EMPLOYEE DENTAL PLAN
SCHEDULE OF BENEFITS

DENTAL BENEFITS

Option 1 Dental PPO Plan	In-Network	Out-of Network
General Plan Information		
Annual Deductible/Individual	$0	$25
Annual Deductible/Family	$0	$75
Waived for Preventative	Yes	Yes
Annual Plan Maximum	$2,000	$1,500
Covered Services		
Diagnostic and Preventative	100%	80%
Oral Exams	100%	80%
Bitewing X-Rays	100%	80%
Full Mouth X-Rays	80% limited to once in any 36 consecutive month period	80% limited to once in any 36 consecutive month period
Cleaning and Scaling	80%	80%
Prophylaxis treatments	80%	80%
Space Maintainers	80% limited to persons under age 16; initial appliance only	80% limited to persons under age 16; initial appliance only
Sealants	80%	80%
Basic Services		
Basic	80%	80%
Oral Surgery Extractions and Other Surgical Procedures	80%	80%
Restorative:		
Amalgam, Synthetic Porcelain and Plastic Restorations (Filling)	80%	80%
Endodontic Treatment	80%	80%
Re-linings and Re-basings of Existing Removable Dentures	80% limited to once per denture in any 12 consecutive month period	80% limited to once per denture in any 12 consecutive month period
Major Services		
Periodontic Treatment	80%	60%
Major	80%	60%
Crowns, Jackets and Cast	80%	60%
Restoration Benefits		
Prosthodontic Benefits (Fixed Bridges, Partial/Complete Dentures)	80%	80%
Implants	$1,000 max	$1,000 max

COVERED DENTAL SERVICES

CLASS 1 – PREVENTIVE DENTAL SERVICES

Office visits and examinations
- Initial or periodic oral exam – limited to one examination in a six consecutive month period.
- Emergency palliative treatment and other non-routine, unscheduled visits.

Prophylaxis and Fluoride Treatments
- Prophylaxis – limited to one treatment in a six consecutive month period.
- Topical application of fluoride – limited to persons under age 18 and limited to one treatment in a six consecutive month period.

X-rays
- Bitewing – limited to a maximum of four films in any six consecutive month period.
- Full mouth series – limited to limited to once in any 36 consecutive month period.
- Other intraoral periapical or occlusal single films.
- Panoramic film – limited to once in any 36 consecutive month period.

Space Maintainers - Limited to covered persons under age 16 and to initial appliance only; allowance includes all adjustments in the first six months after installation. Limited to space maintenance for unerupted teeth and following extraction of primary teeth.

Fixed and Removable Appliances to Inhibit Thumbsucking and other Harmful Habits - Limited to covered persons under age 16 and limited to initial appliance only. Allowance includes all adjustments in the first six months after installation.

Sealants - Limited to covered children between the ages of 6 and 16 and are applied once per tooth per 3 years for cuspids and bicuspids only.

CLASS II – BASIC DENTAL SERVICES

Diagnostic Services
- Diagnostic casts
- Biopsy and examination of oral tissue

Consultations – diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any 12 consecutive month period, and only if no other service is rendered during the visit.

Restorative Services (also see major restorative services)
- Amalgam and synthetic restorations
- Crowns – acrylic or plastic, without metal; stainless steel
- Pin retention
- Recementation of inlays, onlays, crowns, bridges.

Endodontic Services – allowance includes routine x-rays and cultures, but excludes final restoration.
- Pulp capping, direct
- Root canal therapy
- Apicoectomy
- Vital Pulpotomy
- Remineralization (calcium hydroxide) as a separate procedure.

Oral Surgery – allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.
- Extractions – uncomplicated or surgical removal of erupted or impacted teeth
- Other surgical procedures

Other services
- General anesthesia in conjunction with surgical procedures only
- Injectable antibiotics needed solely for treatment of a dental condition.

Prosthodontic Services (Basic) (also see Major Prosthodontic Services)

- Denture repair.
- Denture relining – limited to once in any 12 consecutive month period.
- Denture adjustments – limited to limited to adjustments by a dentist other than the one providing the denture, and adjustments more than 6 months after initial installation.
- Tissue Conditioning – limited to a maximum of one treatment in any 12 consecutive months.
- Adding teeth to partial dentures to replace extracted natural teeth
- Repairs to crowns and bridges

CLASS III – MAJOR DENTAL SERVICES

Restorative services

- Gold fillings
- Inlays, Onlays
- Crowns and Posts

Periodontic Services (gum treatments)

- Gingivectomy
- Sub-gingival curettage per quadrant, limited to a maximum of four quadrants in any 12 consecutive months.
- Osseous surgery
- Occlusal adjustment

Prosthodontic Services (Major)

- Fixed or removable bridges
- Dentures – Full or Partial

ALTERNATE TREATMENT - This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.

EXCLUSIONS: This plan won't pay for:

- Oral hygiene, plaque control or diet instruction. Precision attachments. Treatment which does not meet accepted standards of dental practice.
- Treatment which is experimental in nature.
- Orthodontic treatment
- Appliances or prosthetic devices used to change vertical dimension or restore of maintain occlusion;
- Splint or stabilize teeth for periodontic reasons;
- Replace tooth structure lost as a result of abrasion or attrition;
- Treat disturbances of the temporo-mandibular joint;
- Athletic mouth guards;
- Characterizing and personalizing prosthetic devices.
- Making facings on prosthetic devices for any teeth in back of the second bicuspid.
- Replacing an appliance or prosthetic device with a like appliance or device, unless:
- It is at least five years old and can't be made usable, or
- It is damaged while in the covered person's mouth in an injury suffered while insured, and can't be fixed.
- Replacing a lost, stolen or missing appliance or prosthetic device.
- Making a spare appliance or device
- Treatment needed due to an on-the-job or job-related injury; or
- A condition for which benefits are payable by Workers Compensation or similar laws.
- Treatment for which no charge is made

CLAIM FILING

For prompt service when filing a claim, please submit an itemized bill to the following address. The itemized bill must include the patient(s) name, and date(s) of service, the diagnosis, the procedure codes and the total charge(s). In addition to the above, the name, address and federal tax identification number for the provider of service must be included.

YOU MAY FAX ALL INFORMATION TO:

Transwestern Insurance Administrators, Inc.
(559) 499-2025

OR

MAIL YOUR ITEMIZED BILL TO:

Transwestern Insurance Administrators, Inc.
PO BOX 45019
Fresno, CA 93718

If you have any questions, please feel free to contact us at:

(559) 499-2000 ~or ~ (800) 221-8942

For a Contracted Connection Dental Provider please call – (877) 277-6872
www.connectiondental.com

For a Contracted Dentinex Dental Provider please call – (800) 345-6700
www.healthsmart.com