

APPENDIX A: HOW THE PLAN COVERS ELIGIBLE EXPENSES

Following is a comparison schedule of benefits (**in-network**, **out-of-network** and out-of-area) under the Dental Plan. For a complete description of terms described in this section, see “Appendix C.”

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
<u>Diagnostic and Preventative Services</u>		
<u>Type A Services</u>		
Twice in a calendar year:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> • Routine Periodic Oral Examination • Regular cleaning of teeth when performed by a dentist or dental hygienist 		
In a calendar year:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> • One fluoride treatment, when performed by a dentist or dental hygienist: 		
As specified:	100% of PPO fee	90% of reasonable and customary charges
<ul style="list-style-type: none"> • Space maintainers for Dependents and Employees under the age of 23. <ul style="list-style-type: none"> ⇒ Installation of fixed or removable appliances to maintain existing space by preventing movement of adjacent or opposing teeth (but only as a replacement of prematurely lost or extracted teeth) • Dental X-rays and radiographs: <ul style="list-style-type: none"> ⇒ Full-mouth or panoramic X-rays (not more than once in three rolling years**) ⇒ Vertical bitewings (not more than one set in three rolling years**) ⇒ Supplementary bitewing X-rays, 1-4 films, one set (not more than twice in a calendar year) ⇒ Diagnostic dental X-rays required for a specific condition, except X-rays in conjunction with orthodontics • Diagnostic Testing <ul style="list-style-type: none"> ⇒ Bacteriologic studies for determination of Pathological Agents ⇒ Caries Susceptibility Testing ⇒ Pulp Vitality Tests ⇒ Study Models – Diagnostic Casts • Sealants for dependent children 13 years old and younger (once per permanent molar every 3 rolling years) • Emergency Palliative Treatment 		

X-rays within three years of the last treatment will be **covered if the expense is incurred within the last 30 days of such three-year period.

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
<u>Basic Restorative Services</u>		
<u>Type B Services</u>		
Restorations:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Fillings <ul style="list-style-type: none"> ⇒ Amalgam 1-3 surfaces ⇒ Composite Resin – 1-4 anterior surfaces ⇒ Filling (sedative) • Stainless Steel Crown – Child • Resin Crown • Pin Retention 		
Root Canal Therapy:	80% of PPO fee	70% of reasonable and customary charges
<i>Procedures used to prevent and treat diseases of the dental pulp</i>		
<ul style="list-style-type: none"> • 1-3 canals (traditional) • Pulp cap – direct/indirect • Pulp Treatment: 		
Periodontics:	80% of PPO fee	70% of reasonable and customary charges
<i>Surgical and nonsurgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>		
<ul style="list-style-type: none"> • Periodontic Maintenance after surgery therapy (2 per calendar year) • Gingivectomy (1 per quad/tooth every 3 rolling years) • Gingival Flap • Surgical Tooth Revision • Scaling and Root Planing (4 separate quads per 2 rolling years) 		
Oral Surgery:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Simple Extractions • Surgical removal of residual roots (cutting procedure) • Biopsy Of Oral Tissue • Transseptal Fiberotomy • Alveoplasty • Remove Odontogenic Tumor • I&D Of Abscess • Frenulectomy 		
Other Type B Services:	80% of PPO fee	70% of reasonable and customary charges
<ul style="list-style-type: none"> • Therapeutic Drug Injection • Desensitizing Medication/Resin • Adjust Occlusion • Oral Pathology 		

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
Major Restorative Services		
<u>Type C Services</u>		
Inlays, onlays and crowns:	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Onlays to restore tooth structure • Crowns to restore tooth structure <ul style="list-style-type: none"> ⇒ Resin crown with noble metal ⇒ Porcelain crown ⇒ Porcelain with semiprecious metal crown ⇒ Gold or full cast crown ⇒ Crown Build-up ⇒ Labial Veneer ⇒ Crown Repair 		
Periodontics:		
<i>Surgical procedures to treat the supporting area around the teeth, except periodontal splinting</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Osseous surgery – including flap entry and closure (1-3 teeth, per quadrant) (1 per quad every 3 rolling years) 		
Prostodontics:		
<i>To replace teeth (except wisdom teeth) extracted while covered by the Plan.</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Complete dentures (including six months post-delivery care): <ul style="list-style-type: none"> ⇒ Complete upper ⇒ Complete lower ⇒ Immediate upper ⇒ Immediate lower • Partial dentures (including six months post-delivery care): <ul style="list-style-type: none"> ⇒ Lower with metal frame, resin base (including clasps, rests, teeth) ⇒ Upper with metal frame, resin base (including clasps, rests, teeth) ⇒ Full cast partial with two chrome clasps (upper) • Bridge Pontics: <ul style="list-style-type: none"> ⇒ Cast gold ⇒ Porcelain fused to semiprecious metal ⇒ Resin with noble metal 		
<i>Prostodontic services include:</i>		
Initial installation of fixed bridgework, including inlays and crowns to form abutments.		
Initial installation of partial or full removable dentures, including adjustments during the six-month period after they are installed.		
The addition of teeth to an existing partial removable denture or to bridgework.		
Installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture.		
Replacement of an existing partial denture, full removable denture or fixed bridgework, provided the existing denture or bridge is at least five years old and cannot be made serviceable. (The five-year limitation is waived if additional extractions require the replacement.)		
Repairing or re-cementing inlays, crowns, bridgework, or dentures, or relining of dentures.		

	Amount Plan Pays	
	<u>In-Network or Out-of-Area*</u>	<u>Out-of-Network</u>
Oral Surgery:	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Surgical extractions: • Single teeth, surgical extractions (includes partial or complete bony impaction) • Anesthesia 		
Other Services	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Occlusal guard for bruxism (1 per 3 rolling years) 		
Orthodontics:		
<i>To prevent and correct malocclusion of teeth and associated facial problems</i>	50% of PPO fee	50% of reasonable and customary charges
<ul style="list-style-type: none"> • Appliances for tooth guidance or to control harmful habits, fixed or removable • Comprehensive full-banded treatment, preliminary study including X-rays and treatment plan • Active treatment, including appliances 		
*If you are Out-of-Area, benefits are paid as a percentage of reasonable and customary charges .		

Note: Dental treatment that spans two Plan Years (for example: dentures, bridgework, crown or root canal therapy) will be paid according to the **reasonable and customary** rates in effect when a service is provided. For Dental Plan purposes, a service is considered to be “provided” when treatment begins (when a tooth is prepared or a canal opened).