DENTAL CARE BENEFIT SCHEDULE

DENTAL CARE BENEFIT	
DENTAL CARE DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$50
Calendar Year Deductible applies to these classes of services: Class B Services - Basic and Class C Services – Major	
MAXIMUM BENEFIT AMOUNT	**BENEFIT**
For Class A - Preventive, Class B - Basic and Class C - Major Services Per Covered Person per Calendar Year	$1,500 Unlimited to children under the age of 14.
COVERED CHARGES	
Dental Percentage Payable Class A Services - Preventive Class B Services - Basic Class C Services – Major	 100% 80% 50%

Additional information on Dental Care can be found in the Dental Benefits section of this document.

DENTAL BENEFITS

If a Covered Person incurs expenses for dental care that are Medically Necessary and recommended by a Physician or Dentist, the Plan will pay the Usual and Reasonable Charge amount shown in the Schedule of Benefits.

DEDUCTIBLE

Deductible Amount. 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.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. 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.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A 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. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each calendar year.

(2) One bitewing x-ray series 2 per calendar year.

(3) One full mouth x-ray or panoramic films every 24 months.

(4) Extraoral superior or inferior maxillary film.

(5) One fluoride treatment for covered Dependent children under age 18 each Calendar Year.

(6) Space maintainers for covered Dependent children under age 18 to replace primary teeth.

(7) Emergency palliative treatment for pain and other non-routine, unscheduled visits.

(8) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 18.

(9) Fixed and Removable Appliances to inhibit thumb sucking and other harmful habits (includes night guards) - allowance includes all adjustments in the first 6 months after installation.

(10) Space Maintainers –allowance includes all adjustments in the first 6 months after installation.

- Fixed, unilateral, band or stainless steel crown type
- Fixed, unilateral, cast type
- Removable, bilateral type

Class B Services:
Basic Dental Procedures

(1) Office Visits and Examination – Diagnostic consultation, providing it is:

a. With a dentist other than the one providing treatment, and
b. Not with a dentist specializing in prosthodontics or orthodontics.

(Limited to 1 consultation for each dental specialty per Calendar Year.)

(2) Diagnostic Services – Allowance includes examination and diagnosis including:
Diagnostic casts and
Biopsy and examination of oral tissue

(3) Oral surgery. Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

Extractions
Uncomplicated extraction, 1 or more teeth
Surgical removal of erupted teeth, involved tissue flap and bone removal
Surgical removal of impacted teeth
Excision of pericoronal gingiva, per tooth
Removal of palatal torus
Removal of cyst or tumor
Incision and drainage of abscess
Closure of oral fistula or maxillary sinus
Reimplantation of tooth
Frenectomy
Suture of soft tissue injury
Sialolithotomy for removal of salivary calculus
Closure of salivary fistula
Dilation of salivary duct
Sequestrectomy for osteomyelitis or bone abscess, superficial
Maxillary sinusotomy for removal of tooth fragment or foreign body

(4) Periodontics (gum treatments). Allowance includes the treatment plan, local anesthetics and post-surgical care.

Gingivectomy or gingivoplasty, per quadrant
Gingivectomy, per tooth (fewer than 6 teeth)
Sub-gingival curettage and root planing, per quadrant
(limited to a maximum of 4 quadrants in any 12 consecutive month period)
Pedicle or free soft tissue grafts, including donor sites
Osseous surgery, including flap entry and closure, per quadrant
Osseous grafts, including flap entry, closure and donor sites
Muco-gingival surgery
Occlusal adjustment not involving restorations and done in conjunction with periodonticsurgery, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period)

(5) Endodontics (root canals). Allowance includes routine x-rays and cultures, but excludes final restoration.

- Pulp capping, direct
- Remineralization (Calcium Hydroxide), as a separate procedure
- Vital pulpotomy
- Apexification
- Root canal therapy of non-vital (nerve-dead) teeth
- Traditional therapy
- Medicated paste therapy, N2 Sargenti
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures

(6) Oral Surgery – Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

Extractions

- Uncomplicated extraction, 1 or more teeth
- Surgical removal of erupted teeth, involved tissue flap and bone removal
- Surgical removal of impacted teeth
- Excision of pericoronal gingiva, per tooth
- Removal of palatal torus
- Removal of cyst or tumor
- Incision and drainage of abscess
- Closure of oral fistula or maxillary sinus
- Reimplantation of tooth
- Frenectomy
- Suture of soft tissue injury
- Sialolithotomy for removal of salivary calculus
- Closure of salivary fistula
- Dilation of salivary duct
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Maxillary sinusotomy for removal of tooth fragment or foreign body

If any of the above-listed procedures are covered under the medical plan, they are not eligible under the dental plan.

(7) Fillings, other than gold. Multiple restorations on 1 surface will be considered 1 restoration.

Amalgam restorations

Synthetic restorations

- Silicate cement
- Acrylic or plastic
- Composite resin

Pins

- Pin retention, exclusive of restorative material

Recementation

- Inlay or onlay
- Crown
- Bridge

(8) General anesthetics, upon demonstration of Medical Necessity.

(9) Antibiotic drugs.

Major Dental Procedures
(Subject to Deductible)

(1) **Restorative**

Gold Foil Restorations
- gold foil - 1 surface
- gold foil - 2 surfaces
- gold foil - 3 surfaces

Gold Inlay Restorations
- inlay - gold, 2 surfaces
- inlay - gold, 3 surfaces
- onlay - per tooth (in addition to above)

Porcelain Restorations
- inlay – porcelain

Crowns - Single Restorations Only
- plastic (acrylic)
- plastic (prefabricated)
- plastic with gold
- plastic with nonprecious metal
- porcelain
- porcelain with gold
- porcelain with nonprecious metal
- gold (full cast)
- nonprecious metal (full cast)
- gold (3/4 cast)
- stainless steel
- cast post and core in addition to crown

(3) Other Restorative Services

Crown buildups – pin retained

(4) Complete Dentures – Including 6 months post-delivery care
- Complete upper
- Complete lower
- Immediate upper
- Immediate lower

(5) Partial Dentures – Including 6 months post-delivery care
- Upper - without clasps, acrylic base
- Lower - without clasps, acrylic base
- Upper - with 2 gold clasps with rests, acrylic base
- Lower - with 2 gold clasps with rests, acrylic base
- Lower - with gold lingual bar and 2 clasps, acrylic base
- Lower - with gold lingual bar and 2 clasps, cast base
- Upper - with gold palatal bar and 2 gold clasps, cast base
- Removable unilateral partial denture 1 piece gold casting, clasp attachments, per unit including pontics
- Full cast partial - with 2 gold clasps (upper)
- Full cast partial - with 2 gold clasps (lower)

(6) Additional Units for Partial Dentures

Each additional clasp with rest

Each tooth (applies only to full cast partial)

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

(8) Prosthodontics, Fixed

(9) Fixed Bridges (Each abutment and each pontic constitutes a unit in a bridge)

(10) Bridge Pontic
Cast gold
Cast nonprecious
Slotted facing
Slotted pontic
Porcelain fused to gold
Porcelain fused to nonprecious metal
Plastic processed to gold
Plastic processed to nonprecious metal

(11) Crowns
Plastic (acrylic)
Plastic processed to gold
Plastic processed to nonprecious metal
Porcelain
Porcelain fused to gold
Porcelain fused to nonprecious metal
Gold (3/4 cast)
Gold (full cast)
Nonprecious metal (full cast)

(12) Other Prosthetic Services
Dowel pin, metal
Implants

(13) 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:

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

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(7) **No listing.** Services which are not included in the list of covered dental services.

(8) **Orthodontia.** Orthodontic treatment and orthognathic surgery.

(9) **Personalization.** Personalization of dentures.

(10) **Replacement.** Replacement of lost or stolen appliances.

(11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.