Summary of Benefits – Dental

The following Deductibles, maximums and benefits are per Participant:

DENTAL BENEFITS

Calendar Year deductible,
per person..... $50.00
per Family Unit..... $150.00

The deductible applies to these Classes of Service:

Class B Services - Basic
Class C Services – Major
Class D Services -Orthodontia

Dental Percentage Payable

Class A Services - Preventive 100%

One exam twice per Calendar Year
Cleaning of teeth twice per Calendar Year
Full-Mouth X-rays – once every 36 months
Bite-wing X-rays twice per Calendar Year
Sealants – dependents up to age 18 – to permanent molar teeth
Space Maintainers – dependents up to age 13
Fluoride treatments twice per Calendar Year – for dependents up to age 26

Class B Services - Basic..... 80%

Extractions, Oral Surgery, Fillings, General and IV Anesthetics, Periodontal Treatment, Endodontics Treatment, Injection of Antibiotic Drugs, Root Canals

Class C Services - Major 50%

Gold Restorations, Crowns, Dentures, Bridges and Pontics

Class D Services - Orthodontia 50%
(Dependent Children up to age 26.)

Maximum Benefit Amount

For Class A, B, and C Services (combined):
Per person per Calendar Year $1,500.00

For Class D - Orthodontia:
Lifetime maximum per person $2,000.00

PRE-DETERMINATION OF DENTAL BENEFITS

Before starting a dental treatment for which the charge is expected to be over **$400,** a predetermination of benefits form is requested but not required. The Dentist must itemize all recommended services and costs.

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

Rocky Mountain Administrators
P.O. Box 788 - 809 South Railway Avenue
Worland, Wyoming 82401
307-347-2606 or 800-383-8808

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

DENTAL BENEFITS

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this section. Dental and Orthodontic expense benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Employee for himself/herself and eligible Dependents.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees.

A. Class 1 Services (Preventative)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), twice per calendar year.
2. Periapical x-rays, as required, and bitewing x-rays twice per calendar year.
3. Sealants for Dependent Children under age Eighteen (18), on the occlusal surface of a permanent posterior tooth, once per tooth.
4. Topical application of fluoride for Dependent Children under age Eighteen (18), but not more than twice per calendar year.
5. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age Thirteen (13). No payment will be made for duplicate space maintainers.
6. Palliative Emergency treatment of an acute condition requiring immediate care.
7. Full mouth x-rays, but not more than once in any period of Thirty-six (36) consecutive months.
8. Panoramic x-rays, but not more than once in any period of Thirty-six (36) consecutive months.
9. Periodontal scaling.

B. Class 2 Services (Basic)

1. All Medically Necessary x-rays.
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore Diseased or accidentally broken teeth. Gold foil restorations are not eligible.
3. Simple extractions.
4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant.
6. Periodontal examinations, treatment and Surgery.
7. Consultations.
8. Repair or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures.
9. Oral surgery.
10. Extractions in connection with orthodontic services.
11. Fillings, other than gold.
12. Antibiotic drugs.

C. Class 3 Services (Major)

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
2. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:

    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable.
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.

3. Stainless steel crowns.

D. Class 4 Services (Orthodontia)

Orthodontic services will be eligible only when provided to covered Dependents who are under age nineteen (19) when treatment is received.

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan.
2. Interceptive, interventive or preventive orthodontic services.
3. Fixed and removable appliance placement, and active treatment per month after the first month.

Exclusions and Limitations

The following exclusions and limitations are in addition to those set forth in the sections entitled “General Limitations and Exclusions,” and “Summary of Benefits.”

Adjustments. Charges arising from alteration of dimension or occlusion; to address damage arising from abrasion or attrition; splinting and/or temporomandibular joint disturbances.

Administrative Costs. For administrative costs of completing claim forms or reports or for providing dental records.

After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates. Predetermination of an allowable course of treatment and eligible services (claims for which coverage would be in effect had coverage not terminated) will not extend coverage beyond termination. The Plan will pay for a prosthetic device, crown, such as full or partial dentures, if the preparatory steps (such as an impression) had already initiated and/or been prepared for said device or crown, while the patient was a Participant in the Plan; so long as the device or crown is delivered and installed within two months following termination of coverage, as well as root canal therapy if the Dentist opened the tooth while the patient was a Participant, and treatment is completed within two months of coverage termination.

Anesthetic. Local infiltration anesthetic when billed for separately by a Dentist.

Broken Appointments. For charges for broken or missed dental appointments.

Cosmetic. Charges for cosmetic dental work, exclusive of Orthodontic Treatment if otherwise eligible for coverage, but inclusive of personalization or characterization of dentures or veneers or any cosmetic procedures or supplies.

Crowns. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

Education. Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program.

Experimental. That are Experimental or Investigational, based upon standards set by the American Dental Association.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Implants. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants except, first-time non-cosmetic dental implants.

Late Enrollee. Charges Incurred during the first 24 months of coverage applicable to a late enrollee. This exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Participant. “Late enrollee” means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

Medical Benefits. For charges covered under the "Medical Benefits" section of the Plan.

Miscellaneous. The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

Missing Appliances. The cost of replacing lost, missing or stolen supplies, including implants, appliances, and prosthetics.

More Expensive Course of Treatment. The aforementioned rules regarding Medical Necessity, Usual and Customary, and the least costly yet equally effective treatments shall apply here as well.

No Listing. For services which are not included in the list of covered dental services.

Not Recommended. Charges for services or supplies not administered in accordance with a Dentist or Physician’s approval.

Orthognathic Surgery. For Surgery to correct malposition’s in the bones of the jaw.

Personalization. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

Replacements. Charges for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Participant, resulting in damages that are beyond repair.

Single Provider Care. Charges arising from solely the transfer from one Provider’s care to another, that would not have been Incurred had one Provider been utilized, and thereby in accordance with the Usual and Customary fee.

Splinting. For 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.

Pre-determination of Dental Benefits

If a planned dental service or Participant's proposed course of treatment can be reasonably expected to involve dental charges of $400 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.**