

Dental Plan



The Dental Expense Assistance Plan pays benefits to you and your covered dependents for a wide range of dental services and supplies, including preventive, diagnostic, restorative, prosthodontic and orthodontic care.

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Highlights



Your Dental Plan...

...Encourages Preventive Care

The plan promotes regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings and X-rays, at 100% of reasonable and customary charges with no deductible.

...Offers Protection for More Extensive Treatment

Oral surgery, restorative and prosthodontic services are covered after you meet the annual deductible.

...Provides Orthodontic Benefits for Your Children

Coverage for orthodontic treatment is available for your eligible dependent children under age 24.



What happens to your benefits when...

For more information about what happens to your dental benefits when you have a qualifying life event, see the "About Your Benefits" section.





How the Dental Plan Works

You select and schedule an appointment with the provider of your choice. This plan does not have a network of providers. The plan pays benefits toward covered dental expenses on the basis of “reasonable and customary charges.” Reasonable and customary charges are based on the usual fees charged in your geographic area by dentists with similar training and experience. In determining reasonable and customary charges, the insurance company takes into account any unusual circumstances or complications that require special skills, experience or additional time.

If you incur charges that exceed what is considered reasonable and customary, the plan covers the reasonable and customary charge and you are responsible for paying the balance. Charges beyond reasonable and customary will not count toward the deductible.

Briefly, the plan covers four types of dental services:

- **Type A** - Preventive and diagnostic services
- **Type B** - Oral surgery and restorative services
- **Type C** - Prosthodontic services
- **Type D** - Orthodontic services.

The plan pays different benefits for each of these types of coverage - with one annual deductible required for Type B and Type C services only.

Annual Deductible

You and each covered dependent must satisfy a \$50 individual deductible each calendar year before benefits become payable toward Type B (oral surgery and restorative) services and Type C (prosthodontic) services covered by the plan.

Maximum Benefits

The plan pays up to a maximum of \$1,500 per year and \$10,000 in a lifetime for each covered person for Type A, Type B, and Type C expenses combined. For Type D (orthodontic) services, there is a separate lifetime maximum of \$1,500 in benefits for each covered person.

Four Types of Dental Services

Type A - Preventive and diagnostic services

Type B - Oral surgery and restorative services

Type C - Prosthodontic services

Type D - Orthodontic services.



Covered Expenses

Type A - Preventive and Diagnostic Services

The dental expense assistance plan pays 100% of covered expenses for Type A (preventive and diagnostic) services, with no deductible required.

Covered expenses for preventive and diagnostic services include reasonable and customary charges for:

- oral examinations (once every six months)
- cleaning and scaling of teeth (once every six months)
- bitewing X-rays (one set every six months)
- full-mouth X-rays (one set every 24 months)
- topical fluoride applications for children under age 19 (once every six months)
- space maintainers
- emergency treatment.

Type B - Oral Surgery and Restorative Services

After the deductible has been satisfied, the plan pays 80% of covered expenses for Type B (oral surgery and restorative) services.

Covered expenses for oral surgery and restorative services include reasonable and customary charges for:

- fillings (other than gold)
- treatment of gum disease (periodontics)
- root canal therapy
- extractions and oral surgery
- general anesthesia when medically necessary.

Type C - Prosthodontic Services

After the deductible has been satisfied, the plan pays 50% of covered expenses for Type C (prosthodontic) services.

Covered expenses for prosthodontic services include reasonable and customary charges for:

- inlays, onlays, crowns, and gold fillings
- fixed bridgework installed for the first time to replace missing natural teeth, including inlays and crowns as abutments, but excluding periodontal splinting

- full or partial dentures installed for the first time to replace missing natural teeth and adjacent structures and any adjustments required during the six-month period following installation
- repair or recementing of crowns, inlays, onlays, dentures, or bridgework
- replacement or modifications of dentures or bridgework if required:
 - to replace one or more teeth extracted after the existing denture or bridgework was installed
 - to replace an existing appliance which is at least five years old and cannot be made serviceable
 - to replace a temporary denture that cannot be made permanent and has been in place 12 months or less.

Type D - Orthodontic Services

All covered children through age 23 are eligible to receive benefits for orthodontic services. At age 24, all coverage under the plan ends, even if a course of orthodontic treatment is ongoing.

The plan pays benefits for covered expenses based on a schedule of allowances with no deductible required. This schedule is available from the Benefit Plans Office.

Covered expenses for orthodontic services include charges for:

- braces
- surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion
- surgical extractions
- X-rays
- retention checking.

Covered Expenses (cont'd.)

Example of Dental Benefits

Here is an example to show how the plan can help pay your annual dental expenses. Assume you incur the following expenses during a calendar year and that the charges are considered reasonable and customary. Here are the plan benefits you would receive:

Dental Expenses	Bills	Plan Pays	You Pay
Routine checkups and cleanings (2)	\$140	\$140 (100%)	\$ 0
X-rays	\$ 50	\$ 50 (100%)	\$ 0
Fillings	\$100	No reimbursement on first \$50 \$ 40 (80%)	\$ 50 (annual deductible) plus \$ 10 (20%)
Extractions	\$200	\$160 (80%)	\$ 40 (20%)
Bridgework	\$400	\$200 (50%)	\$200 (50%)
	\$890	\$590	\$300

As you can see, the plan paid a total of \$590 - over 66% of the \$890 in covered dental expenses incurred during the year.

Predetermination of Benefits

When you or your covered dependents require dental care and treatment, you should discuss in advance with your dentist what needs to be done and how much it will cost. If treatment is expected to cost \$100 or more, you should ask your dentist to file for predetermination of benefits. This helps you avoid surprises by letting you know how much is payable for the proposed treatment before it begins.

Here is how it works:

- Your dentist submits the proposed course of treatment to the insurance company by itemizing services and charges on a regular claim form.
- The insurance company then determines the amount the plan will pay and informs you and your dentist by sending each of you a "Notice of Benefits Allowable" statement.
- You are free to pursue any treatment; however, the plan may only pay for the treatment that is indicated on the "Notice of Benefits Allowable."

Whether or not you request predetermination of benefits, the insurance company will pay the claim based on whatever information it has about your treatment.



Alternative Course of Treatment

If, according to generally accepted professional standards of dental practice, there is more than one suitable procedure for the treatment of a dental condition, the plan will pay benefits for the least expensive procedure that can be used for the effective treatment of that condition. The insurance company determines the benefit reimbursement amount when alternative courses of treatment are available.

If you and your dentist elect to use a more expensive procedure or material than the one determined to be appropriate by the insurance company, you will be required to pay the difference between the dentist's bill and the costs covered by the plan.

Treatment in Progress

The plan does not cover treatment received before your insurance becomes effective. However, if a course of treatment is started before the effective date and completed after the effective date, part of

the cost may be covered. The insurance company will determine whether a portion of the dentist's fee can be allocated to treatment received after the effective date and covered under the plan.

Claiming Benefits

You should file a claim whenever you and your covered dependents incur covered dental expenses. Claim forms are available from the Benefit Plans Office. Claims must be filed no later than 90 days after the plan year in which the services were rendered.

Completed forms should be mailed to the insurance company at the address listed on the claim form.

The insurance company will send an explanation of payment with the benefit check. If you have authorized the insurance company to pay your dentist directly, the dentist will receive an explanation of payment with the check, and you will receive a copy of the explanation.



Coordination of Benefits

The dental expense assistance plan has a Coordination of Benefits (COB) provision that is designed to prevent duplication of payments when a person can collect benefits from more than one employer group dental plan.

Under this provision, when coverage is provided both by the Company and another employer group plan, you can receive up to 100% of your covered expenses from both plans, but no more than that.

Other Company Benefits

If you have an accidental injury, seek recommended care through your primary care physician to receive in-network benefits. Without a primary care physician referral, benefits will be paid at the out-of-network level. Treatment of injuries to your natural teeth by a dentist, physician or surgeon is covered under your medical coverage as long as services are provided within 12 months of the accident.

File your medical claim. You have two years from the date you incur the expense to file your claim.

Dental benefits payable under a Company medical plan will reduce your benefits otherwise payable under the dental expense assistance plan.

Whenever dental expenses are covered under a Company medical plan, you should file a claim under the medical plan first. After you receive notice of payment from that plan, you should submit the notice of payment with your claim under the dental expense assistance plan.



Exclusions

The dental expense assistance plan does not cover certain expenses, including charges for:

- services provided before plan coverage becomes effective
- services other than those specifically covered by the plan
- services and supplies that are not provided by a legally licensed dentist or physician (or a licensed hygienist for the scaling or cleaning of teeth and topical application of fluoride under the dentist's supervision)
- services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- replacement of a lost, missing, or stolen prosthetic device
- services covered by any workers' compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part
- services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer
- services or supplies for which a covered person would not legally have to pay if there were no coverage
- services or supplies which do not meet accepted standards of dental practices, including charges for services or supplies which are unnecessary or experimental in nature
- services or supplies received as a result of dental disease, defect or injury due to an act of war, if declared or not
- dental services or supplies that are payable by any government
- any duplicate prosthetic devices or appliances
- sealants (material, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay), oral hygiene, and dietary instruction
- plaque control programs
- implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth)
- periodontal splinting
- myofunctional therapy.

Expenses incurred for any of the services or supplies listed above may not be used to satisfy your deductible.

Extended Dental Care Benefits

If your coverage ends because your employment terminates, you retire, or you lose eligibility, benefits for covered expenses incurred before your termination remain payable under the plan.

If you are undergoing a course of treatment when your coverage ends, benefits are payable for most covered charges related to that treatment and incurred up to 30 days after your termination.

Exceptions to this 30-day extension include treatment involving:

- **prosthetic devices** - impressions and tooth preparation must be completed before coverage ends and the device must be installed or delivered within two calendar months following the end of coverage
- **crowns** - tooth preparation must be completed before the coverage ends and the crowns installed within two calendar months following the end of coverage
- **root canal therapy** - the tooth must be opened before coverage ends and treatment completed within two calendar months following the end of coverage
- **orthodontia** - not extended, under any circumstance.

Continuation of Coverage

You and your eligible dependents may be eligible to continue your coverage under the dental expense assistance plan in certain cases when coverage would

otherwise end. For more information, refer to COBRA within the "Administrative Information" section.

Conversion Privileges

Dental coverage may not be converted to individual coverage.



