefits.** If the Member's coverage ends before the completion of the Dental Implant services, the cost of any remaining treatment is the Member's responsibility.

c. **Dental Implant Surgery.** The Dental Implant services listed below are covered at 100% up to an annual Dental Implant benefit maximum of $1,500. The annual Dental Implant benefit maximum is the maximum dollar amount this Contract will pay for Dental Implant services in a calendar year.

CDT Code and Procedure Description
D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery

2. Limitations. The benefit for Dental Implants is subject to the following limitations:

a. Benefits for surgical placement of a Dental Implant are limited to 1 implant per calendar year.

b. Dental Implants to replace an existing bridge or existing denture are not covered, unless 5 years have elapsed since the placement of the bridge or delivery of the denture.

3. Exclusions. The following services are not covered under this benefit for Dental Implants:

a. Any Dental Implant services and related services that are not listed as covered on this Dental Implant Section.

b. Bone grafting.

c. Cone beam CT X-rays and tomographic surveys.

d. Dental Implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).

e. A Dental Implant surgically placed prior to the Effective Date of the Member's Contract, that has not received final restoration.

f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.

g. Maintenance, repair, replacement, or completion of an existing implant started or placed by a Non-Contracting Dentist without a referral from a Contracting Dentist.

h. Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the Effective Date of the Member's Contract.

i. Treatment of a primary or transitional dentition.

Exclusions and Limitations

In addition to the exclusions and limitations of this Contract, the exclusions and limitations listed below apply to the entire Contract, unless otherwise specified. No benefits are available under this Contract for the following:

General Exclusions

- Procedures that are not included in the List of Covered Dental Services and Copayments; or that are not Medically Necessary for the care of a Member's dental condition; or that do not have uniform professional endorsement.
- Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than sixty (60) days after termination of coverage.
- Charges for services that were started prior to the Member's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:
  - For full dentures or partial dentures: on the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
  - For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal Surgery: on the date the Surgery is actually performed.
  - For all other services: on the date the service is performed.
  - For orthodontic services, if benefits are available under this Contract: on the date any bands or other appliances are first inserted.
- Dental Implants, including attachment devices and their maintenance, except as indicated on Attachment C.
- Endodontic services, prosthetic services, and Dental Implants that were provided prior to Member's Effective Date. Such services or supplies are the responsibility of the Member.
- Endodontic therapy completed more than sixty (60) days after termination of coverage.
- Services that are Investigational in nature.
- Exams or consultations needed solely in connection with a service or supply not listed as covered in the attachments as part of this Contract.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or Dental Implants; and occlusal rehabilitation, including crowns, bridges, or Dental Implants used for the purpose of splinting, altering vertical dimension, restoring occlusion or correction attrition, abrasion, or erosion.
- General anesthesia, moderation sedation and deep sedation.
- Inpatient or Outpatient care or facility fees for dental procedures.
- Maxillofacial prosthetic services.
- Occlusal guards (nightguards).
- Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointments cancelled without twenty-four (24) hours prior notice.
- Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Contracting Provider.
- Services or supplies provided by any person other than a Provider.
- Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.
- Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Member is entitled to Benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Member claims such benefits or compensation or recovers losses from a third party.
- Services or supplies for treatment of injuries sustained while practicing for or competing in a professional paid athletic contest of any kind.
- Provided or paid for by any federal governmental entity or unit except when payment under this Contract is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Contract.

COUNTY OF TWIN FALLS

Eye Care Highlight Sheet

Vision Perfect® Plan Summary **Policy # 23400**

Deductibles	$0*
Maximum per benefit period	None
Annual Eye Exam	Up to $115
Lenses (per pair)	
Single Vision	Up to $60
Bifocal	Up to $80
Trifocal	Up to $95
Lenticular	Up to $100
Progressive	Up to $100
Contacts	
Elective/Medically Necessary	Up to $185
Frame Allowance	$135
Frequencies (months)	
Exam/Lens/Frame	12/12/24 Based on date of service***

**Deductible applies to the first service received*
****Please submit claims within 90 days of the date of service so that the plan can consider benefits (subject to State requirements).*

Monthly Rates

Employee Only (EE)	$11.32
EE + Family	$26.68

LASIK Advantage® Plan 1

LASIK Advantage provides coverage for LASIK and related procedures, including standard LASIK, Custom LASIK, LASIK with Wavefront Technology, CustomVue LASIK, LASIK with IntraLase technology and Photorefractive Keratectomy (PRK). Members earn a lifetime benefit per eye over time. The benefit amount increases over time, with the highest coverage provided at year three or four. Members earn benefits for each eye and may not combine benefits earned for each eye to pay for a covered procedure for a single eye. If a member enrolls after the initial enrollment period, they must wait 12 months from enrollment to be eligible for coverage; after 12 months the member will begin coverage at the year-one benefit. The LASIK Advantage benefit is available to members age 18 and older. Adult and child coverage is allowed - adult only and child only coverage are not. LASIK Advantage is only available with dental plans with preventive, basic and major coverage. There is no network tied to this coverage.

Lifetime Benefit Earned *(both eyes)*	Year One	Year Two	Year Three
	$350	$350	$700

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of **COUNTY OF TWIN FALLS.** At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com.

COUNTY OF TWIN FALLS

Eye Care Highlight Sheet

Ameritas

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Basic Life and AD&D Insurance

For Twin Falls County

How the Plan Works

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- **Eligibility Requirement**
  If you are a full-time active employee working a minimum of 40 hours per week on a regular basis, you will be covered with these benefits.
- **Who pays for the coverage?**
  Life and AD&D Insurance premiums are paid for by your employer.
- **Dependent Eligibility Requirement**
  Dependents must be a Legal Spouse and or Dependent Child(ren) up to age 26 of the covered employee to be eligible for coverage.
- **Guarantee Issue**
  With no questions asked, you will be covered for up to $50,000 in Basic Life and AD&D Insurance.

Benefits Summary

Plan Benefits	
Employee Life Insurance	1 time your annual earnings, rounded to the next higher $1,000, to a maximum of $50,000.
Employee AD&D Insurance	1 time your annual earnings, rounded to the next higher $1,000, to a maximum of $50,000.
Dependent Life Insurance	Spouse $5,000 Child(ren): $5,000
Guarantee Issue Amount	
Employee	$50,000
Spouse	$5,000
Dependent Child(ren)	$5,000
Plan Features	
Accelerated Benefit	A covered employee who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Portability	You may elect to port your Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium	Life coverage continued without payment of premium if insured becomes totally disabled (proof of disability required). Coverage may be continued up to age 65.

Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 50% at age 70, to 30% at age 75, and to 20% at age 80.

Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

AD&D Benefits Included

- Adaptive Home/Vehicle Benefit
- Rehab Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault

LifeMapCo.com

1 (800) 794-5390

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.

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Additional Benefits

- **Travel Assistance**
  When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.

- **Repatriation**
  If death occurs more than 100 miles from your primary residence, a benefit may be payable to prepare and ship your body to the place of burial or cremation.

- **Seat Belt**
  If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of $10,000 in addition to the Basic Life and Basic AD&D benefits described above.

Limitations & Exclusions

- **Life:** No restrictions or exclusions regarding time, place or circumstances of death.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
  - suicide or such attempts;
  - participation in a riot;
  - war or act of war;
  - military service for any country;
  - committing or attempting to commit an assault or felony;
  - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
  - heart attack or stroke;
  - bodily infirmity or disease from bacterial or viral infections not the result of an injury; or
  - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician.
  - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
  - the insured Employee's intoxication

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