III. Dental Program

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About This Section

Good dental care is essential to your good health, but it can be expensive. By seeing your dentist regularly for routine check-ups, you can often identify minor problems before they become serious and more costly. The dental program options help protect your health by encouraging preventive and diagnostic dental care. This section describes the dental coverage available to you and your family.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims, your right to continue health care coverage when coverage is lost and your rights under ERISA.

An Overview of Your Dental Program Options

The dental program pays all or part of the cost toward a wide range of dental services and supplies for treatment of dental disease, dental defect and accidental injury to the teeth or mouth. You have a choice of coverage through Delta Dental and Cigna (where available). You also have the option of waiving coverage under the Plan.

Each option covers the same types of services, which fall into four broad categories.

- **Preventive and Diagnostic Services** – including routine oral exams, cleanings, fluoride treatment for children under age 19, full-mouth x-rays, bitewing x-rays and space maintainers
- **Basic Services** – including periodontics (gum treatment), root canal therapy, restorative dentistry including fillings and denture repairs.
- **Major Services** – including crowns, bridges and dentures.
- **Orthodontic Services** – including braces and other treatments and appliances to straighten teeth (for adults and dependent children).

The Cigna plan is a dental health maintenance organization (DHMO). The chart below compares the dental options.

Services	***Delta Dental PPO (Premier Network or PPO Network)***		***Cigna DHMO***
	In-Network	***Out-Network (up to R&C)***	***In-Network Only***
Annual Deductible *Does not apply to preventive and diagnostic services*	$50 individual $150 family	$50 individual $150 family	None None
Annual Maximum	$2,000		None
Prev & Diagnostic Services	100% in-network	100% in-network	100%
Basic Services (including endodontics, periodontics & simple surgery)	80% after deductible	80% after deductible	Copays vary by service. Please refer to the Cigna DHMO Patient Charge Schedule available at pearsonbenefitsus.com
Major Services (including prosthetics and repairs/adjustments & complex surgery)	50% after deductible	50% after deductible	
Ortho (children & adults)	50%, no deductible	50%, no deductible	
Ortho Lifetime Maximum	$2,500 per person		

Delta Dental Option

The covered services and applicable limits below apply to Delta Dental.

Preventive/Diagnostic Care

- Oral examinations: two per calendar year
- Prophylaxis (cleanings): two per calendar year
- Topical fluoride applications: one treatment per calendar year for dependent children up to the 19th birthday
- Bitewing x-rays: Twice per calendar year
- Full mouth x-rays: one per 60 months
- Space maintainers: for dependent children up to age 19
- Sealants: one application of sealant material every 60 months for each non-restored, non-decayed lst and 2nd molar of a dependent child up to age 19

Basic Restorative Care

- Fillings
- Simple extractions
- Consultations twice per year
- Crown, denture and bridge repair
- Endodontics: root canal treatment limited to once per tooth per 24 months
- Periodontics: periodontal scaling and root planning one per quadrant, every 24 months; periodontal surgery once per quadrant, every 36 months. Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
- Injections of antibiotic drugs
- Relining and rebasing of existing removable dentures, but not more than once per 36 months.

Major Restorative Care

- General anesthesia: when dentally necessary in connection with oral surgery, extractions or other covered dental services
- Oral Surgery
- Bridges and dentures: initial placement to replace one or more natural teeth which are lost while covered by the Plan; dentures and bridgework replacement once every seven years; replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed; dentures or bridges to replace congenitally missing teeth if member has been continuously enrolled for 24 months.
- Crowns/inlays/onlays: replacement limited to once every seven years.
- Dental implants – every seven years

Orthodontics

- Diagnostic procedures and appliances to realign the teeth.

How the Plan Works

When you enroll in Delta Dental, you have a choice of using in-network or out-of-network dental providers. The Plan will pay a percentage of covered services as outlined in the chart on page 2, up to a maximum benefit of $2,000 per person per year. There is no deductible for preventive or diagnostic care, but you must meet an annual deductible before the plan begins to pay for most other services.

In-network services are based on a discounted fee, so you will save money by paying a percentage of the discounted fee. In network dentists have agreed to accept the Delta Dental payment as payment in full. You will not be responsible for any charges above Delta Dental's discounted fee. Using an in-network provider is an easy way to save money. You have access to two Delta networks: the Delta PPO network and the Delta Premier network. The difference in networks is the size. If you choose a provider in the smaller Delta PPO network, you will pay less out of pocket. If you use the larger Delta Premier network, you will have slightly higher costs. You can obtain a list of current Delta Dental participating providers at www.deltadentalmn.org or by calling 1-800-448-3815.

Out-of-network services are based on the reasonable and customary (R&C) charge for a service. You are responsible for any charges in excess of R&C.

Pre-treatment Estimate

If your dentist recommends treatment that is likely to cost $300 or more, you should ask your dentist to submit a pre-treatment estimate. A pre-treatment estimate enables you and your dentist to know how much the Plan will pay before the treatment starts. This is especially prudent if you are considering major services or orthodontic procedures. Both you and your dentist will know beforehand which services will be approved and the benefit amounts that will be paid.

Your dentist can obtain a "real-time" pre-treatment estimate online or over the phone within minutes, detailing what your plan will cover and at what payment level. Alternatively, you can obtain a pre-treatment estimate by submitting a completed dental claim form, leaving the dates of service blank and checking the box called "Pre-Treatment Estimate." The form should be submitted to Delta Dental, at the address on the claim form, prior to the commencement of the course of treatment. You or your dentist can contact Delta Dental at 1-800-448-3815 with any questions about the pre-treatment estimate process.

Orthodontia

Orthodontic treatment is covered for adults and dependent children. Benefits are payable at 50% with no deductible. There is a lifetime maximum of $2,500 per person. (Orthodontic related tooth extractions do not count toward this maximum.) Under Delta Dental, benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted. Orthodontic benefits end at cancellation of coverage or when the lifetime maximum benefit has been paid.

Work in Progress

Delta Dental pays benefits based on the service completion date, including work-in-progress.

Extension of Coverage

Under Delta Dental, benefits end on the day your coverage ends. You may elect COBRA continuation to extend your benefits.

Claiming Benefits

If you use a network provider, the provider will file for reimbursement for you. If you choose a non-network provider, you or your provider must file the claim after receiving the care or service. You can obtain a Delta Dental out-of-network claim form at www.deltadentalmn.org or by calling 1-800-448-3815.

If a claim is denied, you may request a review of the denial. See the *Benefits Highlights* section of this document for more information on filing claims.

Dental Health Maintenance Organization (DHMO)

The Dental Health Maintenance Organization (DHMO), administered by Cigna, covers a full array of dental treatment and services.

How the Plan Works

The DHMO generally covers the same services as the Delta Dental option. However, you must use providers associated with the DHMO (except in the case of emergencies) in order to receive benefits. If you do not use a DHMO provider, you will not receive benefits from the Plan.

Under the DHMO, you have no deductibles to meet, no annual maximums, and no claim forms to complete.

Most preventive and diagnostic care, as well as certain restorative procedures, are covered at 100%. For other services, you are generally responsible for a copayment, the amount of which varies based on the specific procedure. You can obtain a Patient Charge Schedule that lists covered procedures and the corresponding patient charges from the benefits website or by calling Cigna at 1-800-842-4221.

Using Participating Providers

You select your DHMO primary care dentist during enrollment. You may select a different primary care dentist for each covered family member. After enrollment, you will receive an ID card, which lists your DHMO dentist's name and phone number. In order to obtain care from a network specialist, you must obtain a referral from your primary care dentist, and your treatment plan must be approved by Cigna.

Emergency treatment by any licensed dentist is covered if you are out of your service area and need to see a dentist right away.

You can obtain a list of current participating providers online at www.cigna.com or by calling 1-800-842-4221.

Orthodontia

The DHMO covers diagnostic procedures and appliances to realign the teeth for adults and dependent children. Payment information is listed on the Patient Charge Schedule.

Work in Progress

Generally, the DHMO plan does not cover work-in-progress, including:

- Crowns and fixed bridgework when the teeth were prepared prior to the start date of your coverage in this Plan
- Appliances when the impression was taken prior to the start date of your coverage in this Plan
- Root canal therapy when the pulp chamber was opened prior to the start date of your coverage in this Plan
- Orthodontic treatment when an active appliance has been placed prior to the effective date of your coverage in this Plan.

Extension of Coverage

If your coverage ends during a course of treatment, you and your covered dependents are eligible for limited dental benefits after you stop working for the Company. To be covered, the treatment must be delivered within the timeframe specified by Cigna and must not be covered through another employer. Eligible charges include the following:

- Charges for an appliance, or alteration if the impression was made while you or your dependents were covered by the Plan
- Charges for a crown, bridge or gold restoration if the tooth was prepared while you or your dependents were covered by the Plan
- Charges for root canal therapy if the pulp chamber was opened while you or your covered dependents were covered by the Plan.

Services Not Covered

The following list is intended to give you a general description of the services and supplies not covered under any of the dental options. There may be services and supplies in addition to these that are not covered by the Plan. Some expenses not covered by the Plan may be eligible for reimbursement through the health care flexible spending account. See the *Flexible Spending Accounts* section of this document for more information.

Services not covered under any of the dental program options include:

- Services not reasonably necessary or not customarily performed
- Treatment not furnished by a dentist. This does not apply if the service is performed by a licensed dental hygienist under the direction of a dentist

- Services furnished by government plans
- Replacement or modification of a denture or a bridge, for adding teeth to either, or for a replacement or modification of a cast or processed restoration, including crowns, within five years after installed
- A denture or bridge if it includes replacement of one or more natural teeth missing before the person became covered. This does not apply if the denture or bridge also includes replacement of a natural tooth that (i) is removed while the person is covered, or (ii) was not an abutment to a partial denture or removable or fixed bridge installed during the prior five years
- An appliance, crown, bridge, cast or processed restoration or root canal therapy started before the person became eligible; a cast or processed restoration or crown unless it is for decay or traumatic injury and cannot be restored with a filling material or the tooth is an abutment to a fixed bridge; and an active appliance for orthodontics installed before the person became eligible
- Crown lengthening
- Cosmetic treatment, except for certain accidental injuries. Facings on molar crowns or pontics will always be considered cosmetic
- Replacement of lost or stolen appliances
- Appliances or restorations needed to alter verticular dimension or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion; or treatment for problems of the jaw joint (e.g., TMJ)
- Work-connected sickness or injury
- Care provided under any other program paid for in full or in part, directly or indirectly by the employer. This includes insured and uninsured programs. If a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge
- Expenses above the reasonable and customary charge for the service area.