DENTAL BENEFIT SUMMARY

Washoe County provides one Dental Benefit Plan for ALL benefited Employees and their covered dependents regardless of their selection of Medical Plans.

Dental benefits are available through the Retiree Health Benefits Program as an *optional* benefit, with the entire premium payment made by the retiree.

CHOICE OF DPPO OR NON-DPPO PROVIDERS

The Plan Sponsor has contracted with a Dental Preferred Provider Organization (DPPO) called DentalGuard Preferred Select Network. You can obtain a list of the dental providers by going to their website at www.guardiananytime.com.

When obtaining dental care services, a Covered Person has a choice of using a dental provider who is participating in the DPPO network or any other Covered Provider of his/her choice. Because DPPO providers have agreed to provide dental services at negotiated rates, when a Covered Person uses a DPPO provider his/her out-of-pocket costs may be reduced because he/she will not be billed for expenses in excess of "Usual, Customary and Reasonable" or in excess of the negotiated rates.

SCHEDULE OF DENTAL BENEFITS

MAXIMUM BENEFIT	
Dental Calendar Year Maximum, per person	$3,000
Orthodontia Lifetime Maximum, per person	$1,500
CALENDAR YEAR DEDUCTIBLE Individual Deductible	$50
There is no deductible on Preventive services. The above dental deductible is applied to Basic, Major or Orthodontic services only and must be met by each covered person in each calendar year before benefits are payable for covered expenses each calendar year.	
ELIGIBLE DENTAL EXPENSES	**Benefit**
Preventive Services (Deductible waived)	100%
- routine oral examinations and cleanings are limited to 4 exams/cleanings per Calendar Year; - fluoride is limited to 2 applications per Calendar Year, for children under age 18; - routine bitewings are limited to 2 sets per Calendar Year; - Panoramic (full-mouth) X-rays are limited to once per 3-year period;	
Basic Services	80%
Major Services	50%
Orthodontic Services	50%

IMPORTANT: Certain eligible dental expenses are subject to benefit limits. See the **SCHEDULE OF DENTAL BENEFITS** for that information.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Plan Administrator recommends that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Administrator reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the services are actually incurred. The pre-treatment estimate is valid for ninety (90) days from the date of issue.

ELIGIBLE DENTAL EXPENSES

1. Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed below, which are: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he/she is licensed.

2. For benefit purposes, dental expenses will be deemed incurred as follows:
   - for an appliance or modification of an appliance, on the date the final impression is taken;
   - for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;
   - for root canal therapy, on the date the pulp chamber is opened; or
   - for any other service, on the date the service is rendered.

   NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

IMPORTANT: Certain eligible dental expenses are subject to benefit limits. See the **SCHEDULE OF DENTAL BENEFITS** for that information.

PREVENTIVE SERVICES

1. **Exams & Cleanings, Routine** - Routine oral examinations and routine cleaning and polishing of the teeth.

2. **Fluoride** - Topical application of stannous or sodium fluoride.

3. **Prophylaxis** - see "Exams & Cleanings, Routine"

4. **X-rays, Routine** - Routine full mouth X-rays, routine bitewing X-rays and supplementary periapical X-rays as necessary. "Full mouth X-rays" means a panorex plus bitewings or fourteen (14) periapical films plus bitewings.

BASIC SERVICES

1. **Anesthesia** - General anesthesia when administered in connection with oral Surgery.

   NOTE: Hypnosis and relative analgesia are not covered unless the patient is completely anesthetized to a state of unconsciousness as with a general anesthetic.

2. **Endodontia** - Endodontic services including but not limited to: root canal therapy (but not on a primary tooth), pulpotomy, apicoectomy and retrograde filling.

3. **Extraction** - See "Oral Surgery"

4. **Fillings, Non-Precious** - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

   Replacement of a filling if the existing restoration is at least twenty-four (24) months old.

5. **Injections** - Injection of antibiotic drugs.

6. **Night Guard/Occlusal Guard** - For the treatment of bruxism (grinding or clenching teeth) up to a maximum of $250 once every 5 years (including adjustment or repairs).

7. **Non-Routine Exams/Visits** - Office visits other than those covered as "Preventive Services."

8. **Oral Surgery** - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Biopsy of oral tissue (but not including laboratory costs), and other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

9. **Palliatives** - Emergency treatment for the relief of dental pain.

10. **Periodontia** - Periodontal scaling and root planing and surgical procedures (i.e., gingivectomy, osseous surgery and mucogingival surgery). Any allowance for periodontal surgery includes postoperative care for six (6) months following the surgery.

11. **Repairs & Adjustments** - Repair of bridgework or dentures, the relining of dentures (see NOTE) and prosthetic adjustments.

    NOTE: Relines are limited to laboratory relines. Office relines are considered to be temporary and are not covered.

IMPORTANT: Certain eligible dental expenses are subject to benefit limits. See the **SCHEDULE OF DENTAL BENEFITS** for that information.

12. **Sealants** - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars which are free of decay or prior restoration.

    Any allowance made for sealants includes any necessary repair or replacement within thirty-six (36) months from time of application.

13. **Space Maintainers** - Fixed and removable appliances to maintain (not change) the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

14. **X-Rays, Non-Routine** - X-rays other than those covered as "Preventive Services."

MAJOR SERVICES

1. **Crowns** - A crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary. The maximum allowance for a crown on a primary tooth will be the allowance for a stainless steel crown.

   Replacement of a crown, if the existing crown is at least five (5) years old.

2. **Implants** - Placement of an implant to replace a missing tooth.

3. **Inlays, Onlays & Gold Restorations** - An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

   Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old.

4. **Prosthetics** - Initial placement of a full or partial denture or bridge.

   Addition of teeth to a partial denture or bridge.

   Replacement of an existing full or partial denture or bridgework, but only if the existing denture or bridgework cannot be made serviceable and is at least five (5) years old.

   NOTE: Fixed bridges are <u>not</u> covered for a child under sixteen (16) years of age. An allowance will be made for a partial denture.

ORTHODONTIA SERVICES

1. **Consultation**

2. **Initial banding or placement of orthodontia appliance(s)**

3. **Models, X-rays and other diagnostic services**

4. **Periodic adjustments**

5. **Retainers**

IMPORTANT: Certain eligible dental expenses are subject to benefit limits. See the **SCHEDULE OF DENTAL BENEFITS** for that information.

DENTAL LIMITATIONS AND EXCLUSIONS

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

1. **Cosmetic Dentistry** - Treatment rendered purely for cosmetic purposes.

2. **Discoloration Treatment** - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

3. **Excess Care** - Services which exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could have been performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

   Duplicate prosthetic devices or appliances.

4. **Experimental Procedures** - Services which are considered experimental or which are not approved by the American Dental Association.

5. **Hospital Expenses**

6. **Implant Removal** - The removal of implants.

7. **Lost or Stolen Prosthetics or Appliances** - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

8. **Medical Expenses** - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

9. **Myofunctional Therapy** - Muscle training therapy or training to correct or control harmful habits.

10. **Non-Professional Care** - Services rendered by someone other than:
    - a dentist (DDS or DMD);
    - a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
    - a Physician furnishing dental services for which he/she is licensed.

11. **Oral Hygiene Instruction and Supplies, Etc.** - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

13. **Orthognathic Surgery** - Surgery to correct a receding or protruding jaw.

14. **Personalization or Characterization of Dentures** - Excess charges for the personalization or characterization of dentures.

15. **Prescription Drugs** - See the **Prescription Drugs** section

16. **Prior to Effective Date / After Termination Date** - 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 and Expenses incurred after termination of coverage.

IMPORTANT: Certain eligible dental expenses are subject to benefit limits. See the **SCHEDULE OF DENTAL BENEFITS** for that information.

17. **Replanted / Transplanted Teeth** - Restorations on replanted or transplanted teeth.

18. **Splinting** - Appliances or restorations for splinting teeth.

19. **Temporary Restorations and Appliances** - Excess charges for temporary restorations and appliances. The Eligible Expenses for the permanent restoration or appliance will be the maximum covered charge. (MAJOR)

20. **TMJ Treatment** - Procedures, restorations or appliances for the treatment of temporomandibular joint dysfunction syndrome. See Eligible Expenses under Medical

- *(See also **General Exclusions** section)* -