SCHEDULE OF DENTAL BENEFITS
DNTM

Service Type	Description	Coverage %	Annual Deductible	Annual Maximum Benefit (all classes combined)
CLASS A	PREVENTIVE	90% of MAP[1]	$0	$1,000
CLASS B	BASIC	60% of MAP	$50 - Individual $100 - Family	
CLASS C	MAJOR	50% of MAP		

Class A: Routine Preventive and Diagnostic Services

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two per Member each Plan Year.
2. One bitewing x-ray series. Limited to two per Member each Plan Year.
3. One full mouth x-ray. Limit one per Member every three Plan Years.
4. Two fluoride treatments for enrolled dependent children under age 19 each Plan Year.
5. Space maintainers for enrolled dependent children under age 19 to replace primary teeth.
6. Emergency palliative treatment for pain.
7. Sealants on the first and second molars for dependent children from age 5 to 15. One reapplication per tooth is covered.

Class B: Basic Dental Procedures

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. Periodontics (gum treatment).
4. Endodontics (root canal).
5. Extractions. This service includes local anesthesia and routine post-operative care.
6. Recementing bridges, crowns or inlays.
7. Fillings, other than gold.
8. General anesthetics (including nitrous oxide) upon demonstration of Medical Necessity.
9. Antibiotic drugs.

Class C: Major Dental Procedures

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 and repair of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during the 6 month period following the installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of bridgework and removable dentures.

[1] "MAP" stands for Maximum Allowable Payment, as defined in the Summary Plan Document.

7. Repair of bridgework and removable dentures.
8. Rebasing or relining of removable dentures.
9. Implants and/or orthodontia for the treatment of one or more congenitally missing teeth.
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; or
    b. The existing denture is temporary. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

Exclusions

The following are not Covered:

1. Administrative costs of completing claim forms or reports or for providing dental records.
2. Charges for missed dental appointments.
3. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
4. Oral hygiene, plaque control programs or dietary instructions.
5. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except for the treatment of a congenitally missing tooth.
6. Services which are not included in the lists of Covered Dental Services.
7. Orthognathic surgery.
8. Orthodontic treatment, except for the treatment of a congenitally missing tooth.
9. Personalization of dentures.
10. Replacement of lost or stolen appliances.
11. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
12. Cosmetic services.
13. The cost of Covered Dental Services that exceed the Maximum Allowable Payment
14. Covered Dental Services which are not Medically Necessary.