

Dodge County Hospital Employee Healthcare Plan
Open Enrollment Quick Reference Summary
Effective January 1, 2012

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	\$2.42	–
Employee + 1	\$4.95	\$5.61
Family	\$6.92	\$8.79
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	Type B: Basic Procedures	Type C: Major Procedures	Type D: Orthodontia Procedures
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> One complete series of x-rays (once each three year period) Bite wing 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) <ul style="list-style-type: none"> Panoramic Sialography TMJ Cephalometric film Posteroanterior and lateral skull and facial bone survey Biopsy of oral tissue Diagnostic test (once each two year period) 	<ul style="list-style-type: none"> Fillings (amalgam, silicate, plastic, or composite) Stainless steel crown Oral Surgery <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Gingivectomy Osseous surgery Scaling and root planting (twice each quadrant in one calendar year) Endodontic Services <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Inlays and Onlays Crowns (other than stainless steel crowns which is a Class II expense) Fixed bridges Dentures – full or partial <p>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.</p> <p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> Overbite or overjet of at least four millimeters Maxillary and mandibular arches in either 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