LOOK AT ALL THE RESTRICTIONS, EXCLUSIONS AND LIMITS OF COMMON DENTAL PLANS!

GENERAL LIMITATIONS

ORAL EXAMINATIONS covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per calendar year, limited to one time every 6 months.
COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to onetime per 36 months.
BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year
EXTERNAL RADIOGRAPHS Limited to 2 films per calendar year
DENTAL PROPHYLAXIS Limited to 2 times per calendar year, limited to once every 6 months.
DIAGNOSTIC CASTS Limited to one per 24 months
FLORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis
SEALANTS Limited to Covered Person under the age of 16 years once per first or second permanent molar every 5 years.
SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years, once per lifetime Benefit includes all adjustment within 6 month of installation.
AMAGUM RESTORATIONS Multiple restorations on one surface will be treated as a single filling.
PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.
GOLD INLAYS AND OUTLAYS Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth.
CROWNS Limited to one time per 5 calendar years. Covered only when a filling cannot restore the tooth.
POST AND CORES Covered only for teeth that have had root canal therapy.
SEDATIVE FILLINGS Covered as a separate benefit only if no other services other than X-rays and exam were done during the visit.
SCALING AND ROOT PLANING Limited to 1 time per quadrant per 24 months.
PERIODONAL MAINTENACE Limited to 2 tomes with the first 12 months following active and adjunctive periodontal therapy, exclusive of gums debridgemant.
FULL DENTURES No additional allowance for overdentures or customized dentures.
PARTIAL DENTURS No additional allowances for precision or semi-precision attachments.
RELINING DENTURES Limited to relining done more than 6 months after the initial insertion. Limited to 1 time per calendar year.

GENERAL EXCLUSIONS

1. Dental Services that are not necessary
2. hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic and aesthetic reasons (Cosmetic procedure are those procedures that improve physical appearance).
4. Reconstructive Surgery of whether or not the surgery which is indicated to a dental disease, injury or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an Experiment, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Workman's Comp or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county or other public subdivision. The exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures began prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental services provided in a foreign country unless required as an emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to coverage unless the patient has been eligible under the plan for 12 consecutive months. If loss of a tooth requires the addition of a clasp, poetic and/or

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14. abutment (s) within the 12 month period, the plan is responsible only for the procedures associated with the addition.
15. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 consecutive months.
16. Full mouth radiograph series in excess of once every 36 months. Panasonic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts or neoplasms.
17. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingioplasty, gingival curettage, osseos surgery, pedical grafts, and free soft tissue grafts.
18. Osseos grafts with ore without reasonable or nonresonable GTR membrane placement in exce4ss of once every 36 month per quadrant or surgical site.
19. Root planning and scaling in excess of once every 25 months per quadrant.
20. Full mouth degridgement in excess of once every 36 months
21. Replacement of complete or partial dentures, fixed bridgework, or crown previously submitted for payment under the Plan within sixty months of initial or supplemental placement. This includes retainers, habit appliances and any fixed or removable interceptive orthodontic appliances.
22. Denture relines for complete or partial conventional dentures for the month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial denture for the first six months. After the six month period, recliners are covered not more than once every 12 months.
23. Fixed and removable prosthetic restoration procedure for compete and rehabilitation or reconstruction.
24. Procedures related to the reconstruction of a patients correct vertical dimension of occlusion.
25. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
26. Setting of facial bony fractures and any treatment associated with dislocation of facial skeletal hard surfaces.
27. Drugs/medication obtainable with or without a prescription unless they are diagnosed and utilized in the dental office during the patient visit.
28. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

THERE MUST BE SOMETHING BETTER!

THERE IS. MOUNTAIN WEST BENEFITS.

1-877-343-1060

THE TRADITIONAL DENTAL PLAN, STILL IN USE TODAY, WAS CREATED IN 1960.

- Benefits are based on procedure codes and ones permitted by insurance companies
- Limits are placed on how often you can see the dentist.
- Age limits are placed to restrict specific care to specific patients.
- Care is controlled by forcing the employee to use "least expensive alternative treatment".
- Dollars paid are based on percentiles of "reasonable charges" for the specific area.
- Control and freedom of care rights are removed away from the employee.

TAKE A LOOK AT THE TRADITIONAL DENTAL PLAN:

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Maximum (combined for both In-Network and Out-of- Network services)	$1000 per person per calendar year	$1000 per person per calendar year

New enrollees have a 12-month waiting period applicable to major services

COVERED SERVICES	IN-NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS*	BENEFIT GUIDELINES
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	100%	Up to 2 per year
Bite-Wing X-rays	100%	100%	One series of films / year
Complete Series or Pane = X-rays	100%	100%	One time per 36 months
Dental Prophylaxis (Cleanings)	100%	100%	Up to 2 per year
Fluoride Treatments	100%	100%	For covered persons under the age of 16 years, up to 2 per year
Sealants	100%	100%	For covered persons under the age of 16 years, once per first or second once per first or second molar every 5 years
BASIC DENTAL SERVICES (MINOR RESTORATIVE, ENDODONTICS, PERIODONTICS AND ORAL SURGERY)			
Amalgam Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years
Composite Resin Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years
Space Maintainers	80%	80%	For covered persons under the age of 16 years
once per lifetime			
Root Canal Treatment	80%	80%	Once per site per lifetime
Root Planing	80%	80%	Once every 24 months per quadrant
Periodontal Surgery	80%	80%	Once every 36 months/site
Simple Extraction	80%	80%	
Surgical Extraction including impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary
Pallative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit
MAJOR DENTAL SERVICES			
Crowns	50%	50%	Once every 5 years
Fixed Bridges	50%	50%	Once every 5 years (altern-ate benefits for a partial denture may be applied)
Full Dentures	50%	50%	Once every 5 years; no allowance for precision or semiprecision attachments
Inlays or Onlays	50%	50%	Once every 5 years
Partial Dentures	50%	50%	Once every 5 years; no allowance for precision or semiprecision attachments
Relining Dentures	50%	50%	Once every year after the 6 month period following initial insertion
Repairs to Full Dentures, Parital Dentures, Bridges	50%	50%	For repairs or adjustments done after 12 months following initial insertion

IT GETS WORSE