Dodge County Hospital Employee Healthcare Plan
Open Enrollment Quick Reference Summary
Effective January 1, 2013

Dental Coverage

Calendar Year Maximum	$1,000 per covered Individual
Lifetime Maximum for Orthodontic Services	$1,200 per covered Individual (not to exceed $600 in annual benefits)

PREMIUMS (per pay period)		
	Dental Only	**Dental + Optional Ortho**
Employee	$2.54	–
Employee + 1	$5.20	$5.89
Family	$7.27	$9.23

Calendar Year Deductible Per Covered Individual (Waived for Diagnostic and Preventive)	
Type B – Basic Procedures	$50
Type C – Major Procedures	$50

COINSURANCE	
Type A – Diagnostic and Preventive	100% of Usual & Customary
Type B – Basic Procedures	80% of Usual & Customary
Type C – Major Procedures	80% of Usual & Customary
Type D – Orthodontia Procedures	50% of Usual & Customary

WAITING PERIOD FOR LATE ENROLLEES	
Type A – Diagnostic and Preventive Type B – Basic Procedures Type C – Major Procedures	Covered Once Coverage is in Force
Type D – Orthodontia Procedures	One (1) Year Waiting Period

Plan Payment Provisions – Dental

The following is a summary of Covered Dental Procedures under this Dental Expense Benefit. For the complete listing, consult your Plan Document.

Type A: Diagnostic and Preventive

- Oral examination (one each six month period)
- Prophylaxis (Cleaning of teeth, including scaling and polishing; twice per calendar year)
- Topical Fluoride application (Applicable only to dependent children; once per calendar year)
- Space maintainers (Applicable only to children under age 14)
- Topical application of sealers (Applicable only to children under age 14; covered once each quadrant in each four year period)
- Intraoral X-Rays
  - One complete series of x-rays (once each three year period)
  - Bitewing x-rays (twice per calendar year)
  - Occlusal
  - Periapical
- Extraoral X-Rays (Only one of the listed extraoral procedures is covered twice in one calendar year)
  - Panoramic
  - Sialography
  - TMJ
  - Cephalometric film
  - Posteroanterior and lateral skull and facial bone survey
- Biopsy of oral tissue
- Diagnostic test (once each two year period)

Type B: Basic Procedures

- Fillings (amalgam, silicate, plastic, or composite)
- Stainless steel crown
- Oral Surgery
  - Extraction of non-impacted teeth
  - Removal of dental cysts and tumors
  - Tooth replantation
- Periodontic Services (Only one of the listed surgical procedures will be covered for each quadrant per calendar year)
  - Gingivectomy
  - Osseous surgery
  - Scaling and root planting (twice each quadrant in one calendar year)
- Endodontic Services
  - Pulp cap
  - Root canal therapy, including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care
  - Retrograde filling
- General Anesthesia
- Repairs to bridges and full or partial dentures
- Recementing inlay, crown, bridge, or space maintainer

Type C: Major Procedures

- Inlays and Onlays
- Crowns (other than stainless steel crowns which is a Class II expense)
- Fixed bridges
- Dentures – full or partial

Initial placement of fixed bridges or dentures (full or partial) to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this Plan for 24 consecutive months, unless the fixed bridgework or dentures (full or partial) also included replacement of a natural tooth extracted while covered.

Replacement of fixed bridges or dentures (full or partial) is covered only if the original bridge or existing denture cannot be made serviceable and (a) the individual has been covered under this Plan for at least 12 consecutive months, and (b) five years have elapsed since the last placement.

Type D: Orthodontia Procedures

Eligible expenses are those incurred for diagnosis, surgical therapy, and appliance therapy. This includes related oral exams, surgery, and extractions; however, these will be an eligible expense only if the insured dependent child is under the age of 19 and the treatment is for:

- Overbite or overjet of at least four millimeters
- Maxillary and mandibular arches in ether protrusive or retrusive relation of at least one cusp
- Cross-bite
- An arch length difference of more than four millimeters in either the maxillary or mandibular arch
- Bimaxillary protrusion of 10 millimeters or more

DENTAL TREATMENT PLANS THAT ARE EXPECTED TO EXCEED $200 MUST BE PRE-AUTHORIZED