

DENTAL BENEFITS
(Eligible Employees and Eligible Dependents)

The Plan pays for the following dental care expenses:

Type I Expenses (Preventive and Diagnostic Treatment)
100% of covered dental charges for diagnostic x-rays, oral examinations, cleaning and scaling of teeth, fluoride applications, space maintainers and emergency treatments for relief of dental pain.

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Type II Expenses (Basic/Routine Treatment)
80% of covered dental charges for fillings, extractions, oral surgery, general anesthesia, periodontics, endodontics, antibiotic injections, denture and crown repair and consultations.

Type III Expense (Major Restorative Treatment)
50% of covered dental charges for crowns, fixed bridgework, inlays, onlays, gold fillings and full or partial dentures, other than charges incurred for repairs or additions to existing dentures.

Type IV Expense (Orthodontia)
50% of covered charges.

Deductible Amount

Type I Expenses None
Type II and III Expenses \$50 per Calendar Year per person (\$150 per family)
Type IV Expenses None

Maximum Benefit

<u>Type of Expense</u>	<u>Maximum Benefit</u>
Type I, II and III	\$3,000 per Calendar Year per person
Type IV	\$1,500 Lifetime Maximum

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished, except that such charge will be deemed incurred:

1. with respect to fixed bridgework, crowns, inlays, onlays or gold restorations, on the first date of preparation of the tooth or teeth involved.
2. with respect to full or partial dentures, on the date the impression was taken, and
3. with respect to endodontics, on the date the tooth was opened for root canal therapy.

Deductible Amount

The deductible applies separately to the Employee and each Dependent per Calendar Year, except that not more than a total deductible of \$150 will be applied against all covered dental charges incurred during any one Plan year by members of a family. The deductible must be met before payment of benefits is considered.

Covered Dental Charges

Covered dental charges are charges by a dentist or Physician for services and supplies for dental care and treatment of any disease, defect or accidental injury, or for preventive dental care.

Not included is any charge in excess of the Reasonable and Customary charges made for similar services and supplies by dentists or Physicians in the locality concerned, or where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

Employees are encouraged to request a pre-treatment estimate of benefits payable when the total cost associated with the proposed dental work is expected to exceed \$200. The dental claim form contains a provision for requesting such information prior to the date treatment is rendered.

A treatment plan is a plan of proposed dental services necessary in the professional judgment of the attending dentist and shows the cost of the proposed treatment.

The filing of a treatment plan may help to avoid any misunderstanding as to the extent of coverage. This process identifies coverage and clarifies benefit specifications, such as deductibles, coinsurance and limits. It also gives the patient and dentist an opportunity to review the proposed treatment and the extent of coverage before any work is started.

Type I Expenses (Preventive and Diagnostic Treatment)

1. Charges for cleaning and scaling of teeth but not more often than once every 6 months.
2. Charges for fluoroide application for dependent children's teeth through age 18, but not more often than once in a Calendar Year.
3. Charges for space maintainers and their fittings.
4. Charges for diagnostic x-rays.
5. Charges for emergency treatment for relief of dental pain on a day for which no other benefit other than for x-rays is payable hereunder.
6. Oral examinations but not more often than once every 6 months.
7. Charges for Sealants for dependent children through age 18.
8. Study models and diagnostic casts (other than for orthodontics.)

Type II Expenses (Basic/Routine)

1. Initial amalgam, silicate, silicate, acrylic or composite restorations.
2. Replacement of an amalgam, silicate, acrylic or composite restorations.
3. Charges for extraction of one or more teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examination.
4. Charges for treatment of gums and supporting structure of the teeth.
5. Charges for root canal therapy and other endodontic treatment.
6. Charges for general anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations.
7. Local anesthesia (not in connection with operative or surgical procedures, regional block and trigeminal division block anesthesia or analgesia).
8. Charges for injectable antibiotics administered by a dentist or physician.
9. Charges for recementing inlays or crowns at least 90 days after the date the inlay or crown was provided.
10. Relining, rebasing or repairing of an existing prosthesis (fixed bridgework, removable partial or complete dentures) at least 90 days after the date the installation or repair of the prosthesis was performed.
11. Consultation required by the attending dentist.

Type III Expenses (Major Treatment)

1. Charges for fillings and crowns necessary to restore the structure of teeth broken down by decay or injury, but:
 - a. the charge for a crown, inlays, onlays, or gold fillings will be limited to the charge for a silver, porcelain or other filling unless the tooth cannot be resorted with such other material, and
 - b. the charge for replacement of a crown, inlays, onlays, or gold filling is covered only if the crown or filling is over 5 years old.

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2. Charges for specialized techniques involving precision attachments, personalization or characterization are not covered. Additional charges for adjustments within 6 months from installation are not included as covered dental charges.

Type IV Expense (Orthodontia)

50% of covered charges.

After Coverage Terminates

The benefits described herein are also provided for covered dental charges:

1. for services or supplies furnished within 90 days after coverage terminates if the charges were incurred while coverage was in force, and
2. incurred within 90 days after coverage terminates if an accident resulting in injury to natural teeth sustained while coverage was in force causes continuous total disability from the date of termination; provided benefits are not payable for such expenses under any other group insurance policy or plan.

Note: Claims for injury to natural teeth should be filed with the medical benefits insurance carrier.

Limitations and Exclusions

The Plan will not pay for the following:

1. Dental procedures which are included as covered medical expenses under any other comprehensive or major medical plan provided by the Plan;
2. Treatment by someone other than a dentist or physician, except when performed by a duly qualified technician under the direction of a dentist or physician;
3. Dental treatment required as a result of self-inflicted injury, war, whether declared or not, riot or insurrection;
4. Charges for broken appointments or form preparation;
5. Services and supplies cosmetic in nature;
6. Training in or supplies used for dietary counseling, oral hygiene or plaque control;
7. Replacement of an existing prosthesis (fixed bridgework, removable partial or complete dentures) which has been lost, mislaid or stolen;
8. Dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute;
9. Replacement of existing prosthodontic appliances unless:
 - a. the existing appliance is at least 5 years old and cannot be made servicable;
 - b. the existing appliance is temporarily installed after the effective date of this plan;
 - c. the replacement appliance is made necessary as the result of an initial placement of an opposing denture;
 - d. the replacement is made necessary as a result of an accidental injury;
10. Services or supplies which do not meet acceptable standards of dental practice, including charges for services or supplies which are experimental in nature;
11. Examinations for use by a third party;
12. Emergency prescriptions or other drugs and/or medicaments;
13. Dental procedures which do not directly involve the teeth or the tissue or bones which support the teeth;
14. Surgical implants of any type;
15. Charges for athletic mouth guards;
16. Charges for any duplicate prosthetic device or any other duplicate appliance;

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17. Services and supplies furnished in a U.S. Government Hospital, or which the employee would not be required to pay if there were no plan;
18. Services and supplies furnished in connection with injuries sustained while engaged in any occupation for remuneration or profit, or disease for which Workers' Compensation or similar benefits are payable;
19. Service or treatment for which a Dependent is entitled to benefits as an employee or former employee of the Plan;
20. Dental treatment received from a dental or medical department maintained by an Employer, association, labor union trust or similar type of group;
21. Services and supplies rendered for full mouth reconstruction, orthognathic surgery or for a correction of temporal mandibular joint dysfunction (TMJ); and
22. Veneers.

VISION BENEFITS (Eligible Employees and Eligible Dependents)

The Plan will pay Usual, Customary and Reasonable charges up to the maximum shown in the Schedule below:

<u>Benefit</u>	<u>Maximum Payable</u>
*Examinations	
*Lenses (50% for single lens)	\$ 50.00
Single Vision	
Bifocal Vision	\$ 75.00
Trifocal Vision	\$125.00
Lenticular Vision	\$125.00
**Frames	\$125.00
*Contact Lenses	\$ 65.00
Single Vision	
Bifocal Vision	\$ 75.00
	\$125.00

(A single lens benefit is 50% of the maximum payable)

Note: Both "eyeglasses" and "contact lenses" are covered in the same benefit period.

- * Payable once every 12 months
- ** Payable once every 24 months

Safety Glasses (Employees Only)

<u>Lenses</u>	<u>Benefit</u>	<u>Maximum Payable</u>
	Single Vision	\$ 75.00
	Bifocal Vision	\$125.00
	Trifocal Vision	\$125.00
	Lenticular Vision	\$125.00
Frames		\$ 65.00

Benefits for Safety Glasses are payable once every 12 months.

Limitations And Exclusions

The Plan will not pay for the following:

1. Charges for services or supplies which are covered in whole or in part under any medical expenses benefit provided by the Plan;
2. Expenses for which benefits are payable under any Workers' Compensation or similar legislation;

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3. Special procedures, such as orthoptics or vision training, and special supplies, such as non-prescription sunglasses and subnormal vision aids;
4. Anti-reflective coating or charges for tinting and charges for sunglasses or light-sensitive glasses;
5. Eye examinations required by an Employer as a condition of employment, other than for safety glasses;
6. Services or supplies received principally for cosmetic purposes;
7. Drugs or medications, except if used for vision examination;
8. Medical or surgical treatment of the eyes;
9. Special procedures and experimental services or supplies;
10. Service or supplies not prescribed as necessary by a licensed Physician, optometrist or optician;
11. Charges for replacement or lost, stolen or broken lenses or frames;
12. Duplicate glasses, lenses or frames;
13. Service or materials not listed in Schedule of Vision Benefits.