HEALTH & WELFARE DEPARTMENT
OF THE
CONSTRUCTION & GENERAL LABORERS'
DISTRICT COUNCIL OF CHICAGO AND VICINITY
GROUP DENTAL PLAN

Group #1133

DENTAL BENEFITS BOOKLET

Administered by Delta Dental of Illinois ("DDIL")

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IMPORTANT

You will notice that some of the terms used in your Dental Benefits Booklet begin with a capital letter. These terms have a special meaning under the Fund's plan and are listed in "Glossary" in alphabetical order. Refer to this section for a detailed explanation.

These benefits may be reduced if you or your Dependent has health or dental benefits under another plan. How this works is described in "Coordination of Benefits."

PLAN HIGHLIGHTS
Dental Benefits for You and Your Dependents

DENTAL CARE BENEFIT	DELTA DENTAL PPO DENTIST	NON-DELTA DENTAL PPO DENTIST
Non-Orthodontic Benefits		
Maximum benefit per Calendar Year	$2,000	$2,000
Covered charges payable by the Fund's plan	You pay only the **Patient Co-Payment Amount** listed in the Schedule of Dental Benefits, pages 6 through 17 of this booklet	You pay any remaining percentage of the Approved Amount after the Fund's plan pays the percentage listed in the Schedule of Dental Benefits, pages 6 through 17 of this booklet. You also may be responsible for the difference between your Dentist's billed fee and DDIL's Approved Amount.
Maximum benefit for bite guards	$500 per appliance, including any repairs; $1,000 per lifetime; benefits apply to PPO calendar year maximum	Not covered
Orthodontic Benefits		
Covered charges payable by the Fund's plan	You pay only the Patient Co-Payment Amount of $242.11,* which is the difference between the lifetime orthodontic benefit maximum and the Delta Dental PPO Orthodontic Reimbursement Amount	Plan pays 100% of DDIL's Approved Amount, **up to the lifetime orthodontic benefit maximum**
Maximum per person per lifetime	$3,757.89	$1,000

* The orthodontic Patient Co-Payment Amount is subject to change. Please verify the orthodontic Patient Co-Payment Amount in effect before receiving orthodontic treatment.

EFFECT OF DELTA DENTAL PPO

Delta Dental PPO is a program made up of agreements between certain Dentists and DDIL. These Dentists (called Delta Preferred Option Dentists) have agreed to provide services to Covered Individuals and to abide by DDIL's bylaws, rules and regulations. If your Dentist is a Delta Dental PPO Dentist, you pay only the co-payment amount in the Schedule of Dental Benefits, pages 6 through 17 of this booklet. Generally, the Fund's plan will pay a greater portion of certain covered charges if you use Delta Dental PPO Dentists. Thus, there will be fewer expenses left for you to pay out of your own funds for dental bills.

A list of Delta Dental PPO Dentists in your area is available from the Welfare Fund Office, your local Union office, or on DDIL's Web site at www.deltadentalil.com.

For the effect of the Delta Dental PPO on orthodontic benefits, see page 22.

EFFECT OF NON-DELTA DENTAL PPO

If you or your Dependent receive dental care and treatment from a Dentist who is **not** a Delta Dental PPO Dentist, the Fund's plan will pay:

. 100% of DDIL's Approved Amount for Preventive, certain Diagnostic and Therapeutic services;
. 100% of DDIL's Approved Amount for Orthodontia, up to the maximum lifetime benefit of $1,000;
. 70% of DDIL's Approved Amount for General Services; and
. 50% of DDIL's Approved Amount for Major Services.

Where the Fund's plan pays less than 100%, you will be responsible for the remaining percentage of the Approved Amount. If you go to a Non-Delta Dental PPO Dentist, you may **also** be responsible for the difference between your Dentist's billed fee and DDIL's Approved Amount.

DEFINITIONS

Emergency - Emergency treatment for relief of pain or discomfort is covered by the plan. If treatment for relief of pain or discomfort is provided in connection with a covered dental treatment, the benefit to be paid will be the amount payable for the covered dental procedure. Treatment for relief of pain or discomfort provided in connection with a scheduled procedure that is not covered by the plan also is not covered.

Enhanced Benefits Program - Procedures listed in the Schedule of Dental Benefits with a single asterisk (*) are part of Smile Smart. Coverage will be at the group-contracted benefit level, with the additional frequency allowance being the only change. There is no age requirement and the patient may be the Subscriber, or other covered Dependents

Delta Dental PPO Dentist - A Dentist who has signed an agreement with DDIL to participate as a Delta Dental PPO Dentist. These Dentists have agreed to provide dental services to Covered Individuals and to abide by DDIL's bylaws, rules and regulations. Please contact the Welfare Fund Office or your local Union office, or visit DDIL's Web site at www.deltadentalil.com for the current listing of Delta Dental PPO Dentists in your area.

DENTAL CARE BENEFIT

The Dental Care Benefit provides payment for a wide range of dental expenses (called covered charges) charged to you or your Dependent by a Dentist while covered.

Covered charges will not include any expenses which are payable in a Calendar Year under the Employer's basic insurance plan.

The benefit pays the percentage of covered charges shown in "Plan Highlights" up to a maximum benefit.

In addition to other provisions of the Fund's plan, the percentage of covered charges payable under the plan is affected by the section titled "Effect of Delta Dental PPO."

For these reasons, if you use Delta Dental PPO Dentists, generally there will be fewer expenses left for you to pay out of your own funds for dental bills.

Benefit Determination

Benefits under the Fund's plan pay for dental treatment that begins after you or your Dependent becomes covered. The person must be covered on the date dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are some kinds of treatment that take more time to complete. In these cases, treatment will be considered to have been received on the date shown below:

- As to fixed bridgework, crowns, inlays, onlays and gold restorations -- the date the tooth or teeth are first prepared.
- As to full or partial removable dentures -- the date the impression is taken.
- As to root canal work -- the date the tooth is opened.

Allowed Amount

The Allowed Amount is the charge for the dental services and procedures which the Fund's plan will pay. DDIL will compare the charge for each treatment with the charges for comparable treatment made by the other Dentists in Illinois. The Allowed Amount is the charge which is not more than the amount customarily charged by nine out of 10 Dentists in Illinois, as determined by DDIL. In most cases, the Dentist's charges will be well within the range of prevailing fees in Illinois.

However, if the Dentist's charge is more than the customary charge as determined by DDIL, you may have to pay the difference if you go to a Non-Delta Dental PPO Dentist.

SCHEDULE OF DENTAL BENEFITS

The Fund's plan will pay for those dental services or procedures listed in this Schedule, subject to the exclusions, terms and conditions set forth in this Schedule. Benefit payments are subject to any applicable deductibles, waiting periods and coverage limits listed in the Dental Plan Specifications.

The level of covered benefits paid under the Fund's plan depends on whether you go to a Delta Dental PPO Dentist or a Non-Delta Dental PPO Dentist. The following outlines the level of Dental Benefits paid.

IF YOUR DENTIST IS A DELTA DENTAL PPO DENTIST, you pay only the co-payment amount listed in the Schedule of Dental Benefits.

IF YOUR DENTIST IS A NON-DELTA DENTAL PPO DENTIST, the Fund's plan will pay the designated co-payment percentage, as listed in this Schedule, of DDIL's Approved Amount. Where the plan pays less than 100%, you will be responsible for the remaining percentage of the Approved Amount. You may also be responsible for the difference between your Dentist's billed fee and DDIL's Approved Amount.

The benefits furnished under the Fund's plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of contract benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which the Fund's plan is required to make.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	COVERED DENTAL BENEFITS		
	DIAGNOSTIC BENEFITS		
D0120	Periodic oral evaluation: *twice per calendar year*	$ 0.00	100%
D0140	Limited oral evaluation - problem focused	$ 0.00	100%
D0150	*Comprehensive oral evaluation: once per Dentist*	$ 0.00	100%
D0160	Detailed and extensive oral evaluation - problem-focused: *once per Dentist*	$ 0.00	100%
D0170	Re-evaluation - limited, problem-focused	$ 0.00	100%
D0180	Comprehensive periodontal evaluation - new or established patient: *once per Dentist*	$ 0.00	100%
D0210	X-Ray (complete series) including bitewings: *once in a 36-month interval*	$ 0.00	100%
D0220	X-Ray, periapical - first film	$ 0.00	100%
D0230	X-Ray, periapical - each additional film	$ 0.00	100%
D0240	X-Ray, occlusal film	$ 0.00	100%
D0270	X-Ray, bitewing - one film	$ 0.00	100%
D0272	X-Ray, bitewing - two films	$ 0.00	100%
D0274	X-Ray, bitewing - four films	$ 0.00	100%
D0277	Vertical bitewings - 7 to 8 films: once in a 36-month interval	$ 0.00	100%
D0330	X-Ray, panoramic - maxilla and mandible film	$ 0.00	100%
D0340	X-Ray, cephalometric film (with orthodontic coverage only)	$ 0.00	100%
D0470	Diagnostic casts	$ 0.00	100%

If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation.

Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage

A full mouth x-ray includes bitewing x-rays; panoramic x-ray in conjunction with any other x-ray is considered a full mouth x-ray. A set of vertical bitewings or full-mouth x-ray within 36 months following the initial set of vertical bitewings or full-mouth x-ray is not a covered benefit.

Bitewing x-rays (other than vertical bitewings) are limited to not more than two series per calendar year.

Diagnostic casts are a covered benefit only when rendered more than 30 days prior to definitive treatment.

PREVENTIVE BENEFITS

D1110	Prophylaxis, adults: *twice per calendar year**	$ 0.00	100%
D1120	Prophylaxis, children: *twice per calendar year**	$ 0.00	100%
D1203	Topical fluoride application, excluding prophylaxis: *twice per calendar year for dependent children under age 19*	$ 0.00	100%
D1351	Sealants, once per tooth	$ 0.00	70%
D1510	Space maintainer, fixed - unilateral type	$ 0.00	100%
D1515	Space maintainer, fixed - bilateral type	$ 0.00	100%
D1520	Space maintainer, removable - unilateral type	$ 0.00	100%
D1525	Space maintainer, removable - bilateral type	$ 0.00	100%
D1550	Recementation of space maintainer	$ 0.00	100%

Sealants are a covered Dental Benefit when applied once per tooth to first and second permanent molars that are free of cavities and restorations; for dependent children under age 16.

Space maintainers are a covered Dental Benefit once per lifetime for dependent children under age 14.

**With an indicator for diabetes, the enrollee will be eligible for four periodontal maintenance visits or two prophylaxis (general cleaning) and two periodontal*

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage

maintenance per year.
**With an indicator for pregnancy, the enrollee will be eligible for one additional prophylaxis (general cleaning) or periodontal maintenance visit during the time of pregnancy.*
**With an indicator of periodontal surgery or disease, the enrollee will be eligible for four periodontal maintenance visits per benefit year or two prophylaxis (general cleaning) and two periodontal maintenance visits per year. Additionally, following periodontal surgery, the enrollee will be eligible for two applications of topical fluoride in a benefit year*

RESTORATIVE BENEFITS

D2140	Amalgam, one surface, primary or permanent	$ 0.00	70%
D2150	Amalgam, two surfaces, primary or permanent	$ 0.00	70%
D2160	Amalgam, three surfaces, primary or permanent	$ 0.00	70%
D2161	Amalgam, four or more surfaces, primary or permanent	$ 0.00	70%
D2330	Resin-based composite - one surface, anterior	$ 0.00	70%
D2331	Resin-based composite - two surfaces, anterior	$ 0.00	70%
D2332	Resin-based composite - three surfaces, anterior	$ 0.00	70%
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$ 0.00	70%
D2390	Resin-based composite crown, anterior	$ 0.00	70%
D2391	Resin-based composite-one surface, posterior	$ 0.00	70%
D2392	Resin-based composite-two surfaces, posterior	$ 0.00	70%
D2393	Resin-based composite-three surfaces, posterior	$ 0.00	70%
D2394	Resin-based composite-four or more surfaces, posterior	$ 0.00	70%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	Amalgam and resin restorations (fillings) are limited to once per surface in a 12-month interval.		
	When a resin restoration is placed on a molar or pre-molar (except on the facial surface of a pre-molar), the level of benefits will be limited to that of an amalgam.		
	CAST RESTORATIONS (permanent teeth only)		
D2542	Onlay - metallic - two surfaces	$ 66.00	50%
D2543	Onlay - metallic - three surfaces	$ 66.00	50%
D2544	Onlay - metallic - four or more surfaces	$ 66.00	50%
D2710	Crown - resin-based composite (indirect)	$ 31.00	50%
D2720	Crown - resin with high noble metal	$ 68.00	50%
D2721	Crown - resin with predominantly base metal	$ 55.00	50%
D2722	Crown - resin with noble metal	$ 55.00	50%
D2740	Crown - porcelain/ceramic substrate	$ 62.00	50%
D2750	Crown - porcelain fused to high noble metal	$ 68.00	50%
D2751	Crown - porcelain fused to predominantly base metal	$ 64.00	50%
D2752	Crown - porcelain fused to noble metal	$ 60.00	50%
D2780	Crown - ¾ cast high noble metal	$ 68.00	50%
D2781	Crown - ¾ cast predominantly base metal	$ 68.00	50%
D2782	Crown - ¾ cast noble metal	$ 68.00	50%
D2783	Crown - ¾ porcelain/ceramic	$ 68.00	50%
D2790	Crown - full cast high noble metal	$ 68.00	50%
D2791	Crown - full cast predominantly base metal	$ 60.00	50%
D2792	Crown - full cast noble metal	$ 60.00	50%
D2793	Crown - titanium	$ 68.00	50%
D2910	Recement inlay, onlay or partial coverage restoration	$ 0.00	50%
D2915	Recement cast or prefabricated post and core	$ 0.00	50%
D2920	Recement crown	$ 0.00	50%
D2930	Prefabricated stainless steel crown - primary	$ 19.00	50%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
D2950	Core build-up, including any pins	$ 15.00	50%
D2951	Pin retention - per tooth, in addition to restoration	$ 5.00	50%
D2952	Cast post and core	$ 27.00	50%
D2954	Prefabricated post and core in addition to crown	$ 21.00	50%
D2971	Additional procedures to construct new crown under existing partial denture framework	$ 0.00	50%

When a cast restoration with a cosmetic component is requested or placed on a molar, the level of benefits will be limited to that of a cast metal restoration.

When the retentive quality of a tooth does not qualify for a cast restoration (radiographic evidence of decay or missing tooth structure on less than four surfaces), the level of benefits will be limited to that of an amalgam or resin restoration.

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam.

ENDODONTIC BENEFITS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament: *primary teeth*	$ 0.00	70%
D3221	Pulpal debridement	$ 0.00	70%
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$ 0.00	70%
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$ 0.00	70%
D3310	Root canal, anterior (excluding final restoration)	$ 0.00	70%
D3320	Root canal, bicuspid (excluding final restoration)	$ 0.00	70%
D3330	Root canal, molar (excluding final restoration)	$ 0.00	70%
D3332	Incomplete endodontic therapy; inoperable, unrestorable or		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	fractured tooth	$ 0.00	70%
D3333	Internal root repair of perforation defects	$ 0.00	70%
D3346	Retreatment of previous root canal therapy - anterior	$ 0.00	70%
D3347	Retreatment of previous root canal therapy - bicuspid	$ 0.00	70%
D3348	Retreatment of previous root canal therapy	$ 0.00	70%
D3351	Apexification/recalcification - initial visit	$ 0.00	70%
D3352	Apexification/recalcification - interim medication replacement	$ 0.00	70%
D3353	Apexification/recalcification - final visit	$ 0.00	70%
D3410	Apicoectomy/periradicular surgery - anterior	$ 0.00	70%
D3421	Apicoectomy/periradicular surgery - bicuspid	$ 0.00	70%
D3425	Apicoectomy/periradicular surgery - molar	$ 0.00	70%
D3426	Apicoectomy/periradicular surgery - each additional tooth	$ 0.00	70%
D3430	Retrograde filling - per root	$ 0.00	70%
D3450	Root amputation - per root	$ 0.00	70%
D3920	Hemisection (including any root removal), not including root canal therapy	$ 0.00	70%

Endodontics includes pulpal and root canal therapy.

Pulpal therapy (resorbable filling) is a covered Dental Benefits once per tooth per lifetime.

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

SURGICAL AND NON-SURGICAL PERIODONTIC BENEFITS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	or bounded teeth spaces per quadrant	$ 0.00	70%
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 0.00	70%
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$ 0.00	70%
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 0.00	70%
D4245	Apically positioned flap	$ 0.00	70%
D4249	Clinical crown lengthening - hard tissue	$ 0.00	70%
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$ 0.00	70%
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 0.00	70%
D4263	Bone replacement graft - first site in quadrant	$ 0.00	70%
D4264	Bone replacement graft - each additional site in quadrant	$ 0.00	70%
D4270	Pedicle soft tissue graft procedure	$ 0.00	70%
D4271	Free soft tissue graft procedure (including donor site surgery)	$ 0.00	70%
D4273	Subepithelial connective tissue graft procedures, per tooth	$ 0.00	70%
D4274	Distal or proximal wedge procedure	$ 0.00	70%
D4275	Soft tissue allograft	$ 0.00	70%
D4276	Combined connective tissue and double pedicle graft, per tooth	$ 0.00	70%
D4341	Periodontal scaling and root planing - four or more teeth, per quadrant	$ 0.00	70%
D4342	Periodontal scaling and root		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	planing - one to three teeth, per quadrant	$ 0.00	70%
D4910	Periodontal prophylaxis: *twice per calendar year**	$ 0.00	70%

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

**With an indicator for diabetes, the enrollee will be eligible for four periodontal maintenance visits or two prophylaxis (general cleaning) and two periodontal maintenance per year.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional prophylaxis (general cleaning) or periodontal maintenance visit during the time of pregnancy.*
**With an indicator of periodontal surgery or disease, the enrollee will be eligible for four periodontal maintenance visits per benefit year or two prophylaxis (general cleaning) and two periodontal maintenance visits per year. Additionally, following periodontal surgery, the enrollee* will be eligible for two applications of topical fluoride in a benefit year

PROSTHODONTIC BENEFITS

D5110	Complete upper denture	$ 88.00	50%
D5120	Complete lower denture	$ 86.00	50%
D5211	Upper partial denture - resin base (including any conventional clasps, rests and teeth)	$ 101.00	50%
D5212	Lower partial denture - resin base (including any conventional clasps, rests and teeth)	$ 83.00	50%
D5213	Upper partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 101.00	50%
D5214	Lower partial denture - cast metal framework with		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	resin denture bases (including any conventional clasps, rests and teeth)	$ 105.00	50%
D5225	Upper partial denture - flexible base (including any clasps, rests and teeth)	$ 101.00	50%
D5226	Lower partial denture - flexible base (including any clasps, rests and teeth)	$ 83.00	50%
D5410	Adjust complete upper denture	$ 0.00	50%
D5411	Adjust complete lower denture	$ 0.00	50%
D5421	Adjust partial upper denture	$ 0.00	50%
D5422	Adjust partial lower denture	$ 0.00	50%
D5510	Repair broken complete denture base	$ 0.00	50%
D5520	Replace missing or broken teeth - complete denture (each tooth)	$ 0.00	50%
D5610	Repair resin denture base	$ 0.00	50%
D5620	Repair cast framework	$ 0.00	50%
D5630	Repair or replace broken clasp	$ 0.00	50%
D5640	Replace broken teeth - per tooth	$ 0.00	50%
D5650	Add tooth to existing partial denture	$ 0.00	50%
D5660	Add clasp to existing partial denture	$ 0.00	50%
D5670	Replace all teeth and acrylic on cast metal framework (upper)	$ 0.00	50%
D5671	Replace all teeth and acrylic on cast metal framework (lower)	$ 0.00	50%
D5710	Rebase complete upper denture	$ 0.00	50%
D5711	Rebase complete lower denture	$ 0.00	50%
D5720	Rebase upper partial denture	$ 0.00	50%
D5721	Rebase lower partial denture	$ 0.00	50%
D5730	Reline upper complete denture (chairside)	$ 0.00	50%
D5731	Reline lower complete denture (chairside)	$ 0.00	50%
D5740	Reline upper partial denture (chairside)	$ 0.00	50%
D5741	Reline lower partial denture (chairside)	$ 0.00	50%
D5750	Reline upper complete denture (laboratory)	$ 0.00	50%
D5751	Reline lower complete denture		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	(laboratory)	$ 0.00	50%
D5760	Reline upper partial denture (laboratory)	$ 0.00	50%
D5761	Reline lower partial denture (laboratory)	$ 0.00	50%
D6205	Pontic - indirect resin-based composite	$ 68.00	50%
D6210	Pontic - cast high noble metal	$ 68.00	50%
D6211	Pontic - cast predominantly base metal	$ 56.00	50%
D6212	Pontic - cast noble metal	$ 56.00	50%
D6214	Pontic - titanium	$ 68.00	50%
D6240	Pontic - porcelain fused to high noble metal	$ 68.00	50%
D6241	Pontic - porcelain fused to predominantly base metal	$ 60.00	50%
D6242	Pontic - porcelain fused to noble metal	$ 60.00	50%
D6250	Pontic - resin with high noble metal	$ 60.00	50%
D6251	Pontic - resin with predominantly base metal	$ 59.00	50%
D6252	Pontic - resin with noble metal	$ 68.00	50%
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$ 45.00	50%
D6610	Onlay - cast high noble metal, two surfaces	$ 66.00	50%
D6611	Onlay - cast high noble metal, three or more surfaces	$ 66.00	50%
D6612	Onlay - cast predominantly base metal, two surfaces	$ 66.00	50%
D6613	Onlay - cast predominantly base metal, three or more surfaces	$ 66.00	50%
D6614	Onlay - cast noble metal, two surfaces	$ 66.00	50%
D6615	Onlay - cast noble metal, three or more surfaces	$ 66.00	50%
D6634	Onlay - titanium	$ 66.00	50%
D6710	Crown - indirect resin-based composite	$ 58.00	50%
D6720	Crown - resin with high noble metal	$ 59.00	50%
D6721	Crown - resin with predominantly base metal	$ 55.00	50%
D6722	Crown - resin with noble metal	$ 58.00	50%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
D6750	Crown - porcelain fused to high noble metal	$ 70.00	50%
D6751	Crown - porcelain fused to predominantly base metal	$ 60.00	50%
D6752	Crown - porcelain fused to noble metal	$ 60.00	50%
D6780	Crown - ¾ cast high noble metal	$ 68.00	50%
D6781	Crown - ¾ cast predominantly base metal	$ 68.00	50%
D6782	Crown - ¾ cast noble metal	$ 68.00	50%
D6790	Crown - full cast high noble metal	$ 68.00	50%
D6791	Crown - full cast predominantly base metal	$ 56.00	50%
D6792	Crown - full cast noble metal	$ 56.00	50%
D6794	Crown - titanium	$ 68.00	50%
D6930	Recement bridge	$ 0.00	50%
D6970	Cast post and core in addition to fixed partial denture retainer	$ 27.00	50%
D6971	Cast post as part of fixed partial denture retainer	$ 27.00	50%
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$ 21.00	50%
D6973	Core build-up for retainer, including any pins	$ 15.00	50%

Prosthodontics includes cast restorations, fixed partial dentures, removable partial dentures, complete dentures, denture service and repair. Reline or rebase of an existing appliance is covered once in a 24-month interval.

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments, or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

IMPLANT SERVICES

D6010	Surgical placement of implant body	$155.00	50%
D6040	Surgical placement: eposteal implant	$114.00	50%
D6050	Surgical placement: transosteal Implant	$148.00	50%
D6055	Dental implant supported connecting	$ 55.00	50%
D6056	Prefabricated abutment	$ 21.00	50%
D6057	Custom abutment bar	$ 27.00	50%
D6058	Abutment supported porcelain/ceramic crown	$ 62.00	50%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$ 68.00	50%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$ 64.00	50%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$ 60.00	50%
D6062	Abutment supported cast metal crown (high noble metal)	$ 68.00	50%
D6063	Abutment supported cast metal crown (predominantly base metal)	$ 60.00	50%
D6064	Abutment supported cast metal crown (noble metal)	$ 60.00	50%
D6065	Implant supported porcelain/ceramic crown	$ 62.00	50%
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$ 60.00	50%
D6068	Abutment supported retainer for porcelain/ceramic FPD	$ 82.00	50%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$ 70.00	50%
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$ 60.00	50%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$ 60.00	50%
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$ 68.00	50%
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$ 56.00	50%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$ 56.00	50%
D6075	Implant supported retainer for ceramic FPD	$ 21.00	50%
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$ 21.00	50%
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$ 21.00	50%
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$142.00	50%
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$109.00	50%
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	prosthesis	$ 0.00	50%
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/ abutment supported prosthesis, per attachment	$ 0.00	50%
D6092	Recement implant/abutment supported crown	$ 5.00	50%
D6093	Recement implant/abutment Supported fixed partial denture	$ 7.00	50%
D6094	Abutment supported crown - (titanium)	$ 68.00	50%
D6100	Implant removal	$ 0.00	50%
D6194	Abutment supported retainer crown For FPD - (titanium)	$ 68.00	50%
	ORAL SURGERY		
D7111	Extraction, coronal remnants	$ 0.00	70%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 0.00	70%
D7210	Surgical removal of erupted tooth	$ 0.00	70%
D7220	Removal of impacted tooth - soft tissue	$ 0.00	70%
D7230	Removal of impacted tooth - partially bony	$ 0.00	70%
D7240	Removal of impacted tooth - completely bony	$ 0.00	70%
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$ 0.00	70%
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 0.00	70%
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	$ 0.00	70%
D7280	Surgical access of an unerupted tooth	$ 0.00	70%
D7283	Placement of device to facilitate eruption of impacted tooth	$ 0.00	70%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
D7285	Biopsy of oral tissue - hard (bone, tooth)	$ 0.00	70%
D7286	Biopsy of oral tissue - soft	$ 0.00	70%
D7288	Brush biopsy - transepithelial sample collection	$ 0.00	70%
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$ 0.00	70%
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$ 0.00	70%
D7410	Excision of benign lesion up to 1.25 cm	$ 0.00	70%
D7411	Excision of benign lesion greater than 1.25 cm	$ 0.00	70%
D7412	Excision of benign lesion, complicated	$ 0.00	70%
D7413	Excision of malignant lesion up to 1.25 cm	$ 0.00	70%
D7414	Excision of malignant lesion greater than 1.25 cm	$ 0.00	70%
D7415	Excision of malignant lesion, complicated	$ 0.00	70%
D7440	Excision of malignant tumor - lesion diameter up to l.25 cm	$ 0.00	70%
D7441	Excision of malignant tumor - lesion diameter greater than l.25 cm	$ 0.00	70%
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to l.25 cm	$ 0.00	70%
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than l.25 cm	$ 0.00	70%
D7460	Removal of benign nonodontogenic cyst/tumor - lesion diameter up to 1.25 cm	$ 0.00	70%
D7461	Removal of benign nonodontogenic cyst/tumor - lesion diameter		

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	greater than l.25 cm	$ 0.00	70%
D7465	Destruction of lesion(s) by physical or chemical method, by report	$ 0.00	70%
D7471	Removal of exostosis - per site	$ 0.00	70%
D7472	Removal of torus palatinus	$ 0.00	70%
D7473	Removal of torus mandibularis	$ 0.00	70%
D7485	Surgical reduction of osseous tuberosity	$ 0.00	70%
D7510	Incision and drainage of abscess - intraoral soft tissue	$ 0.00	70%
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated	$ 0.00	70%
D7520	Incision and drainage of abscess - extraoral soft tissue	$ 0.00	70%
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated	$ 0.00	70%
D7880	Occlusal orthotic device	$ 0.00	70%
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$ 0.00	70%
D7970	Excision of hyperplastic tissue - per arch	$ 0.00	70%
D7971	Excision of pericoronal gingiva	$ 0.00	70%
D7972	Surgical reduction of fibrous tuberosity	$ 0.00	70%

Oral Surgery includes extractions and other oral surgery (pre- and post-operative care) when provided in a Dentist's office.

ORTHODONTIC SERVICES

Only if specifically included in the Dental Plan Specifications	$242.11* (the difference between the maximum lifetime benefit and the DeltaPreferred Option Orthodontic Reimbursement Amount)	100% of Approved Amount, up to the maximum lifetime benefit of $1,000

* The orthodontic Patient Co-Payment Amount is subject to change. Please verify the orthodontic Patient Co-Payment Amount in effect before receiving orthodontic treatment.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Patient Co-Payment Amount	NON-DELTA DENTAL PPO DENTIST Plan Co-Payment Percentage
	ADJUNCTIVE SERVICES		
D9110	Palliative - emergency - treatment of pain, minor procedures	$ 0.00	100%
D9220	Deep sedation/general anesthesia - first 30 minutes	$ 0.00	70%
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$ 0.00	70%
D9310	Consultation (per session) - Non-Treating Dentist	$ 0.00	100%
D9450	Case presentation, detailed and extensive treatment planning	$ 0.00	100%
D9940	Occlusal guards	$ 0.00	70%

General anesthesia is a covered benefit when provided in conjunction with Oral Surgery procedures (other than procedure codes 7111 and 7140) that are listed in this Schedule of Dental Benefits.

EXCLUSIONS

Exclusions that apply to diagnostic services:

(1) Consultation by a Dentist performing the treatment is not a covered benefit.

Exclusions that apply to preventive services:

(1) Repairs of space maintainers are not a covered benefit.

(2) Recementation of a space maintainer by the same office within six months of initial placement is not a covered benefit.

Exclusions that apply to restorative services:

(1) A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purpose, including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

(2) Restorations are not a covered benefit when crowns are allowed for the same teeth.

Exclusions that apply to endodontic services:

(1) Root canal therapy is not a covered benefit when radiographs indicate incompletely filled canals or unresolved periapical pathology.

(2) A root canal filled with material not approved by the American Dental Association for endodontic therapy is not a covered benefit.

(3) When a benefit has been issued for endodontic services, retreatment of the same tooth by the same office is not a covered benefit.

(4) Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

(5) Pulpal therapy on deciduous teeth which are non-vital is not a covered benefit.

Exclusions that apply to oral surgery:

(1) Alveolectomy/Alveoloplasty performed in conjunction with surgical or multiple simple extractions is not a covered benefit.

Exclusions that apply to cast restorations:

(1) Replacement of any existing cast restoration (crowns, onlays and ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

(2) A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

(3) Restoration of a tooth is not a covered benefit when radiographs indicate incompletely filled canals or unresolved periapical pathology.

(4) When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

(5) The repair of any component of a cast restoration is not a covered benefit.

(6) Recementation by the same office within six months of initial placement is not a covered benefit.

Exclusions that apply to surgical periodontic services:

(1) In the absence of radiographic evidence of bone loss, surgical periodontal therapy is not a covered benefit.

(2) Grafts, if not performed in conjunction with surgical periodontal procedures, are not a covered benefit.

(3) Guided tissue regeneration is not a covered benefit.

(4) Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

Exclusions that apply to non-surgical periodontic services:

(1) In the absence of radiographic evidence of bone loss, non-surgical periodontal therapy is not a covered benefit.

(2) Periodontal maintenance procedures (includes examination, prophylaxis and all related procedures) performed within three months following active periodontal therapy is not a covered benefit.

Exclusions that apply to prosthodontic services:

(1) Replacement or repair of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement or repair of existing appliance is not a covered benefit.

(2) When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

(3) Any prosthodontic appliance connected to an implant is not a covered benefit.

(4) Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

(5) A fixed partial denture for a patient under age 16 is not a covered benefit.

(6) Tissue conditioning is not a covered benefit.

(7) When the edentulous space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

(8) Recementation by the same office within six months of initial placement is not a covered benefit.

General exclusions that apply to all procedures:

Coverage is NOT provided for:

(1) Services compensable under Worker's Compensation or Employer's Liability laws.

(2) Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

(3) Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia. This exclusion does not apply to newborn children.

(4) Services performed for purely cosmetic purposes, including but not limited to veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits do not fall within this exclusion.

(5) Charges for services completed prior to the date the person became covered under this program.

(6) Services for anesthetists or anesthesiologists.

(7) Temporary procedures.

(8) Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

(9) Services performed on non-functional teeth (second or third molar with no opposing tooth).

(10) Services performed on deciduous teeth near exfoliation.

(11) Drugs or the administration of drugs, except for general anesthesia.

(12) Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

(13) Services with respect to any disturbance of the temporomandibular joint (jaw joint), except for occlusal orthotic appliances and occlusal guards.

(14) Procedures, techniques or materials related to implantology or edentulous ridge enhancement.

(15) Services performed as a component of another procedure.

(16) The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

(17) Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

ORTHODONTIA

This section of the Dental Care Benefit provides payment for orthodontic treatment for you or your Dependent while covered.

The benefit pays the percentage of covered charges shown in the Plan Highlights on page 2 of this booklet. There is a lifetime maximum benefit that applies to each Covered Individual. It is also shown in the Plan Highlights.

Covered Charges for Orthodontia

Covered charges are customary charges made by a Dentist for straightening teeth. This includes the following:

. diagnostic procedures; and
. appliances to realign the teeth.

Necessary space maintainers and pulling of teeth are covered under the non-orthodontic section of this benefit.

If you go to a Delta Dental PPO Dentist, you will be responsible for the Patient Co-Payment Amount of $242.11,* which is the difference between the lifetime orthodontic benefit maximum and the Delta Dental PPO Orthodontic Reimbursement Amount. The Delta Dental PPO Orthodontic Reimbursement Amount is the amount that Delta Dental PPO Dentists have agreed to accept as full reimbursement for orthodontic treatment. This amount is subject to change, but not until notice of such change is received by the Fund.

* The orthodontic Patient Co-Payment Amount is subject to change. Please verify the orthodontic Patient Co-Payment Amount in effect before receiving orthodontic treatment.

If you go to a Non-Delta Dental PPO Dentist for orthodontic services, the charges made by a Dentist for treatment which are in excess of the lifetime maximum of $1,000 will not be covered.

The Dentist's charges will be included as covered charges only if both of the following conditions are met:

(a) the first active appliance is installed while the person is covered; and

(b) the Dentist diagnoses one of the following problems:

. the upper teeth protrude over the lower teeth by 4 or more millimeters;

. there is an open bite (front upper and lower teeth do not meet) of 4 or more millimeters;

- the gum area is more than 4 millimeters too large or small for the teeth (arch length discrepancy of 4 or more millimeters); or

- teeth are in crossbite (extreme buccolingual version of teeth).

Benefits for orthodontia stop when coverage stops. There are no benefits available for charges made after coverage stops, except that benefits will be continued, after coverage has stopped, if an active appliance has been installed for a Covered Individual, for as long as treatment is required and given.

PREDETERMINATION OF BENEFITS

This is a way of telling you ahead of time how much will be paid for dental work. It will help to avoid surprises.

Many times dental work is likely to cost more than $200. If so, you should ask the Dentist to file for Predetermination of Benefits with DDIL. Most Dentists know about this procedure. Here is how it works:

1. The Dentist lists the services and charges on a claim form and sends it to DDIL. This is called the "treatment plan."

2. DDIL reviews the treatment plan. A determination made by DDIL imposes no restrictions on methods of treatment by the Dentist and only relates to the level of payment which the Fund's plan is required to make.

3. DDIL tells you and the Dentist what amount the benefit will pay.

You should discuss the treatment plan with your Dentist before the work is begun so that problems or complications regarding the cost of such treatment can be avoided.

If the Dentist changes the treatment plan, the amount of payment may change. If the Dentist makes a major change, a new dental claim form should be sent to DDIL.

If you do not use Predetermination of Benefits, payment will be based on whatever information DDIL has about the case.

You do not need to file for Predetermination of Benefits ahead of time if:

(a) the Dentist does not expect that the total cost of the dental work will be more than $200;
(b) you are accidentally injured and receive an emergency examination or treatment;
(c) you receive emergency treatment for dental pain or discomfort (see below for treatment of pain or discomfort that is received in connection with a dental procedure provided to fix the cause of the pain); or
(d) you are injured and need oral surgery.

If you go in for emergency treatment of pain and the dentist performs a covered treatment to fix the cause of the pain, the benefit to be paid will be the benefit payable for the covered treatment procedure. Predetermination is requested in connection with any scheduled dental procedure and any treatment for pain or discomfort provided in connection with such a procedure will be paid for as part of the benefit payable for the procedure.

COORDINATION OF BENEFITS

This provision will coordinate the health benefits payable under the Fund's plan with similar benefits payable under other plans.

You or your Dependent may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it.

The other plan could also be any of the following:

. a government or tax-supported program. This does not include Medicare or Medicaid.
. a no-fault automobile insurance law.

Franchise insurance will not be included.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the actual charges for that Calendar Year.

The expenses must be a covered benefit under the Fund's plan. The expenses must be covered in part under at least one of the other plans.

How Does Coordination Work

One of the plans involved will pay benefits first. (This plan is primary.) The other plans will pay benefits next. (These plans are secondary.)

If the Fund's plan is primary, it will pay benefits first. Benefits under the Fund's plan will not be reduced due to benefits payable under other plans.

If the Fund's plan is secondary, benefits under the Fund's plan may be reduced due to benefits payable under other plans primary to the Fund's plan.

The amount of actual charges will be determined first. Then the amount of benefits paid by plans primary to the Fund's plan will be subtracted from this amount. The Fund's plan will pay you the difference but no more than the amount it would have paid without this provision.

Which Plan is Primary

In order to pay claims, DDIL must find out which plan is primary and which plans are secondary.

There are rules to find out which plan is primary and which plans are secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

1. A plan which has no coordination of benefits provision will be primary to a plan which does have a coordination of benefits provision.

2. A plan which covers the person as an Employee will be primary to a plan which covers the same person as a Dependent.

3. A person may be covered as a Dependent under two or more plans.

   (a) The plan which covers that person as a Dependent of the person whose birthday is earlier in the Calendar Year will be primary to a plan which covers that person as a Dependent of a person whose birthday is later in the Calendar Year.

   (b) The other plan may not have a rule based on birthdays similar to this rule. The rule in the other plan will determine which plan is primary.

4. However, the person may be covered as a Dependent under two or more plans of divorced or separated parents. The rules that are used to find out which plan is primary and which plans are secondary are as follows:

   (a) The plan of the parent with custody will be primary to a plan of the parent without custody. Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:

      (i) The plan of the parent with custody will pay benefits first.
      (ii) The plan of the stepparent with custody will pay benefits next.
      (iii) The plan of the parent without custody will pay benefits next.

   (b) There may be a court decree which gives one parent financial responsibility for the medical, dental or other health expenses of the dependent child. A plan of the parent with this financial responsibility will be primary to any other plan which covers that dependent child.

5. A plan may cover a person as an Employee who is not laid off or retired, or as a Dependent of that employee. The Fund's plan will be primary to any plan which covers the person as a laid-off or retired employee, or as a Dependent of that employee. The other plan may not have a rule for laid-off or retired employees similar to this rule. In this case, this rule will not apply.

6. If none of the above rules apply, the plan which has covered the person for the longest time will be primary to all other plans.

You will have to give information about any other plans when you file a claim.

CLAIMS INFORMATION

To use your Group Dental Plan, follow these steps:

(1) Please read this Dental Benefits Booklet carefully so you understand how the Fund's plan works.

(2) A claim form must be sent to DDIL. If your Dentist is a Delta Dental PPO Dentist, he/she will fill out a claim form and send it to DDIL for you. If your Dentist is not a Delta Dental PPO Dentist, you may need to fill out a claim form and give it to the Dentist.

(3) If you need to fill out a claim form yourself, please read the form carefully and answer as many of the questions as you can. Be sure you write the following information on the claim form:

(a) your full name and address;
(b) your social security number;
(c) the name and date of birth of the person receiving dental treatment; and
(d) the group name and number.

If your Dentist is not familiar with the Fund's plan or has any questions regarding the Fund's plan, he/she may contact Delta Dental of Illinois, 801 Ogden Avenue, Lisle, Illinois 60532; telephone (630) 964-2400 or (800) 323-1743.

To claim benefits you must give DDIL written proof of your loss within 90 days after the date of the loss or the date the expenses are incurred.

If the Fund's plan provides any periodic payment which depends on continuing loss, the proof must be given within 90 days after the end of the period for which the plan is liable.

If it is not possible to give the proof within 90 days, give the proof as soon as possible. Your claim will not be reduced or denied if you give the proof as soon as reasonably possible.

Proof of loss must be given within one year from the time you have to give proof as described above. The only time that this one-year limit will not apply would be if the person is not legally able to do so or was unaware that the claim had not been filed by the dentist and paid by the Fund.

It is important to keep separate records for each person in your family, since maximum amounts and other provisions apply separately to each person.

Be sure to save all bills and attach copies of them to the claim form. Keep a record of the date of service and the type of service given.

DDIL can request any needed proof of loss in connection with a claim under the Dental Care Benefit. This includes the following:

. Dentist's or physician's statement of treatment;
. study models; and
. x-rays taken before and after treatment.

All benefits will be paid immediately after DDIL receives satisfactory proof of loss. If you go to a Delta Dental PPO Dentist, benefits will be paid to the Dentist directly. If you go to a Non-Delta Dental PPO Dentist, benefits will be paid, at the plan's option, to either you or the Dentist, and the right to receive such payment shall not be assignable.

Remedies Available Under the Plan for Redress of Denied Dental Claims

You will be notified in writing by DDIL if a claim or any part of a claim is denied. If you are not satisfied with the explanation of why the claim was denied, you may ask to have your claim reviewed by DDIL or you may appeal to the Fund's Claims Committee immediately.

The claim denial will tell you the name and address of the person at DDIL you can write to for the review, as well as how to file an appeal with the Fund's Claims Committee.

The procedures for requesting review of claims by DDIL and for filing appeals with the Fund's Claims Committee also are described below.

How to Request Review of a Claim by DDIL

If you think you have more information that can help your claim, you can send it to DDIL with your request.

You can ask for and receive copies of documents important to the claim. In some cases you may be asked to sign a release in order to obtain confidential information such as medical records.

You must submit information and comments in writing.

A decision will be made by DDIL within 60 days after receipt of request for review.

DDIL will notify you in writing about the decision on your review. The reasons for the decision will be stated in a manner you can understand.

How to File an Appeal of a Claim with the Fund's Claims Committee

If your claim is denied in whole or in part, you will receive a written explanation giving detailed reasons for the denial, specific reference to policy provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim, and an explanation of why such material or information is necessary, as well as an explanation of our claim appeal procedure.

If you are not satisfied or do not agree with the reasons for the denial of your claim, you may appeal the decision to the Claims Appeal Committee of the Board of Trustees of the Laborers' Welfare Plan, 11465 West Cermak Road, Westchester, Illinois 60154, telephone (708) 562-0200. The Committee is the fiduciary under the plan designated to review any claim appeal by you.

The appeal **must be in writing,** and can be made by you or your duly authorized representative. It must set out your reasons for your appeal and your dissatisfaction or disagreement. Any evidence or documentation to support your position should be submitted with your written appeal. Upon written request, you may review pertinent documents that pertain to your claim and its denial.

Your appeal must be made within 60 days of the date you receive the letter denying your claim.

The Committee will promptly review your claim and appeal. It will advise you of its decision in writing, giving specific reasons for the decision with specific references to pertinent policy provisions on which the decision is based. This written decision will be sent to you no later than 60 days after the Committee's receipt of your written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information, or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after receipt by the Committee of your written appeal.

BENEFITS AVAILABLE AFTER COVERAGE STOPS

Dental Care Benefit

The Fund's plan will pay Dental Care Benefits in the following cases:

(a) when a tooth or teeth are first prepared for fixed bridgework, crowns, inlays, onlays or gold restorations while the person is covered and the service or supply is given within 90 days after coverage stops;
(b) when the impression for full or partial removable dentures is taken while the person is covered and the dentures are installed within 90 days after coverage stops;
(c) when a tooth is opened for root canal work while the person is covered and the work is completed within 90 days after coverage stops; or
(d) when orthodontic treatment is in progress and an active appliance has been installed.

The Fund's plan will not pay for expenses which are payable under any other group plan.

GLOSSARY

These definitions apply when the following terms are used in this Dental Benefits Booklet.

Approved Amount - This is the lesser of the Dentist's submitted fee or DDIL's Maximum Plan Allowance, which is calculated as a percentile based upon the billed fees of Dentists in a particular region.

Calendar Month - Any one of the 12 named months of the year beginning with the first day of that month.

Calendar Year - The period of 12 consecutive months beginning with the first day of each January.

Delta Dental PPO Dentist - A Dentist who has signed an agreement with DDIL to participate as a Delta Dental PPO Dentist. These Dentists have agreed with DDIL to provide dental services to Covered Individuals and to abide by the bylaws, rules and regulations established by DDIL. (See the Welfare Fund Office for the current listing of participating Delta Dental PPO Dentists in your area.).

Delta Dental PPO Orthodontic Reimbursement Amount - The amount that Delta Dental PPO Dentists of DDIL have agreed to accept as full reimbursement for orthodontic treatment.

Dentist - a person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Employer Contributor (Sub-Group) - Any employer who contributes to the Health and Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity.

DDIL - Delta Dental of Illinois, Lisle, Illinois.

Fund - The Health and Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity. The Board of Trustees and Administrator are responsible for administering the Fund, also known as the Laborers' Welfare Fund.

Union - The Construction and General Laborers' District Council of Chicago and Vicinity, AFL-CIO, and the Local Unions that are part of the District Council.

Welfare Fund Office - The administrative offices of the plan administrator, located at 11465 West Cermak Road, Westchester, Illinois 60154; telephone (708) 562-0200.

Definitions of Common Dental Terms

Anesthesia - General - The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anesthesia - Local - The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

Anesthetic - A drug that produces loss of feeling or sensation, either generally or locally.

Bitewing - Dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Fillings - Porcelain, Silicate, Acrylic, Plastic or Composite - Materials used to fill cavities which have less durability, thus they are placed on non-stress-bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of silver amalgam.

Fillings - Silver Amalgam - Material used to fill cavities that is usually placed on the tooth surface that is used for chewing because it is a particularly durable material.

Fluoride - A solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

Gingivae - The gums or soft tissue surrounding the teeth and bone.

Gingivectomy - The cutting away of the diseased gums (gingivae) when the underlying bone is not yet affected.

Periodontal Disease - A disease which weakens and destroys the gums, bone and membrane surrounding the teeth. Periodontal disease is the principal cause of tooth loss in people over age 30. This disease is sometimes called Vincent's disease, gingivitis or pyorrhea.

Periodontist - A Dentist whose practice is limited to the treatment of periodontal disease.

Prophylaxis - The removal of tartar and stains from the teeth; the cleaning of the teeth by a Dentist or dental hygienist.

Root Canal Therapy (Endodontic Therapy) - Treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling the spaces with sealing material.

Scale - To remove calculus (tartar) and stains from teeth with special instruments.

Topical - Painting the surface of teeth as in fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

TREATMENT PLANS AND CLAIMS ARE TO BE SENT TO:

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