

SCHEDULE OF DENTAL BENEFITS

Verification of Eligibility: 616-285-2480 or 1-800-732-3412

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

PLAN LIMITS

Maximum Calendar Year Benefit for Combined Type I, II, III and IV Services

Only one annual family maximum will apply if both members of the household are eligible to participate in the County Dental Plan.

Family	\$2,500
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DEDUCTIBLES AND COINSURANCE PERCENTAGES

Class A - Type I (Preventive) Services	See Attached Schedule
Class B - Type II (Basic) Services	50%
Class C - Type III (Major) Services	50%
Class D - Type IV (Orthodontic) Services	50%

COVERED CHARGES

This *plan* provides dental benefits for *covered charges*. *Covered charges* are the actual cost charged to a *covered person* for *medically necessary* dental services and supplies or specified routine care. In addition, to be a *covered charge*, a charge must be incurred for services and supplies which are:

- provided by or under the direction of a *physician* or *dentist*, except as specifically provided;
- started and completed while a *covered person* is enrolled in this *plan*;
- specifically listed in this *plan* as a covered dental service or supply; and
- not excluded or limited by any provision of this *plan*.

Class A Services: Type I, Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar Year paid at 100%, services in excess of the 2 per Covered Person per Calendar Year will be covered at 50%.
- (2) One bitewing x-ray series per Calendar Year covered at 100%, services in excess of the one per Covered Person per Calendar Year will be covered at 50%.
- (3) One full mouth x-ray every Calendar Year covered at 100%, services in excess of the one per Covered Person per Calendar Year will be covered at 50%.
- (4) One fluoride treatment for per Calendar Year, covered at 50%
- (5) Space maintainers covered at 50%.
- (6) Emergency palliative treatment for pain, covered at 50%.
- (7) Topical application of Sealant(s), covered at 50%.

Class B Services: Type II Basic Dental Procedures-Class B Covered at 50%

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Amalgam, Composite Resin, Acrylic, Plastic, Silicate cement synthetic or porcelain restorations.
- (4) Endodontics (root canals).
- (5) Extractions. This service includes local anesthesia and routine post-operative care.
- (6) Recementing bridges, crowns or inlays.
- (7) General anesthetics, upon demonstration of Medical Necessity.
- (8) Antibiotic drugs.

Class C Services: Type III

Major Dental Procedures-Class C Covered at 50%

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Addition of clasp or rest to existing partial removable dentures.
- (5) Initial installation of fixed bridgework to replace one or more natural teeth.
- (6) Repair of crowns, bridgework and removable dentures.
- (7) Rebasing or relining of removable dentures.
- (8) Endodontics (Root canals).
- (9) Periodontics (Gum disease).
- (10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
- (11) Implants including any appliances and/or crowns and the surgical insertion or removal of implants.

Class D Services: Type IV

Orthodontic Treatment and Appliances-Class D Covered at 50%

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Employees and Dependents and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.
- (3) **Broken appointments.** Charges for broken or missed dental appointments.
- (4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (5) **Cosmetic Procedures** – Any treatment, care or surgery which is performed solely for cosmetic purposes and results in no functional improvement is not covered under the Plan (i.e. Bleaching Teeth, Veneers, Acid Etch, etc)
- (6) **Customized Dental Work** – Services, supplies and appliances which, by accepted standards of dentistry are more elaborate than those customarily employed, including specialized techniques or other personalization or characterization of dentures.
- (7) **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the charge.
- (8) **Criminal behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other wrongful behavior, or by participating in a riot or public disturbance.
- (9) **Prosthetic Dental Appliances Installed after Termination** – Charges for any prosthetic dental appliances finally installed or delivered more than 90 days after such person's termination of coverage under this Plan.
- (10) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (11) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (12) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (13) **No listing.** Services which are not included in the list of covered dental services.

ABOUT THIS SECTION

This section lists supplies, services and expenses for which the plan will not pay.

The items listed here are in addition to any exclusions listed in the section of this plan on covered charges.

EXCLUSIONS (continued)

A charge for the following is not covered:

- (14) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (15) **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.
- (16) **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.
- (17) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (18) **Personalization.** Personalization of dentures.
- (19) **Plan design.** Charges excluded or limited by the Plan design as stated in this document.
- (20) **Relative.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (21) **Replacement.** Replacement of lost or stolen appliances.
- (22) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (23) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (24) **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (25) **War.** Any loss that is due to a declared or undeclared act of war.