Liberty Regional Medical Dental Plans

Liberty Regional Medical Center offers two dental plan choices for you and your dependents. There is no dental network, so you can visit any dentist you choose. For any questions, please call Core at 1-888-741-2673.

Dental Plan Summary

Plan Details	Basic Plan: DE-100905A	Preferred Plan: DE-100905B
Calendar Year Deductible	$50 per person Applies to Basic Services	Applies to Basic & Major Services $50/Person
Preventative Services	Covered at 100%	Covered at 100%
Basic Services	Covered at 80% (you pay 20%)	Covered at 80% (you pay 20%)
Major Services	Not Covered	Covered at 50% (you pay 50%)
Calendar Year Maximum	$1,000	$2,000
Orthodontia (to age 19)	Not Covered	Covered at 50% (you pay 50%) Lifetime maximum of $1,000

Dental Care Schedule of Benefits

Dental Care Benefits Eligibility

See Eligibility and Effective Date of Coverage section for Dental Plan Enrollees.

Covered Types of Dental Care:

Type A: Diagnostic and Preventive

Type B: Basic Procedures

Type C: Major Procedures

Type D: Orthodontia Procedures (to age 19 and $1,000 Lifetime maximum)

Calendar Year Deductible

Basic: $50 per person, applies to Basic Services

Preferred: $50 per person, applies to Basic and Major Services

Calendar Year Maximum

Basic: $1,000 per person

Preferred: $2,000 per person

Coinsurance

The Calendar Year Coinsurance for This Plan is as follows:

	Basic	Preferred
Type A:	100% of Allowable Charge	100% of Allowable Charge
Type B:	80% of Allowable Charge	80% of Allowable Charge
Type C:	50% of Allowable Charge	50% of Allowable Charge
Type D:	Not Covered	50% of Allowable Charge

Benefits from Other Sources

For instance, your dependent may be covered by this plan and a similar plan through your Spouse's Employer. If your dependent is, we coordinate our benefits with the benefits from the other plans. We do this so no one gets more in benefits than the charges incurred. Read **"**Coordination of Benefits" for details.

Plan Payment Provisions – Dental

PRE-TREATMENT DETERMINATION

It is required that a Dental Treatment Plan be filed before treatment begins when charges for a period of dental treatment (other than emergency treatment) are expected to exceed $200. The phone number for pre-authorization is 1-888-741-2673.

COVERED CHARGES

Covered charges will be the actual cost charged to you or your Dependent for treatment or service, but not more than the prevailing charge. Also:

- If it is determined that more than one procedure could be performed to correct a dental condition, covered charges will be limited to the maximum allowance for the least

expensive of the procedures that would provide professionally acceptable results.

- Covered charges will include only those charges for treatment or services that begin (as defined in the following provision) while you and your Dependents are covered under this Plan.
- Covered charges will include only those charges for treatment or service that is completed while you and your Dependents are covered under the Plan.

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

TYPE A – Diagnostic and Preventive

- EXAMINATIONS – Oral Examination - Only one oral examination (other than emergency examination) will be covered in each six (6) month period.
- RADIOGRAPHS
  - Intraoral X-Rays
    - Complete Series - Covered once each three (3) year period
    - Bitewing - Only two (2) will be covered in a calendar year
    - Occlusal
    - Periapical
  - Extraoral X-Rays - Only one (1) of the listed extraoral procedures will be covered twice in a calendar year
    - Panoramic
    - Sialography
    - TMJ
    - Cephalometric film
    - Posteroanterior and lateral skull and facial bone survey
  - Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Class I covered charges
- PREVENTIVE SERVICES
  - Prophylaxis (Cleaning of teeth, including scaling and polishing) - Covered twice in a calendar year
  - Topical application of fluoride (including prophylaxis) - Applicable only to Dependent Children. Only one application will be covered each calendar year- Applicable only to children under age fourteen (14)
  - Space maintainers - Applicable only to children under age fourteen (14)
  - Topical application of sealers - Applicable only to children under age fourteen (14) - Covered once each quadrant in each four (4) year period
- OTHER SERVICES
  - Biopsy of oral tissue
  - Palliative treatment - Covered as a separate procedure only if no other service (except x-rays) is provided during the visit

- Bacteriologic culture
- Histopathologic examination
- Pulp vitality test
- Diagnostic test - Covered once each two (2) year period

TYPE B – Basic Procedures

- RESTORATIONS
  - Fillings (Amalgam, silicate, plastic or composite, including pin retention when necessary)
  - Stainless steel crown
- ORAL SURGERY
  - Extraction of non-impacted teeth
  - Alveoplasty
  - Removal of dental cysts and tumors
  - Surgical incision and drainage of dental abscesses
  - Other surgical procedures
  - Tooth replantation
  - Surgical exposure to aid eruption
  - Surgical repositioning of teeth
  - Excision of hyperplastic teeth
- PERIODONTIC SERVICES
  - Surgical procedures - Only one (1) of the listed surgical procedures is covered for each quadrant per calendar year
    - Gingivectomy
    - Gingival curettage
    - Osseous surgery
    - Osseous graft
  - Scaling and root planting (full mouth) - Twice each quadrant in a calendar year
  - Periodontal appliance - One appliance each three (3) year period
  - Periodontal prophylaxis
- ENDODONTIC SERVICES
  - Pulp cap
  - Vital pulpotomy
  - Root canal therapy, including treatment plan, diagnostic x-rays, clinical procedures and follow-up care
  - Apexification
  - Apicoectomy
  - Retrograde filling
  - Apicoectomy and retrograde filling covered as a separate procedure only if performed more than one (1) year after root canal therapy is complete
  - Apical curettage
  - Root resection
  - Hemisection
- ANESTHESIA
  - General Anesthesia - Covered as a separate procedure only when required for complex oral surgical procedures covered under the Plan (and only when not performed in

Hospital)

- OTHER SERVICES
  - Repairs to bridges and full or partial dentures
  - Adding tooth to partial denture
  - Relining full or partial dentures (upper or lower) - Covered only if relining is done more than one (1) year after the initial installation, and then not more than once each two (2) year period
  - Recementing inlay, crown, bridge, or space maintainer
  - Consultation with specialist
  - Antibiotic drug injection

TYPE C – Major Procedures

- RESTORATIONS
  - Gold foil
  - Gold inlays and onlays
  - Gold restorations - Covered only if the tooth cannot be restored by a silver filling and, for replacements, at least five (5) years have elapsed since the date of the last placement
  - Porcelain inlay
  - Crowns (single restoration only)
    - Plastic (acrylic)
    - Plastic, prefabricated
    - Plastic with non-precious metal
    - Plastic with semi-precious metal
    - Plastic with gold
    - Porcelain with non-precious metal
    - Porcelain with semi-precious metal
    - Porcelain with gold
    - Gold (3/4 cast)
    - Gold (full cast)
    - Non-Precious metal (full cast)
    - Semi-Precious metal (full cast)
    - Crowns are covered only if the tooth cannot be restored by a filling and, for replacements, at least five (5) years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimensions or restoring occlusion are not covered.
  - Cast post and core - Covered only for teeth that have had root canal therapy. Steel post and composite or amalgam
- PROSTHODONTICS, FIXED
  - Fixed bridges - Replacement of fixed bridges is covered only if (a) the original bridge cannot be made serviceable and (b) five (5) years have elapsed since the last placement.
- PROSTHODONTICS, REMOVABLE
  - Full or partial dentures - Replacement of a full or partial removable denture will be covered only if (a) the existing denture cannot be made serviceable and (b) five (5) years have elapsed since the last placement. Covered charges do not include any additional charges for overdentures or for precision or semi-precision attachments.

TYPE D – Orthodontia Procedures (*OPTIONAL COVERAGE*)

If elected, eligible expenses under Orthodontic Services are those incurred for diagnosis, surgical therapy, and appliance therapy. This includes related oral exams, surgery and extractions. But these will be an eligible expense only if the insured Dependent child is under the age of nineteen (19) and the treatment is for:

- 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; or
- Bimaxillary protrusion of 10 millimeters or more.

BEGINNING DATE OF TREATMENT

Treatment or service will be considered to begin:

- For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
- For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
- For full or partial dentures, on the date the master impression is made; and
- For all other, on the date the treatment or service is performed.

General Limitations and Exclusions – Dental

Except as specifically stated, no benefits will be payable under this Plan for:

1) **Analgesia** – Separate charges for pre-medication, local anesthesia, analgesia, or conscious sedation.
2) **Appliances** – Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.
3) **Congenital or Development Conditions** – The treatment of congenital (hereditary) or developmental (following birth) malformations.
4) **Cosmetic Dentistry** – Treatment rendered for cosmetic purposes.

NOTE: The maximum allowance for a necessary crown or pontic posterior to the second bicuspid will be the allowance for a gold crown or pontic. That is, facings on molar crowns will be considered cosmetic and will not be covered.

5) **Crowns** – Crowns placed for the purpose of periodontal splinting.
6) **Customized Prosthetics** – Precision or semi-precision attachments, overdentures, or customized prosthetics.
7) **Discoloration Treatment** – Any treatment to remove or lessen discoloration except in connection with endodontia.
8) **Excess Care** – Services, which exceed that necessary to achieve acceptable level of dental care. If the Plan Administrator determines that alternative treatment could be (could have been) provided for the least costly procedure (s) which would produce a professionally satisfactory result.
9) **Duplicate prosthetic devices or appliances** – Temporary crowns, temporary partials, temporary bridgework and temporary dentures.
10) **Excess Charges** – Charges in excess of the Reasonable charges for dental services or supplies.
11) **Experimental Procedures** – Services which are considered experimental or which are not approved by the American Dental Association.
12) **Grafting** – Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).
13) **Implants** – Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
14) **Lost or Stolen Prosthetics or Appliances** – Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
15) **Medical Plan Coverage** – Any dental services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan.
16) **Myofunctional Therapy** – Muscle training therapy or train to correct or control harmful habits.
17) **Non-Professional Care** – Services rendered by other than a dentist (D.D.S or D.M.D) or a dental hygienist or x-ray technician under the supervision of a dentist.
18) **Occlusal Restoration** – Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh) or change vertical dimension, except as outlined in Type D.
19) **Oral Hygiene Counseling** – Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, water-piks, and mouthwashes.
20) **Orthognathic surgery.**
21) **Personalization or Characterization of Dentures.**
22) **Prescription Drugs** – Prescription drug coverage is provided only under the terms of the Medical portion of this Plan, if any.
23) **Prior to Effective Date** – Charges for courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.
24) **Prosthetics** – Initial placement of a prosthetic (i.e., a bridge, partial or full denture, including crowns or inlays used as abutments) for teeth extracted/lost prior to the effective date of coverage under this Plan or the prior plan of the Employer. Replacements will only be covered if the original is at least five years old and no longer serviceable or damaged in an accident while covered.
25) **Addition of teeth to partial dentures or fixed bridgework**, except for the replacement of teeth

which are extracted while the person is covered under the Plan. Also, adjustment of prosthetic appliances within six (6) months of initial installation and not included in the cost of such appliance.

26) **Sealants** – Materials applied to the teeth to seal developmental imperfections, such as pits and fissures. (Covered up to age sixteen (16).)
27) **Service or Supply** not shown on the Schedule of Covered Procedures.
28) **Splinting** – Wiring or bonding teeth or crowns to act as a splint for any reason.
29) **Treatment or services:**
    a) for malignancies, cysts and neoplasm's.
    b) which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage, or that is paid for or furnished by the United States Government or one of its agencies (except Medicaid).
    c) that results from war or act of war, or from voluntary participation in criminal activities.
    d) incurred for any condition for which a Covered Person is eligible for coverage or benefits under Workers' Compensation, Occupational Disease law, or similar law.
30) **Temporomandibular Joint Dysfunction / Maxillofacial Surgery** – Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or for the prevention of Temporomandibular Joint Dysfunction Syndrome, including the correction of abnormal positioning and relationship of teeth. **(See also Medical Plan section)**

NOTE:

No benefits will be payable for a prosthetic where the impression(s) was taken during the last thirty (30) days of eligibility. In addition, no benefits will be payable for prosthetics that are placed after the termination date of coverage, regardless of when the impression was taken.