OPEX DENTAL BENEFITS

Dental Percentage Payable

Class A Services-
Preventive……100%

Class B Services-
Basic…….80%

Class C Services-
Major……50%

Dental Implants ……..50%

Class D Services-
Orthodontia up to age 19……..100%

Maximum Benefit Amount

For other than Class D-Orthodontia:

Per person per Calendar
Year……$1,200

For Class D-Orthodontia:

Lifetime maximum per person……..$2,000

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

DENTAL CHARGES
Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

Usual and Reasonable Charge is a charge which is not higher than the 80th percentile of MDR; or in the absence of available data, the 80th percentile of the Physician's Fee Advisory.

A dental charge is incurred on the date the service or supply for which it is made is performed furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services: Preventative and Diagnostic Dental Procedures

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per Covered Person each Calendar Year.
2. One bitewing x-ray series two times per Calendar Year.
3. One full mouth x-ray every 3 Calendar Years.
4. Two fluoride treatments for covered Dependent children under age 19 per Calendar Year.
5. Space maintainers. Includes all adjustments.
6. Emergency palliative treatment for pain.
7. Sealants on permanent molar teeth (one per tooth, for children up to age 14).

Class B Services: Basic Dental Procedures

1. All dental x-rays not listed under Class A services.
2. Special consultation. Consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist.
3. Oral surgery. Includes local anesthesia and routine post-operative care. Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
4. Periodontics (gum treatments).
5. Endodontics (root canals).
6. Extractions. This service includes local anesthesia and routine post-operative care.
7. Recementing bridges, crowns or inlays.
8. Fillings, other than gold.
9. General anesthetics, upon demonstration of Medical Necessity.
10. Antibiotic drugs.
11. Installation of crowns.
12. 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.

Class C Services: Major Dental Procedures

1. Installing precision attachments for removable dentures.
2. Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation.

3. Addition of clasp or rest of existing partial removable dentures.
4. Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.
5. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
6. Repair of crowns, bridgework and removable dentures.
7. Rebasing or relining of removable dentures.
8. 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 in replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
    a. The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.
    b. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
    c. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

Class D Services: Orthodontic Treatment and Appliances:

Orthodontic treatment means the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Such movement of teeth must result from:

1. Overbite or overjet of at least four millimeters;
2. Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp; or
3. Crossbite

This coverage applies to orthodontic treatment (a program to straighten teeth) for a child who is age 19 or less on the date the treatment commences and who is covered for Dental Expense Coverage.

Payments for comprehensive full-banded orthodontic treatment are made in installments up to the lifetime maximum benefit as shown in the Schedule of Benefits.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $300 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Processor at this address:

Insurance Administrator of America, Inc.
PO Box 5082
Mount Laurel, NJ 08054
(800) 989-OPEX

The Claims Processor will notify the Dentist of the benefits payable under the Plan. The Covered Person and Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets you or a Covered Dependent know in advance approximately what portion of the expenses will be considered covered dental expenses by us.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. The 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.
For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

1. **Broken appointments.**
2. **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
3. **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
4. **Experimental procedures.**
5. **Hospitalization charges.** Hospitalization charges including hospital visits.
6. **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
7. **Laboratory tests.**
8. **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
9. **No listing.** Services which are not included in the list of covered dental services.
10. **Orthognathic surgery.** Orthognathic surgery.
11. **Personalization.** Personalization of dentures.
12. **Replacement.** Replacement of lost or stolen appliances.
13. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
14. **TMJ.** Treatment for temporomandibular joint (TMJ) syndrome.
15. **Services** performed prior to the effective date of coverage.