Meadows Regional Medical Center Employee Healthcare Plan
Open Enrollment Quick Reference Summary
Effective January 1, 2013

Dental Benefit Year: Jan 1 through Dec. 31, 2013

Calendar Year Maximum Per Person	$1000.00 per covered Individual
Lifetime Maximum Per Person for Orthodontic Services	$1000.00 per covered Individual
PREMIUMS (per pay period)	
Employee	$14.70
Employee + Spouse	$29.40
Employee + Child(ren)	$32.55
Employee + Family	$46.20
Calendar Year Deductible Per Covered Individual	
Type B: Restorative & Surgical	$50.00
Type C: Prosthodontic Procedures	$50.00
COINSURANCE	
Type A: Diagnostic & Preventive	100% of Usual & Customary
Type B: Restorative & Surgical	80% of Usual & Customary
Type C: Prosthodontic Procedures	50% of Usual & Customary
Type D: Orthodontia Procedures	50% of Usual & Customary
WAITING PERIOD FOR LATE ENROLLEES	
Type A: Diagnostic & Preventive	Covered Once Coverage is in Force
Type B: Restorative & Surgical Type C: Prosthodontic Procedures Type D: Orthodontia Procedures	One (1) Year Waiting Period

Plan Payment Provisions - Dental

The following is a complete list of Covered Dental Procedures under this Dental Expense Benefit. Any procedure not listed is excluded.

Type A: Diagnostic & Preventive

Preventive, diagnostic, emergency or palliative services and some corrective surgical procedures.

Twice in any 12 month period:

* Recall oral examinations
* Bitewing x-rays
* Prophylaxis
* Topical Fluoride application

Once During any 36 month period:

* One complete initial oral examination, diagnosis & charting
* One complete series of x-rays, or pantographic x-rays

In addition, to the above, as required:

* Emergency or specific examinations
* X-ray to diagnose a symptom or to examine progress of a particular course of treatment, other than x-rays required for root canal therapy
* Required consultations with another dentist or specialist
* Emergency or palliative services
* Diagnostic tests and laboratory examinations, other than x-rays, study models or similar records prepared for root canal therapy
* Provision of space maintainer for missing primary teeth for dependent children under age 16. Benefits limited to the initial appliance
* Appliances to correct harmful habits

Type B: Restorative & Surgical

* Diagnostic casts and tissue biopsy
* Dental sealants for children under age 16, limited to once per 36 month period
* Fillings - amalgam composite, acrylic or equivalent
* Removal of teeth, other than impacted teeth
* Performed stainless steel crowns and repairs to preformed stainless steel crown, for primary teeth only
* Endodontics - (root canal therapy)
* Periodontics - (treatment of the gums, and other supporting tissues of the teeth)
* Repair of bridges or dentures
* Re-base or reline of an existing partial or complete denture conjunction with a cutting procedure
* Oral surgery, and related anesthesia (includes extractions) partial or bony impactions, will be paid under major medical
* Occlusal Adjustment
* General Anesthesia when administered in dentist's office in conjunction with a cutting procedure

Type C: Prosthodontic Procedures

* Inlays and Onlays
* Crowns, and repairs to crowns (other than preformed stainless steel crowns which is a Type B expense)
* Prosthodontic Services - Construction and insertion of bridges and dentures, except those expenses for initial installation of bridgework or dentures whose sole purpose is to replace natural teeth extracted prior to becoming insured under the plan
* Denture Repair

Type D: Orthodontia Procedures

* Orthodontic care or treatment provided to you or your insured dependents, up to any maximum age or other limitations specified in the Schedule of Benefits