

## VIII. DENTAL BENEFITS

### A. DENTAL BENEFITS PAYABLE

**Individual Calendar Year Deductible:**                      **\$50**

Before Plan benefits are paid for many dental expenses, **you** must pay a **deductible**, which is the first \$50 of eligible charges **incurred** each calendar year. The **deductible** does not apply to preventive services.

**Maximum Family Calendar Year Deductible:**            **\$150**

The calendar year **deductible** will be limited to \$150 for members of any one family. The family calendar year **deductible** amount can be accumulated through charges **incurred** by any combination of family members.

### **Benefit Percentages**

The Plan will pay the following percentages of **usual, customary and reasonable fee** for covered services:

<i>Preventive Services</i>	100%
<i>Basic Services</i>	80%*
<i>Major Services</i>	50%*
<i>Orthodontic Services</i>	50%*

\*After satisfaction of the **deductible**

### **Maximum Benefits**

Calendar Year Maximum                      \$1,200 per individual

Dental benefits for preventive, basic and major dental care combined are limited to \$1,200 payable per covered individual in a calendar year.

Orthodontic **Lifetime** Maximum    \$1,500 per individual

The **lifetime** maximum payable for orthodontic expenses is \$1,500 per covered individual. Payments for orthodontic expenses are not included in calculating the calendar year maximum benefit.

### B. PREDETERMINATION OF BENEFITS

If the proposed dental treatment plan will cost over \$200, **you** or your **dentist** may contact the **claim administrator** to voluntarily predetermine the necessity of services and the allowable amount. This will enable **you** to estimate in

advance, the amount that will be paid by the Plan and the amount for which **you** may be responsible. When the post-service claim is received by the **claim administrator**, benefits will be determined without giving deference to the predetermination.

### C. COVERED EXPENSES

The following are covered expenses under this Plan. Benefits for these covered expenses are payable at the applicable **benefit percentage** and are subject to the **deductibles** and maximums shown above.

#### 1. Preventive Services

- Preventive cleaning and scaling of teeth (above the gum line), but not more than twice in any calendar year;
- Fluoride application for individuals under age 19, but not more than twice in any calendar year;
- Space maintainers and their fitting for **children** age 13 and under;
- Diagnostic services to determine necessary care limited to:
  - Full mouth x-rays, not more than once in any three calendar year period, or more frequently if required in connection with the diagnosis of specific conditions;
  - Bitewing x-rays, but not more than twice in any calendar year;
  - Diagnostic oral examinations, but not more than twice in any calendar year;
  - X-rays and exams for **emergency** office visits, provided that charges for other dental services are not **incurred** during the same visit.

#### 2. Basic Services

- Extracting one or more teeth, cutting procedures in the mouth, treating fractures and dislocations of the jaw;
- Treating gums and the supporting structure of the teeth;
- Periodontal scaling of teeth (below the gum line);
- Root canals and other endodontic treatment;

- General anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations;
- Antibiotics injected by a **dentist** or **physician** in conjunction with treatment of a covered dental expense;
- Fillings other than gold fillings (for gold fillings, see Major Services);
- Repairing existing dentures and fixed bridges (replacing such dentures and fixed bridges is described under Major Services);
- Adding teeth to an existing denture or fixed bridge, if required by the loss of natural teeth;
- Tooth sealants for **children** age 6 through 13. Coverage will be provided for the treatment of each permanent molar no more often than once every three calendar years.

### 3. Major Services

- One full or partial denture or fixed bridge. Replacing an existing device is covered if two conditions are met:
  - The existing device cannot be made serviceable; and
  - The device is more than five years old;.
- Implants as an alternative to a bridge or other covered service. Benefits for implants will be limited to the amount payable under the Plan for the other service;
- Gold fillings and crowns necessary to restore the structure of teeth broken down by decay, **injury**, or severe attrition;
- Replacing a crown or gold filling (if the covered individual is charged for both temporary and permanent crowns or dentures, only the permanent charge is covered).

### 4. Orthodontic Services

- Orthodontic care includes treatment necessary for the proper alignment of teeth.
- Orthodontic coverage is provided only to individuals who are under age 19 at the time services are rendered.

#### **D. DENTAL EXCLUSIONS AND LIMITATIONS**

Benefits are not payable for or in connection with:

- a. Services or supplies partially or wholly **cosmetic** in nature;
- b. Facings on pontics or crowns behind the second bicuspid. The cost to improve the **cosmetic** appearance for rear teeth is not covered;
- c. Services or supplies furnished or reimbursed by any government or government program or law, unless payment is legally required;
- d. Injuries arising out of or in the course of any occupation for wage or profit, or an **illness** for which **you** or **your dependent** is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law;
- e. Specialized or personalized services;
- f. Services or supplies not furnished by a **dentist** except x-rays ordered by a **dentist** and services of a Licensed Dental Hygienist under the **dentist's** supervision;
- g. Training in, or supplies used for, dietary counseling, oral hygiene or plaque control;
- h. Procedures, restoration and appliances to increase vertical dimension or restore occlusion, including treatment of Temporomandibular Joint dysfunction (TMJ);
- i. Services or supplies due to war or act of war, declared or undeclared;
- j. Services for which the covered individual would not be required to pay if there were no insurance;
- k. Charges for removing stitches and post-operative examinations that have been included in the initial charge for a procedure listed in the Covered Expenses section;
- l. Charges for adjusting dentures or bridges within six months of installation;
- m. Failure to keep a scheduled visit with the **dentist**;
- n. Services or supplies which do not meet accepted standards of dental practice, including those which are **experimental** in nature;

- o. Orthodontic services for covered individuals other than **dependent children**;
- p. Completion of insurance forms;
- q. Expenses that are **incurred** while **you** are not covered under this Plan. For this purpose, an expense is **incurred** at the time of the service or supply.