SALYER AMERICAN
EMPLOYEE DENTAL PLAN SCHEDULE OF BENEFITS

DENTAL BENEFITS

Plan Year deductible, per person	$25.00
per family	$75.00
Dental Percentage Payable	
Class I Services-Preventive & Diagnostic (Deductible Waived)	100%
Class II Services-Basic	80%
Class III Services-Major	50%
Maximum Benefit Amount	
Per person per Plan Year	$1,200

COVERED DENTAL SERVICES

CLASS 1 – PREVENTIVE & DIAGNOSTIC

Office visits and examinations

- Initial or periodic oral exam – limited to one examination in a six consecutive month period.
- Emergency palliative treatment and other non-routine, unscheduled visits

Prophylaxis and Fluoride Treatments

- Prophylaxis – limited to one treatment in a six consecutive month period.
- Topical application of fluoride

X-rays

- Bitewing – limited to a maximum of 1 series in any six consecutive month period to age 19. After age 19, limited to 1 series in any 12 consecutive months.
- Extraoral superior or inferior maxillary film.
- Full mouth x-rays – limited to once in a two year period.
- Other intraoral periapical or occlusal single films.
- Panoramic film, maxilla and mandible – limited to once in a two year period..

Sealants – limited to covered children 16 and under, for posterior multi-surface teeth only.

Space Maintainers – Limited to space maintenance for unerupted teeth and following extraction of primary teeth.

CLASS II – BASIC DENTAL SERVICES

Diagnostic Services

- Diagnostic casts
- Biopsy and examination of oral tissue

Office Visits and Examinations

- Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any 12 consecutive month period, and only if no other service is rendered during the visit.

Restorative Services

- Amalgam and synthetic restorations

Periodontic Services (gum treatments)

- Gingivectomy
- Sub-gingival curettage and root planing, per quadrant
- Osseous surgery
- Occlusal adjustment not involving restorations and done in conjunction with Periodontic surgery.
- Periodontal scaling and root planning

Endodontic Services – allowance includes routine x-rays and cultures, but excludes final restoration.

- Pulp capping, direct
- Root canal therapy
- Apicoectomy
- Vital Pulpotomy
- Remineralization (calcium hydroxide) as a separate procedure.

Oral Surgery – allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

- Extractions – uncomplicated or surgical removal of erupted or impacted teeth
- Other surgical procedures

Other services

- General anesthesia in conjunction with surgical procedures only
- Injectable antiobiotics needed solely for treatment of a dental condition.

CLASS III – MAJOR DENTAL SERVICES

Restorative services

- Gold fillings
- Inlays, Onlays
- Crowns and Posts

Prosthodontic Services

- Denture repair
- Denture rebasing or relining – limited to services performed more than six (6) months after initial placement, and not more often than once in any two years.
- Denture adjustments –
- Tissue Conditioning –
- Adding teeth to partial dentures to replace extracted natural teeth
- Repairs to crowns and bridges –
- Crown Replacement –
- Fixed or removable bridges
- Dentures – Full or Partial –
- Replacement – replacing an existing or removable partial or full denture or fixed bridgework only if one of the following requirements are met
    - The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
    - The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.
    - The replacement or addition of teeth is required to replace one or more additional natural teeth extracted after becoming insured with this employer.

The replacement or alteration is necessary because of oral surgery.

ALTERNATE TREATMENT

If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

EXCLUSIONS A charge for the following is not covered:

- Charges for all hospital costs and any additional fees charged by the Dentist for Hospital treatment.
- Charges in excess of the Reasonable and Customary Charge.
- Treatment by other than a Licensed Dentist, except charges for dental prophylaxis performed by a dental hygienist under the treatment and direction of a dentist.
- Charges for prescribed drugs.
- Charges for appointments not kept or for completion of claims forms.
- Orthodontic treatment
- Replacing a lost, stolen or missing appliance or prosthetic device.
- Treatment rendered for cosmetic purposes.
- Any service, including any type of prosthesis, started prior to the effective date of this Plan or prior to the date the individual became covered with this employer.
- Services and supplies received after the termination of coverage under this plan except for prosthetic devices which are ordered while insured and delivered within thirty (30) days after termination.

Dental accident benefits provided more than 180 days following the date of the accident, and any services for conditions caused by an accident occurring before the eligibility date.