Allendale Public Schools, WMP125

Benefit Description	Dental Plan
	Limits
Benefit Year	July 1 through June 30
Benefit Percentage Type I - Preventive Dental Services	100% (0% coinsurance)
Type II - Minor Restorative Dental Services	100% (0% coinsurance)
Type III - Major Restorative Dental Services	90% (10% coinsurance)
Type IV - Orthodontic Services (for dependent children under age 19 only)	80% (20% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II, and III Dental Services	$3,000
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	$1,500

Special Provision for Injuries Arising Out of Automobile Accidents

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Summary of Dental Procedures

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document for more details.

Services:	*Special Limitations:*
Type I: Preventive Dental Services	
A. Oral Examination	Limited to two times in any 12-consecutive-month period.
B. Bacteriologic Cultures	None.
C. Dental Prophylaxis (cleaning teeth)	Limited to two times in any 12-consecutive-month period.
D. Fluoride Treatment	Dependent children up to age 19 only. Two times in any 12-consecutive-month period.
E. Palliative Treatment	Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit.
F. Sedative Fillings	Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit.
G. Space Maintainers	None.
H. Emergency Treatment	Exams only.
I. Initial Examination, Radiographs, and Extractions Performed in Preparation for Orthodontic Treatment	Dependent children up to age 19 only.
Type II: Minor Restorative Dental Services	
A. Complete Series or Panorex X-Rays	Limited to one time in any five-consecutive-year period.
B. Occlusal, Extraoral, and Individual Periapical X-Rays	None.
C. Bite-Wing X-Rays	Limited to one full series in any 12-consecutive-month period.
D. Periodontal Exams	Limited to one time in any three-consecutive-month period.
E. Periodontal Prophylaxis	Limited to one time in any three-consecutive-month period.
F. Diagnostic Casts	Limited to one time in any 24-consecutive-month period.
G. Stainless Steel Crowns	None.
H. Re-cement Inlays, Onlays, Crowns, and Bridges	None.
I. Pulpotomy and Osseous Surgery	None.
J. Root Canal Therapy	None.
K. Apicoectomy and Retrograde Filling	None.

Summary of Dental Procedures

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document for more details.

Services:	*Special Limitations:*
Type II: Minor Restorative Dental Services, cont.	
L. Scaling and Root Planing	Limited to two times per quadrant of the mouth in any 12-consecutive-month period.
M. Temporary Splinting	None.
N. Periodontal Appliance	Limited to one appliance in any 36-consecutive-month period.
O. Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments done more than 12 months after the initial insertion.
P. Relining Dentures	Limited to relining done more than 12 months after the initial insertion and then not more than one time in any 24-consecutive-month period.
Q. Simple Extraction	None.
R. Surgical Extraction of Impacted Teeth, Alveoplasty, Gingivectomy, & Vestibuloplasty	No special limitations. The Employer's medical plan will provide primary coverage, and the Employer's dental plan will coordinate as the secondary coverage on any unpaid balance.
S. Root Recovery	None.
T. Incision and Drainage	None.
U. Local and General Anesthesia	None.
V. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.
W. Silicate and Plastic (fillings)	None.
X. Composite Restorations (fillings)	Not covered if placed in a posterior tooth.
Y. Pin Retention	Limited to two pins per tooth.
Z. Gingival Curettage	None.
AA. Osseous Graft	None.
BB. Frenectomy	None.
CC. Occlusal Adjustment	None.
DD. Bite Splint Appliances	Limited to one appliance in any five-consecutive-year period.
EE. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by silver fillings. An expense is considered incurred at the time the tooth or teeth are initially prepared.
FF. Porcelain Restorations	Not covered if placed in a posterior tooth.
GG. Crowns	Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.
HH. Post and Core	None.
Type III: Major Restorative Dental Services	
A. Replacement of Teeth to Bridges and Dentures	None.
B. Full or Partial Dentures	None.
C. Fixed Bridges	An expense is considered incurred at the time the tooth or teeth are initially prepared.
D. Dental Implants	None.
Type IV: Orthodontic Services (Dependent Children Under Age 19 Only)	
A. Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	None.
B. Initial Examination, Radiographs, and Extractions Performed in Preparation for Orthodontic Treatment	Covered as a Type I Preventative Dental Service.