DEPENDENT COVERAGE

Orthodontic coverage..to age 19
Dependent coverage...to age 26

MONTHLY PREMIUM

Single $29.53
Double..$55.90
Family $95.43

TERMS

September 1, 2018 through August 31, 2019

*A minimum of ten employees is required in order to qualify for a group program. Should the group drop below this level during the contract year it may be subject to termination.

PREPAID GROUP DENTAL PLAN

ENHANCED

PLAN E

PROCEDURE	PATIENT COST
DIAGNOSTIC	
Charting history, oral examinations, periodic recall Examination (every 6 months), emergency treatment.	NO CHARGE
Emergency out of area (outside a 50 mile radius) Reimbursement upon paid receipt from dentist (up to $50)	
RADIOGRAPHIC	
Complete intraoral series, periapical and bitewing films	NO CHARGE
Intraoral periapical	NO CHARGE
Each additional single film (periapical or bitewing)	NO CHARGE
Occlusal view x-ray	NO CHARGE
Lateral jaw x-ray each	NO CHARGE
Four bitewing x-ray films	NO CHARGE
Anterior-posterior x-ray of head and jaw	NO CHARGE
Cephalometric examination	NO CHARGE
Panoramic (panography) including bitewings	NO CHARGE
PREVENTIVE	
Oral prophylaxis (every 6 months)	NO CHARGE
Topical fluoride treatment following prophylaxis (up to age 19)	NO CHARGE
Space maintainers – unilateral	NO CHARGE
Space maintainers – bilateral	NO CHARGE
OPERATIVE (RESTORATIVE) SERVICES	
Primary silver amalgam – 1 surface	NO CHARGE
Primary silver amalgam – 2 surfaces	NO CHARGE
Primary silver amalgam – 3 surfaces or more	NO CHARGE
Permanent silver amalgam – 1 surface	NO CHARGE
Permanent silver amalgam – 2 surfaces	NO CHARGE
Permanent silver amalgam – 3 surfaces or more	NO CHARGE
Silver amalgam reinforcement pins – 1st	NO CHARGE
---each additional pin	NO CHARGE
Composite filling (for front teeth)	NO CHARGE
Composite Class III	NO CHARGE
Composite Class IV	NO CHARGE
Composite post and core, or any build up	NO CHARGE

PROCEDURE **PATIENT COST**

PERIODONTIA

Root scaling & root planing (per quadrant)	**NO CHARGE**
Gingivectomy, Gingivoplasty (per quadrant)	**NO CHARGE**
Occlusal adjustments (and/or equilibration)	**NO CHARGE**
Bite guards	**NO CHARGE**
Osseous surgery (per quadrant)	**NO CHARGE**

ENDODONTICS (including radiographs)

Single root canal filling	**NO CHARGE**
Double root canal filling	**NO CHARGE**
Triple or more root canal filling	**NO CHARGE**
Apicoectomy	**NO CHARGE**

SIMPLE EXTRACTIONS (including local anesthesia)

Single tooth	**NO CHARGE**
Each additional tooth	**NO CHARGE**

ORAL SURGERY EXTRACTIONS (including local anesthesia)

Extraction of erupted tooth	**NO CHARGE**
Extraction of tooth (soft tissue impaction)	**NO CHARGE**
Extraction of tooth (partial bony impaction)	**NO CHARGE**
Extraction of tooth (complete bony impaction)	**NO CHARGE**
Alveoplasty/Alveolectomy (per jaw maximums) per quadrant in conjunction with extraction	**NO CHARGE**
Alveoplasty, including ridge extension, arch	**NO CHARGE**
Excision of benign tumor, lesion diameter up to 2.5 cm.	**NO CHARGE**
Removal of cyst up to 2.5 cm. diameter	**NO CHARGE**

PROSTHETICS (including adjustments and relines for 6 months following installation)

Full upper denture	**NO CHARGE**
Full lower denture	**NO CHARGE**
Partial upper or lower denture without clasps, acrylic base	**NO CHARGE**
Partial upper or lower denture with two chrome clasps with rests, acrylic base	**NO CHARGE**
Partial upper or lower with chrome lingual or palatal bar with two claps and rests, acrylic base	**NO CHARGE**
Repair broken full or partial dentures, no teeth damaged	**NO CHARGE**
Repair broken full or partial dentures, replace broken tooth	**NO CHARGE**
each additional tooth	**NO CHARGE**
Repair broken tooth on denture, no other repairs	**NO CHARGE**
each additional tooth	**NO CHARGE**
Adding tooth to partial denture to replace extracted tooth	**NO CHARGE**
each additional tooth	**NO CHARGE**

PROCEDURE	**PATIENT COST**

PROSTHETICS CON'T

Reattaching clasp on denture, clasp intact	**NO CHARGE**
Replacing broken clasp with new clasp on denture	**NO CHARGE**
Relining upper or lower full or partial denture (office) once every three years	**NO CHARGE**
Relining upper or lower full or partial denture (lab) once every three years	**NO CHARGE**
Jump case, complete denture (duplicate of denture) once every three years	**NO CHARGE**

CROWNS

Acrylic jacket	**NO CHARGE**
Acrylic with metal (semi-precious)	**NO CHARGE**
Porcelain jacket	**NO CHARGE**
Porcelain fused to metal (semi–precious)	**NO CHARGE**
¾ cast	**NO CHARGE**
Full cast	**NO CHARGE**

BRIDGE – PONTICS (fixed) *

Cast (per unit)	**NO CHARGE**
Maryland Bridge (per unit)	**NO CHARGE**
Porcelain fused to metal (semi–precious – per unit)	**NO CHARGE**
Plastic processed to metal (semi-precious – per unit)	**NO CHARGE**
* Refer to exclusion A24	**NO CHARGE**

ABUTMENTS

Two surface gold inlay	**NO CHARGE**
Three or more surfaces gold inlay	**NO CHARGE**

ORTHODONTIC BENEFITS

Orthodontic benefits include:

Diagnosis, including models, photographs and cephalograms
Active treatment
Retention treatment

Active treatment will be rendered only for functional problems:

a) One cusp deviation in the occlusion of the maxillary and mandibular arches
b) Overbite – 4mm. or greater
c) Crossbites
d) Overjets – 4mm. or greater
e) Crowding in excess of 4mm.

Maximum Twenty-four (24) months (to age 19)	**NO CHARGE**

Exceptions, Exclusions and Other Limitations

A. The term "Covered Dental Services" as used herein shall exclude the following:

1. Services for which Benefits are otherwise provided under a surgical-medical plan of the Group.

2. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures. This includes porcelain, porcelain fused to gold and all gold crowns.

3. Prosthetic devices (including bridges, crowns, inlays, onlays and complete partial dentures and the fitting thereof) for which the final impressions were taken while the individual was not covered under this Agreement, or for which final impressions were taken while the individual was covered under this Agreement, but are not finally installed or delivered to such individual within sixty (60) days after the termination of coverage.

4. Replacement or repair of an orthodontic appliance.

5. Services which are compensated by Workers' Compensation or Employer's Liability.

6. Dental services which are obtained by a Plan Member outside of the Dental Center in which he is enrolled and which are not pre-authorized by PLAN. This exclusion does not apply to Out-Of-Area Emergency dental services as defined in Article I.

7. Services or supplies from any governmental agency which are obtained by the Plan Member outside without cost in compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.

8. Services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

9. Services for treatment of any automobile-related injury to the extent to which the Plan Member is covered under any no-fault automobile policy.

10. Services rendered through any facility provided or maintained by the Plan Member's employer or such as a medical department or clinic.

11. Services or supplies received for treatment of any dental disease, defect, accident or injury due to an act of war, declared or undeclared or participation or involvement in a riot or act of civil insurrection or during the commission of a felony.

12. Elective dentistry or oral surgery, including removal of impacted teeth that exhibit no symptoms or pathology

13. Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or the prognosis is poor or guarded.

14. Services or supplies which do not meet accepted standards of dental practice, including services and supplies which are experimental in nature.

15. Treatment of fractures, dislocations, malignancies and neoplasms.

16. Treatment of myofacial pain syndrome, temporomandibular joint (TMJ), or temporomandibular dysfunction (TMD) is excluded.

17. Treatment to alter vertical dimension (except when involving full dentures and/or minor occlusal adjustments or orthodontic therapy).

18. Expenses of occlusal equilibration except to the extent necessary to treat periodontal disease.

19. Treatment of congenital defects, such as but not limited to cleft palates, congenitally missing teeth and associated deformities.

20. Implantology, (i.e., implants driven into or resting on a alveolar bone, used to support a crown, a full denture, a partial denture or to act as an abutment for a fixed bridge when no abutment tooth is available or the surgical procedures on the jaws in preparation for the prosthesis). Both the surgical procedure and the prosthetic appliance are excluded.

21. Any duplicate prosthetic device or any other duplicate appliance.

22. Orthodontic treatment for a Plan Member subsequent to such person attaining the age of nineteen (19) unless said Plan Member is banded prior to his nineteenth (19) birthday or unless it is stated otherwise in the Schedule of Benefits. It is to be understood that said Plan Member must remain eligible until the completion of Orthodontic treatment. Should eligibility be terminated, the Plan Member will be responsible for any unpaid balance.

23. Repair of full or partial dentures, except within six (6) months of delivery.

24. Replacement of an existing removable partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing removable or partial or to bridgework, unless:

    A. Satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

    B. The existing denture or bridgework cannot be made serviceable and at least five (5) years have elapsed.

    C. The existing denture is a temporary denture which cannot be made permanent. The replacement by a permanent denture must take place within twelve (12) months of the insertion of the immediate temporary denture.

25. All replacement of teeth where bilaterally edentulous (where teeth are missing on both sides of the same arch) area exist are to be performed with removable prosthesis as compared to a fixed prosthesis.

26. Completion of orthodontic treatment for a patient who presents having prior orthodontic treatment of an inappropriate nature as determined by the Plan. An additional charge will

be incurred for removal, change, or alteration or existing orthodontic appliances, braces or brackets should the Plan decide to accept the transfer of the case.

27. Sealants are not a covered benefit except as stated otherwise in the Group Schedule of Benefits.

28. Posterior composites except on the buccal surfaces of premolars.

29. Athletic mouthguards.

30. Prosthetic services such as precision attachments, copings, over-dentures and stress breakers.

31. Gold teeth in removable prosthesis as well as clear palates in a complete upper denture.

32. General anesthesia or sedation except as provided otherwise in the Group Schedule of Benefits.

33. Prescription drugs, laboratory tests and/or examinations, pre-medications and charges for hospitalization.

34. Orthognathic Surgery and pre and post Orthodontic procedures rendered in conjuction with an Orthognathic surgical case.

35. No coverage is provided due to the effects of abrasion, attrition or erosion, or as the result of injurious oral habits.

36. Services which were started prior to the individual enrolling in the Plan, e.g. root canals, crown and bridge, etc.

37. Treatment of unmanageable children or adults. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or for any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the guardian of the patient.

38. Services arising from any intentionally self-inflicted injury or contusion.

39. Services that can not be performed in the dental facility due to the general medical, mental or physical limitations of the Plan Member. The Plan Member is responsible for any cost incurred.

40. Services that are necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan. The Plan Member is responsible for any cost incurred.

41. Additional covered services, other than a dental emergency, if the Member has previously unresolved copayment balance that has been outstanding for sixty (60) or more days, unless special payment arrangements have been made within the primary care dentist or dental specialist.

42. Full mouth reconstruction. Fragmented treatment plans for the above are also excluded.

43. Repairs to an old prosthesis that has been replaced with a new prosthesis.

44. Continuation of orthodontic treatment where there has been greater than a four (4) month lapse in treatment.

B. Limitations are defined as:

1. Full mouth or panoramic radiographs once every three years.

2. Prophylaxes are covered twice in any contract year except as stated otherwise in the Group Schedule of Benefits.

3. Fluoride is covered up to the age of nineteen (19).

4. Single crowns, bridge abutments and pontics are covered for non-precious metals only.

5. Root canal therapy is covered for traditional fill materials (gutta percha) and not Sargenti type materials.

6. Relines on traditional dentures are covered beginning six (6) month after delivery then once every three years after that. Relines on immediate dentures can be done anytime after delivery (no six month wait necessary) and then once every three years. There is no differentiation between lab and office relines or soft versus hard relines with regard to the same limitations.

7. Since tissue conditioners are generally performed to restore the gingiva to a healthy state prior to relining, rebasing or fabrication of a new prosthesis, tissue conditioners have the same limitations as relines.

8. All adjustments to complete or partial dentures are covered for six months after delivery. After that time, a separate charge will be made for adjustments to either the upper or lower prosthesis. Repairs are limited to the first six months then once a year thereafter.

9. Repairs, replacement or retreatments of restorations are performed at no charge for one year. After that time the applicable Co-payment will apply as identified in the Schedule of Benefits.

10. Re-treatment of root canals shall be handled as follows:

    A. 0-12 Months - No Charge

    B 13-24 Months Applicable - Co-payment will apply

    C. 25 Months plus - Non-Covered

    D. Re-treatment of a root canal prior to the Member enrolling - Non-Covered

11. If any of the procedures performed in Oral Surgery and Periodontics are covered under any medical benefit plan(s), then exception AI would apply.

12. Orthodontics, for those Groups providing an orthodontic Benefit, is covered until the age of nineteen (19) unless stated otherwise in the Group Schedule of Benefits. Unless specified differently in the contract benefits cover 24 months of Comprehensive (Phase II) treatment. For treatment plans extending beyond the benefit amount, the Plan Member will be subject to a monthly office fee. Interceptive (Phase 1) treatment is a non-covered benefit.

13. Optional Treatment: In all cases in which the Plan Member selects a more expensive service or benefit than is customarily provided or for which the PLAN does not believe a valid dental need is shown, the PLAN will allow for the applicable percentage of the fee for the service or benefit, if any, which is customarily provided to restore the tooth to contour and function. Fee of the lesser service or benefit to be applied towards the elected procedure. The Plan Member will pay the difference.

    EXAMPLE:

    A tooth can be satisfactorily restored with amalgam. The Plan Member, however, chooses to have the tooth restored with a more costly material. The PLAN will only provide for the applicable amount that it would have allowed to restore the tooth with amalgam. The Plan Member is responsible for the difference in cost.

14. Authorized or Covered Dental Services incurred as a result of an emergency as defined in Article I shall be covered limited to a maximum reimbursement of fifty dollars ($50.00) (for the relief of pain and suffering) of the Plan's usual and customary and reasonable fee.

    Out-of-Area Emergency Procedures:

    In the event a Plan Member experiences a dental emergency while out of the area, the individual should seek professional care to alleviate pain and suffering. A determination for reimbursement will be made and communicated to the Plan Member within five days of said claim. The claim for the services provided should be submitted to:

    Midwestern Dental® Plans, Inc.
5050 Schaefer Road
Dearborn, MI 48126

15. Patient management for individuals requiring additional or unusual efforts to complete a dental procedure. The Plan Member is responsible for all costs incurred.

16. Dental services for individual's requiring additional or unusual efforts to complete a dental procedure, e.g. denture requiring obturation or treatment by a Prosthodontist, microscopic procedures associated with root canals, surgical correction of dento-facial deformities, etc.. The Plan Member is responsible for any costs incurred.

17. A. All Plan Members that have completed scaling and root planning or periodontal surgery can receive one periodontal maintenance or regular hygiene in a six-month period.

    B. If a Plan provides for three cleanings in a calendar year, a Plan Member can receive a combined total of three periodontal maintenances or a regular cleaning in one calendar year.

C. The above can continue for a maximum of two years then reverts to one routine cleaning in a six-month period.

18. Treatment performed for root canal obstructions (calcified) and separated instruments are non-covered and a charge will apply.

19. Crown and bridge removal. Evaluation of the underlying tooth structure is non-covered.

20. Should a Plan Member's coverage be terminated for any reason while receiving Orthodontic treatment the Plan Member will be financially responsible for continued treatment. In this event the Plan Member's obligation shall be based on the Providers fee at the beginning of the treatment.

LIMITATIONS:

The following services will be subject to the limitations as set forth below:

A. One (1) in a six month period:
   1. Periodic oral exam
   2. Routine prophylaxis
   3. Fluoride treatment
   4. Bitewing x-rays for dependents through the age of twelve (12) maximum four (4) per occurrence.

B. One (1) in a twelve (12) month period:
   1. Bitewing x-rays for dependents through the age of thirteen (13) and over, maximum four (4) per occurrence.

C. One (1) in a twenty-four (24) month period:
   1. Scaling and root planning
   2. Mucogingival surgery
   3. Osseous surgery
   4. Gingival flap per quad
   5. Gingivectomy per quad
   6. Gingivectomy per tooth

D. One (1) in a three (3) year period:
   1. Full mouth series and panoramic x-rays.

E. One (1) in a five (5) year period (if found to be unserviceable):
   1. Complete dentures
   2. Partial dentures
   3. Fixed bridges

F. One (1) per tooth per lifetime:
   1. Prefabricated stainless steel crowns – primary or permanent teeth
   2. Crown lengthening at the applicable Plan co-payment.

G. The following series are specifically limited to:

1. Space Maintainers-

   <for Dependent children through the age of eighteen (18) when used to maintain space as a result of prematurely lost deciduous teeth and permanent first molars or deciduous teeth and permanent molars or have not, or will not ever develop, (see Schedule of Benefits).

2. Sealants-

   <for children through age fourteen (14) on a per tooth basis (see Schedule of Benefits).

   < not eligible within three (3) years of placement unless provided by other than the original dental facility.

H. Orthodontics is a once in a lifetime benefit. If Orthodontic treatment has been completed elsewhere there is no further benefit available under the Member's Plan. Members presently in orthodontic treatment at the time of enrolling in the Plan are eligible for treatment minus time already received in treatment subject to any other exclusions and limitations.

3/19/2013