

BUTLER HEALTH PLAN
DENTAL SCHEDULE OF COVERED EXPENSES AND PROVISIONS
EFFECTIVE JANUARY 1, 2012

I. DENTAL CARE BENEFITS

COVERED EXPENSES AND PROVISIONS	Coverage
Calendar Year Deductible	\$25 per Employee \$50 per Employee +1 \$50 per family
Calendar Year Benefit Maximum	\$2,500 per person
Lifetime Orthodontic Benefit Maximum	\$1,800 per person
Deductible Carry-Over	N/A.
Claims Filing Limit	All charges and corresponding requested documentation must be submitted within 15 months of the date incurred.
All benefits are limited to Usual and Customary Charges.	
ALTERNATE TREATMENT	
If more than one method of treatment is possible, the Covered Dental Charges will be limited to the Reasonable and Customary charges appropriate for those services and supplies which are customarily employed nationwide in the treatment of such condition and which are recognized by the dental profession to be appropriate methods of treatment, taking into account the total oral condition of the family member.	
TREATMENT PLAN	
You may wish to have an estimate of benefits payable before beginning treatment for extensive dental work. To receive this estimate, please have your Dentist submit a Treatment Plan to the Plan Administrator before beginning a course of treatment which can reasonably be expected to involve Covered Expenses of \$500 or more.	

II. PREVENTIVE CARE SERVICES

COVERED EXPENSES AND PROVISIONS	Coverage
Preventive Care Waiting Period	0 months
Routine oral examinations <i>Limited to 2 exams per Calendar Year per Covered Person.</i>	100% <u>Deductible waived.</u>
Prophylaxis <i>Includes cleaning, scaling and polishing. Limited to 2 treatments per Calendar Year per Covered Person. Does not include periodontal cleanings (please see Section III for additional benefit coverage).</i>	100% <u>Deductible waived.</u>
Palliative emergency treatment and emergency oral examinations <i>Limited to reduction of fractures, stopping of bleeding and providing relief from pain.</i>	100% <u>Deductible waived.</u>
Dental X-rays <ul style="list-style-type: none"> • Full mouth X-ray (including panoramic/Panorex) - Limited to 1 every 3 Calendar Years per Covered Person. • Bitewings - Limited to 2 per Calendar Year per Covered Person age 17 and under, 1 per Calendar Year per Covered Person age 18 and over. • Other X-rays as deemed Dentally Necessary. 	100% <u>Deductible waived.</u>
Topical fluoride applications <i>Limited to 1 treatment per Calendar Year per Covered Person.</i>	100% <u>Deductible waived.</u>
Topical application of sealants <i>Limited to once per Calendar Year for Covered Persons age 13 and under.</i>	100% <u>Deductible waived.</u>
Tests and lab work	100% <u>Deductible waived.</u>
Space maintainers	100% <u>Deductible waived.</u>
Mouth guards (occlusal night guards) <i>Limited to one per Covered Person for treatment of bruxism.</i>	80%
Expenses Deemed Incurred for Preventive Care Services	<i>Preventive Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed.</i>

III. BASIC CARE SERVICES

COVERED EXPENSES AND PROVISIONS	
	Coverage
Basic Care Waiting Period	0 months
Basic Primary Care Services limited to: <ul style="list-style-type: none"> • <i>Fillings (basic restorations)</i> • <i>Endodontics (root canals)</i> • <i>Repair of removable dentures and bridgework</i> • <i>Adjustments to dentures or bridgework</i> • <i>Re-cementing of crowns, inlays and/or bridgework</i> • <i>Relining and rebasing of dentures</i> • <i>Additions to dentures</i> • <i>Biopsies of oral tissue</i> • <i>Pulp vitality tests</i> • <i>Visits by a Dentist or Physician to a Covered Person's home when Dentally Necessary to render a covered dental service</i> • <i>Consultations</i> • <i>Oral surgery, including pre- and post-operative</i> • <i>Apicoectomy</i> • <i>Hemisection</i> • <i>Alveoplasty</i> • <i>General anesthesia administered in connection with a covered dental service only if administered by an individual licensed to administer general anesthesia, other than the Dentist or Physician performing the service for which such anesthesia is administered.</i> • <i>Injection of antibiotic drugs</i> 	80%
Extractions limited to: <ul style="list-style-type: none"> • <i>Simple extractions not requiring flap or bone removal</i> • <i>Surgical extractions, including erupted, soft tissue impacted, partial bony impacted, complete bony impacted teeth</i> 	80%
Periodontics (gum treatments) limited to: <ul style="list-style-type: none"> • <i>Gingivectomy and gingivoplasty</i> • <i>Gingival curettage</i> • <i>Osseous surgery, including flap entry and closure</i> • <i>Surgical periodontal examination</i> • <i>Muco-gingival surgery</i> • <i>Management of acute periodontal infection and oral lesions (including locally administered antibiotic treatments such as Arestin)</i> • <i>Periodontal cleanings (perio-prophylaxis)</i> • <i>Scaling and root planing (full mouth)</i> 	80%
Expenses Deemed Incurred for Basic Care Services	<i>Basic Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed. Exception: Expenses in the case of root canal therapy shall incur when work is begun on the tooth.</i>

IV. MAJOR CARE SERVICES

COVERED EXPENSES AND PROVISIONS	
	Coverage
Major Care Waiting Period	0 months
Inlays, onlays, gold fillings, gold foil restorations, crowns <i>Limitations: Covered only if the tooth cannot be restored by a filling. Does not include crowns for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion.</i>	60%
Cast post and core <i>Limited to teeth that have had root canal therapy.</i>	60%
Initial dentures, full or partial, and bridgework, fixed and removable, implants <i>Does not include dentures, bridgework or implants for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion.</i>	60%
Replacement of full or partial dentures or fixed bridgework <i>Limitations: Replacement will be covered only if 5 Calendar Years have elapsed since the date of its installation, unless:</i> <ul style="list-style-type: none"> a) <i>Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth, or</i> b) <i>The denture or bridgework, while being worn, has been damaged beyond repair as a result of an accidental Injury received while the patient is covered by this Plan.</i> <i>Does not include replacement of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.</i>	60%

IV. MAJOR CARE SERVICES

COVERED EXPENSES AND PROVISIONS	
	Coverage
<p>Expenses Deemed Incurred for Major Care Services</p>	<p><i>Except as provided in (1), (2) and (3) below, any expense or charge for Major Care Services will be deemed to be incurred as of the date the particular procedure is performed.</i></p> <ol style="list-style-type: none"> <i>1. Expenses for crowns, inlays, onlays or restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided you (or your Dependent) remain continuously insured during the course of treatment.</i> <i>2. Expenses for full or partial dentures or fixed bridgework will be deemed incurred on the date the final impression is taken provided you (or your Dependent) remain continuously insured during the course of treatment.</i> <i>3. Expenses for rebase of an existing partial or complete denture will be deemed incurred on the first day of preparation of the rebase of such denture provided you (or your Dependent) remain continuously insured during the course of treatment.</i>

V. ORTHODONTIC CARE SERVICES

COVERED EXPENSES AND PROVISIONS	
	Coverage
Orthodontic Care Services - <i>Consisting of installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.</i>	
Orthodontic Care Waiting Period	0 months
Diagnostic services <i>Includes examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs.</i>	60% <u>Deductible waived.</u>
Appliances to control harmful habits <i>Limited to one appliance per Covered Person per Lifetime. Does not include mouthguards for bruxism - please see Section II for additional benefit coverage).</i>	60% <u>Deductible waived.</u>
Active orthodontic treatment <i>Includes appliances for tooth guidance - Limited to one appliance per Covered Person per Lifetime.</i>	60% <u>Deductible waived.</u>
Retention treatment <i>Includes orthodontic retention appliances - Limited to one appliance per Covered Person per Lifetime.</i>	60% <u>Deductible waived.</u>

Expenses Deemed Incurred for Orthodontic Care Services	<p><i>Orthodontic Care Services expenses are deemed to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained, except with respect to charges for Orthodontic Treatment.</i></p> <ol style="list-style-type: none"> 1. <i>Charges incurred for diagnosis and evaluation or pre-orthodontic care preliminary to the Course of Orthodontic Treatment are limited to 25% of the total amount of Covered Expenses for the Course of Orthodontic Treatment.</i> 2. <i>With respect to each month of the Course of Orthodontic Treatment, a maximum monthly amount equal to the quotient of the total amount of Covered Expenses incurred for the Course Of Orthodontic Treatment (less the amount calculated above), divided by the maximum number of months necessary upon the installation of the first appliance to complete the Course of Orthodontic Treatment.</i>
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