

**APPENDIX D**

**ACTIVE EMPLOYEE DENTAL PLAN**

1. **Calendar Year** – January 1 through December 1
2. **Eligibility Period** – First day of the month following completion of 1 month of continuous employment
3. **Eligible Persons** – Full-time employees, their spouses, and qualified dependent children. Children will be covered from birth and may remain covered until their 26 birthday.
4. **Selected Benefits & Percentage Paid by Dental Administrator:**

Coverage A	Diagnostic & Preventive	100%
Coverage B	Restorative	80%
Coverage C	Prosthodontics	50%
Coverage D	Orthodontics	50%
5. **Maximum Calendar Year Benefit** – The maximum amount which the plan will pay is \$1200 per person per Calendar Year (Coverages A, B and C). Coverage D (Orthodontics) has a separate lifetime Maximum of \$1200 for each eligible adult and dependent child.
6. **Deductible** – There is a \$25 deductible per person per Calendar Year, applied to Coverage C services only. Any expense incurred during the last 3 months of a calendar year which is applied against an individual's deductible will also reduce his/her deductible for the next year.
7. **Contribution** – There will be no contribution on the part of the employee for employee (and qualified dependent) coverage.

**COVERAGE A BENEFITS**

**Diagnostic:**

Evaluations to determine required dental treatment

Limited oral evaluation

Comprehensive oral evaluation – one complete comprehensive evaluation per specialist or general Dentist in a lifetime

Periodic Evaluation – once in any period of six (6) consecutive months. This can be by a specialist or a general dentist.

Radiographs (x-rays) – complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) once in any period of six (6) consecutive months; films (x-rays) of individual teeth as necessary

**Preventive:**

Specific procedures employed to prevent the occurrence of dental disease

Prophylaxis (cleaning) – two (2) per calendar year (child prophylaxis up to thirteenth (13) birthday; adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance procedures (Coverage B).

Fluoride treatment – once in a calendar year up to eighteenth (18) birthday

Space maintainers

Sealants

**COVERAGE C BENEFITS**

**Restorative Crowns and Onlays:**

Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations

**Prosthodontics:**

Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures; core buildups; cast and prefabricated post and cores; and precision attachments.

**Implant Supported Prosthetics**

**COVERAGE D BENEFITS**

**Orthodontics:**

Necessary treatment and procedures required for the correction of malposed teeth

Limited to 41,200 lifetime maximum for eligible adults and dependent children.

**GENERAL EXCLUSIONS AND LIMITATIONS**

The dental benefits provided by the dental benefit administrator shall not include the following:

- a. Services for injuries or conditions compensable under Worker's compensation or Employer's liability laws.
- b. Services that are determined by the dental benefit administrator to be rendered for cosmetic reasons, or to correct congenital malformations, or cosmetic surgery. (This exclusions is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)
- c. Services including, but not limited to, endodontics and prosthodontics (including crowns and removable fixed dentures), started prior to the date the Subscriber or Dependent became eligible under the Agreement.
- d. Prescripton drugs, premedications, and/or relative analgesia.
- e. Charges for hospitalization, general anesthesia for restorative dentistry (except as noted in Section III. Coverage B Benefits).