Dental Plan

Dental Benefits are available only to those Participants and their eligible dependents where the Participant Group has opted for this coverage and completed an enrollment form requesting coverage and the premium has been paid. **Note:** Employee enrollment is required to enroll any dependents in the Dental Plan. All general plan provisions apply to this Plan.

> **IMPORTANT NOTE:** If a Participant elects dental coverage, but drops it at the end of the year, there is a two (2) year waiting period before the coverage can be reinstated. Participants may not drop dental coverage mid-year unless they are also dropping medical coverage.

For July renewals the Benefit Period begins on July 1 and ends on June 30 of each year. For September renewals, the Benefit Period begins on September 1 and ends on August 31 of each year.

How the Dental Plan Works

MUST Plan Participants who have dental coverage can elect to see any licensed dentist of their choice. There is no dental network associated with dental coverage.

The allowed amount for Type B and C dental services is based on the 90% dental usual, customary, and reasonable (UCR) fee criteria as it relates to that of other dentists in a given geographical area and is subject to the annual deductible, payment provisions and annual maximums listed in the plan. If a dentist's charge exceeds the amount paid by the Plan, the dentist can balance bill you for the difference.

Annual Deductible, Payment Provisions and Annual Maximum

This Plan has an individual deductible of $25 on Type C dental services. However, the deductible need not be satisfied prior to the Plan paying its portion for Type A and Type B dental services. This Plan has an annual dental benefit maximum of $1,250 per individual.

Orthodontia benefits have a separate, one-time deductible of $50 that must be met prior to the Plan paying its portion. There is a $1,000 benefit maximum for orthodontia services (for Dependents under age 19).

Benefits are payable under the Plan up to the maximums stated in the Dental Benefit Summary for those Participants who have enrolled in the Dental Benefit Plan.

Dental Benefit Summary

Service	Applies to Deductible	Plan Pays
Type A - Preventive and Diagnostic Dental Services		
Emergency Treatment (palliative care to relieve dental pain)	N/A	100%
Fluoride - topical application/fluoride varnish Topical application of fluoride limited to once per Benefit Period. Fluoride varnish allowed up to 12 applications per benefit period age 12 and under and at risk for dental infections.	N/A	100%
Oral evaluation of mouth, teeth and gums 2 per Benefit Period	N/A	100%
Prophylaxis (cleanings) 2 per Benefit Period	N/A	100%
Sealants 1 sealant per permanent tooth per lifetime; under age 19	N/A	100%
Space maintainers for premature loss of primary teeth only	N/A	100%

X-Rays	N/A	100%

Service	Applies to Deductible	Plan Pays
• **Bitewings** (adult/child) 2 per Benefit Period	N/A	100%
• **Full mouth set OR one Panorex** 1 set/film per three Benefit Periods	N/A	100%
• **All other x-rays** (periapical, intraoral, occlusals, etc. as needed.	N/A	100%
Type B - Basic Dental Services		
Anesthesia (e.g. Novocaine) If dental procedure requires general anesthesia within hospital setting coverage is provided under the medical plan, see *Anesthesia* under *Medical Benefits*.	N/A	80%
Consultations	N/A	80%
Endodontics (root canals) Root canal therapy on the same tooth is limited to once in a 3-year period.	N/A	80%
Extractions (simple or surgical)	N/A	80%
Fillings/restorations Composite resin or amalgam (not gold)	N/A	80%
Injection of antibiotic drugs	N/A	80%
Oral surgery	N/A	80%
Periodontics Periodontal scaling and root planing and/or curretage is limited to 1 procedure per quadrant in any 24-month period.	N/A	80%
Prophylaxis for periodontal treatment	N/A	80%
Recementing (of bridges, crowns, inlays, onlays)	N/A	80%
Other Type B Services	N/A	80%
Type C - Major Dental Services		
Bridges (installation and repair)	✓	50%
Crowns (installation and repair)	✓	50%
Dentures (installation and repair)	✓	50%
Implants	✓	50%
Inlays/Onlays	✓	50%
Occlusal guard (adult/child)	✓	50%
Other Type C Services	✓	50%
Orthodontia - $1,000 lifetime maximum $50 orthodontia deductible/benefit period **For children under age 19**	✓	50%

Dental Benefits

Dental Expenses

Dental expenses mean the charges for the dental services and supplies listed below which are provided by your dental professional and are in accordance with generally accepted standards of dental practice.

Type A - Preventive and Diagnostic Dental Services

Preventive and diagnostic dental expenses mean charges for the following services and supplies:

- Emergency care to relieve dental pain
- Topical application of fluoride limited to once per Benefit Period. Fluoride varnish allowed up to 12 applications per benefit period age 12 and under and at risk for dental infections
- Oral evaluations of the mouth and teeth, up to twice per Benefit Period
- Prophylaxis (cleanings) up to twice per Benefit Period
- Sealants for Dependent children under age 19, limited to one sealant per permanent tooth per lifetime
- Space maintainers designed to preserve the space between the teeth caused by premature loss of a primary tooth
- The following dental x-rays required in connection with the diagnosis of a specific condition requiring treatment:
  - Bitewing x-rays: two sets per Benefit Period
  - Full mouth x-rays or one Panorex x-ray: one set/film once every three Benefit Periods
  - Other x-rays: as needed

Type B - Basic Dental Services

Basic dental expenses mean charges for the following services and supplies:

- General anesthesia or conscious intravenous “IV” sedation when Medically Necessary and administered in connection with oral surgery or other covered dental benefits. If dental procedure requires general anesthesia within hospital setting coverage is provided under the medical plan, see *Anesthesia* in Medical Benefits.
- Endodontic treatment, including pulpotomy, pulp capping, apicoectomy, retrograde filling and root canal therapy. Root canal therapy on the same tooth is limited to once in a 3-year period.
- Extractions, simple or surgical extractions of one or more teeth are covered. This includes extractions for Dependents under age 19 related to orthodontia.
- Fillings (restorations) include the use of materials such as amalgam or composite resin (not gold) to restore teeth broken down by decay or injury. Benefits may be paid for restorations placed on the same surface once each 18 months. The maximum fee payable for restoration of primary teeth is the charge for a stainless steel crown. Veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten upper and lower anterior teeth are considered optional and not dentally necessary. Eligible expenses will include only the charge for a corresponding amalgam restoration.
- Injection of antibiotic drugs.
- Oral surgery, for surgical treatment or procedures needed in and about the mouth and jaw, such as surgical extractions and certain other minor surgical procedures.
- Periodontal treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structure, full mouth debridement, periodontal maintenance, root planing, scaling and/or prophylaxis allowed. Periodontal scaling and root planing and/or curretage is limited to one procedure per quadrant in any 24-month period.
- Other Type B services such as antibiotic injections administered by treating dentist.

Type C - Major Dental Services

Major Dental expenses mean charges for the following services and supplies:

- Bridges, the installation (and repair) of one or more artificial teeth attached by crowns to adjacent teeth (used to maintain space and function for missing teeth). If an existing appliance can be made serviceable, only the charges for improving the appliance will be eligible (not replacement costs).
- Crown installations (and repair and replacement) are covered only when teeth cannot be restored with other materials. Replacement of crowns is covered only if 5 years have elapsed since last prior crown was furnished on any tooth.
- Denture installations (full and partial) are covered. Relining dentures are covered only once in a 3 year period. If an existing appliance can be made serviceable, only the charges for improving the appliance will be eligible (not replacement costs).
- Implants, which are artificial tooth roots used to support restorations that resemble a tooth or a group or teeth, are covered.
- Inlays/Onlays, the installation, repair or replacement of, are covered (gold/porcelain). Must be at least 5 years since restoration was initially placed or last replaced, unless replacement is due to extraction of one or more teeth.
- Occlusal guards for adult and/or children are covered.

Orthodontia Benefit

This benefit is available only for Dependent children under 19 years of age.

The following expenses will be considered “Orthodontic” for reimbursement purposes and will be payable as stated in the Benefit Summary and subject to the separate deductible and lifetime maximum noted in *Annual Deductible, Payment of Benefits and Annual Maximum:*

- Treatment for diagnosed malocclusion (excluding treatment for myofacial pain and temporomandibular joint dysfunction)
- Cephalometric x-ray, not more than one in any two Benefit Periods
- One set of study models per covered Participant
- Initial placement of braces or appliances and ongoing treatment adjustment, removal and follow-up related to initial placement

If orthodontic treatment is started before the effective date of coverage for dental benefits, the benefit will only pay for services and supplies actually received while a covered Participant. If orthodontic treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received while a covered Participant.

If the Plan or Participant Group changes service providers (such as the third party administrator), the covered Participant’s $1,000 lifetime maximum benefit for Orthodontia will not start over, and will be adjusted for the benefit used through the prior service providers.

Dental Plan Exclusions and Limitations

No dental benefit will be paid for the following charges:

- Biopsies or oral pathology, except as specifically covered by the Plan
- Charges for anesthesia, other than anesthesia administered by a licensed dentist in connection with covered oral surgical services performed in a dental office. This exclusion includes prescribed drugs, pre-medications, analgesia (nitrous oxide or any euphoric drug) or hypnosis. Prescribed drugs must be filled through the Pharmacy benefit
- Charges for local anesthesia administered in conjunction with covered dental services or procedures when billed separately (unbundled) from the charge for the Covered Service or procedure
- Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant Group, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan
- Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not dentally necessary and performed solely for cosmetic or personal reasons, personal comfort, convenience or beautification items, including charges for personalization or characterization of dentures
- Charges for the replacement of a lost, missing or stolen appliance device or for an additional appliance (spare)
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Charges for oral hygiene/dietary instruction, or other training, education, instructions or educational materials regardless if performed or provided by a dental service provider
- Charges for facility, Ambulatory Surgery Center and Hospital charges, if there is no satisfactory, documented and Dentally Necessary reason that treatment or surgery cannot be performed in the dental service provider's office
- Charges for infection control (OSHA) fees or claim filing
- Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist
- Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis, or treatment of any nature, including, but not limited to, correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery or retrognathia
- Charges which exceed the Allowed Amount for the services or supplies provided
- Fixed bridges for covered Participants under 16 years of age
- Orthodontic services for enrollees and/or Dependents age 19 or older
- Orthognathic surgery, regardless of origin or cause
- Replants, transplants or any treatment rendered on such teeth
- Root canal therapy for which the pulp chamber was opened before the individual became a Participant
- Root canals on primary teeth
- Service to increase vertical dimension, equilibrium and extra-coronal or other periodontal splinting
- Temporary dentures

- To the extent that the covered Participant could have obtained payment, in whole or in part, if s/he had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid
- All other services or supplies not specifically covered