HOW THE DENTAL PLAN WORKS

Annual Deductible

Before the Plan pays certain benefits, you must first meet the deductible. The annual deductible is $50 per person. The deductible applies to Type B, Type C, and Type E Services described below.

How the Plan Pays Benefits

After you meet the calendar year deductible (except for Type A and D Services), the Plan will reimburse you for covered expenses. You are covered for services and supplies customarily used for treatment of that condition and only if it's provided according to accepted standards of dental practice.

Plan Maximums

The maximum benefit the Plan will pay for Type A, Type B, and Type C Services is $1,500 per calendar year for each covered person.

The calendar-year limit on pediatric dental services is removed, defining "pediatric" as for a child up to age 18; and, defining "services" as essential services such as dental exams, dental preventive, general and replacement treatment (Dental Type A, B, and C Services).

There is a lifetime orthodontic benefit of $2,000 for each Dependent child (Type D services).

There is a $3,500 lifetime maximum for each covered person for implants (Type E Services).

COVERED EXPENSES

Type A Services – Preventive

The Plan pays at 100% of covered expenses, no deductible, for the following preventive services up to the $1,500 annual maximum. There is no maximum for "pediatric" dental services.

- routine oral examinations and prophylaxis (scaling and cleaning of the teeth). This benefit is limited to twice in a calendar year;
- topical application of fluoride for children up to age 19. This benefit is limited to one application each calendar year;
- sealants for children up to age 19. This benefit is limited to one application each calendar year;
- space maintainers that replace prematurely lost deciduous (baby) teeth; and
- emergency palliative treatment (treatment of pain or toothache).

Type B and Type C Services – General and Replacement

The Plan pays 85% of covered expenses for the following general replacement services after the calendar year deductible is met, up to the $1,500 annual maximum. There is no maximum for “pediatric” dental services.

- dental X-rays, including full mouth X-rays (but not more than once in any 36 consecutive month period), supplementary bitewing X-rays (but not more than once in any consecutive six-month period), and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment;
- extractions;
- oral surgery;
- amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
- general anesthetics when medically necessary and administered in connection with oral or dental surgery;
- treatment of periodontal and other disease of the gums and tissues of the mouth;
- endodontic treatment, including root canal therapy;
- repair or re-cementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36-consecutive month period;
- inlays, onlays, gold fillings, or crown restorations, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with amalgam, silicate, acrylic, synthetic porcelain, or composite filling;
- treatment for temporomandibular joint syndrome;
- initial installation of fixed bridgework (including inlays and crowns as abutments);
- initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation); and
- replacement of an existing or partial or full removable dentures or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial, removable denture, or bridgework, or to replace extracted natural teeth, but only if:
  - the replacement or addition of teeth is required to replace one or more additional natural teeth and after the existing denture or bridgework was installed;
  - the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable; and
  - the existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Type D Services – Orthodontia

The Plan pays 85% of covered expenses for the following orthodontic services, up to the $2,000 lifetime maximum, for Dependent children:

- orthodontic diagnostic procedures;
- initial and subsequent, if any, installations or orthodontic appliances; and
- surgical therapy and functional therapy, including related oral examinations, surgery, and extractions.

Type E Services – Implants

The Plan pays 85% of covered expenses for implants after the calendar year deductible is met, limited to the $3,500 lifetime maximum. Implants are covered only if:

- the treatment is pre-approved; and
- the implant is FDA approved and ADA acceptable or provisionally acceptable.

PRE-DETERMINATION

Often there is more than one way to treat a dental condition and the differences in cost may be substantial. Pre-determination helps you make an informed decision before a treatment begins by letting you know in advance how much the Plan will pay for certain services. So, when your dentist recommends treatment that is expected to be $500 or more, he or she may submit a pre-treatment plan to the Administrative Office before the work begins.

The dentist must supply complete dental records, including X-rays and details concerning the services your dentist proposes to complete and the charges for those services. After reviewing the pre-treatment plan, the Administrative Office will determine the level of benefits the Fund will provide.

Alternative Course of Dental Treatment

In determining the amount of benefits payable, the Administrative Office may consider alternate courses of treatment appropriate to your condition and capable of accomplishing the desired results. They may base their determination on such an alternative that is:

- customarily employed nationwide in the treatment of the condition; and
- recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account the total oral condition of you or your Dependent.

If this happens, and both you and your dentist agree to proceed with the original course of treatment, or agree to a charge higher than the amount allowed by the Administrative Office, you will be responsible for paying any excess cost incurred.

DENTAL EXPENSES NOT COVERED

In addition to any general Plan exclusions, the following expenses are not covered under the Plan:

- treatment by other than a licensed dentist, except for cleaning of teeth performed by a licensed dental hygienist, under the supervision and direction of a dentist;
- dental care that is included as a covered expense under any medical or comprehensive major medical expense benefit;
- a dental expense that is due to illness or injury that is related to any occupation or employment for wages or profit;
- courses of dental treatment that are received or started before the date you became entitled to dental care benefits or the date dental coverage begins for your participating Union. Treatment is considered started:
  - -for restorative services and endodontic services, when the tooth is prepared; or
  - -for fixed or removable prosthodontics, when the impression for the appliance is taken;
- treatment of any condition caused by war, or by any act of war, declared or undeclared, or by participating in a criminal enterprise or unlawful behavior;
- replacement of a lost or stolen prosthetic device;
- charges for failure to keep a scheduled appointment with a dentist;
- charges for porcelain or plastic pontics or facings on crowns posterior to the second bicuspid;
- extraction of exfoliating deciduous (baby) teeth;
- service with respect to congenital or development malformations or dentistry for purely cosmetic reasons, including, but not limited to, cleft palate, maxillary and mandibular malformation, enamel hypoplasia, fluorosis, and anadenia except for Type D Services;
- charges for the completion of dental care claim forms;
- orthodontia or correction of malocclusion, except as specifically provided in the Plan;
- replacement of an existing prosthodontic appliance unless evidence satisfactory to the Board of Trustees is presented that the existing appliance:
  - -was installed at least five years before its replacement and the existing appliance cannot be made serviceable; or
  - -is a temporary appliance;
- charges for implants, except as specifically provided by the Plan; and
- expenses that exceed allowable charges.