



GRIMMWAY ENTERPRISES, INC.

PPO DENTAL PLAN

BENEFITS	INCLUDES	IN-NETWORK PPO PROVIDER – PLAN PAYS	OUT-OF-NETWORK PROVIDER – PLAN PAYS
TYPE I BENEFITS Diagnostic & Preventive Procedures	Oral examinations; Office visits; X-rays (complete series, panoramic, bitewing, occlusal, periapical, extraoral); Prophylaxis (cleaning); Fluoride; Sealants; Harmful habit appliance; Space maintainers	100% (Deductible Waived)	80% (Deductible Waived)
TYPE II BENEFITS Basic Procedures	Fillings; Stainless steel crowns; Prefabricated resin crown; Endodontic services; Periodontal services; Oral surgery; Other surgical procedures; Anesthesia; Other services	90% (Deductible Applies)	80% (Deductible Applies)
TYPE III BENEFITS Major Procedures	Periodontal surgical procedures; Bone replacement graft; Inlays, onlays, crowns; Removable full & partial dentures; Fixed prosthodontic services	60% (Deductible Applies)	50% (Deductible Applies)
TYPE IV BENEFITS Orthodontics	Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures. Removable or fixed appliances for tooth or bony structure guidance or retention.	50% (No Deductible)	50% (No Deductible)
Calendar Year Maximum (per enrolled member) Combined In-network/Out-of-network		\$1,500	\$1,500
Orthodontic Lifetime Maximum Combined In-Network/Out-of-Network		\$1,500	\$1,500
Calendar Year Deductible (per enrolled member)		\$25	\$50
Family Calendar Year Deductible (per family maximum)		\$75	\$150

When the family maximum Deductible is satisfied, benefits will be payable as if the individual Deductible for each person in the family has been satisfied for the calendar year.

Covered Charges used to satisfy the calendar year Deductible that is applicable when care is received from Out-of-Network Providers will be counted toward satisfaction of the calendar year Deductible that is applicable when care is received from an In-Network Provider, and vice versa.

In no event will the individual calendar year Deductible for combined In-Network Provider and Out-of-Network Providers be more than the Out-of-Network Providers Deductible Amount.

In-Network Provider: A dentist contracted with LIBERTY Dental Plan's PPO Network. In-Network Providers may not charge above their contracted fee. Members will only be responsible for their applicable percentage of the In-Network Provider's contracted fee for covered services, deductibles, any amount over the annual maximum of coverage, and non-covered services.

Out-of-Network Provider: Members have complete freedom of choice to receive services from any dentist; however, in order to avoid higher charges and reduced benefit payment, you are encouraged to obtain dental care from an In-Network Provider whenever possible.

Plan Exclusions:

1. Treatment or service that is not for necessary dental care
2. The services of any person who is not a dentist or dental hygienist
3. Any part of a charge for treatment or service that exceeds the usual and customary regional fee (out-of-network providers)
4. The services of any person who is in the Member's or Dependent's immediate family
5. Implants
6. Treatment or service that does not meet professionally recognized standards of quality
7. Veneers, personalization of dentures or crowns and any other treatment or service that is primarily cosmetic
8. Drugs, medicines, or therapeutic drug injections
9. Instructions for plaque control, oral hygiene, or diet
10. Bite registration or occlusal analysis
11. Treatment or service to alter or maintain vertical dimension or restore or maintain occlusion
12. Treatment or service for the purpose of duplicating a prosthetic device or replacing any such device that is lost or stolen
13. Treatment or service for the purpose of duplicating an appliance or replacing any such appliance that is lost or stolen
14. Orthodontic treatment or service; if the appliance or bands were placed prior to being insured under this Group Policy, unless the Member or Dependent is currently in a treatment plan which was covered under prior group orthodontic coverage, and there has been no lapse in coverage
15. Treatment or service for provisional or permanent splinting
16. Treatment or service for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance
17. Treatment or service that is temporary
18. Treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law)
19. Treatment or service that results from:
 - a. an injury arising out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law
 - b. a sickness covered by a Workers' Compensation Act or other similar law
20. Treatment or service that results from war or act of war
21. Treatment or service that results from commission of or attempted commission of a felony or voluntary participation in an illegal occupation
22. Treatment or service provided outside the United States, unless the Member or Dependent are outside the United States for one of the following reasons:
 - a. travel, provided the travel is for a reason other than securing dental care diagnosis or treatment, and travel is for a period of six months or less; or
 - b. a business assignment, provided the Member or Dependent are temporarily outside the United States for a period of six months or less; or
 - c. full-time student status, provided the student is either:
 - enrolled and attending an accredited school in a foreign country; or
 - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
 - Mormon missionary work of a Dependent Child, and such missionary work is for a period of two years or less
23. Treatment or service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction
24. Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years
25. Treatment or service that is paid for by a Medicare Supplement Insurance Plan
26. Treatment or service for temporomandibular joint disorders

Plan Limitations:

1. Two oral examinations in any 12 consecutive month period
2. One complete series (full-mouth x-rays including bitewings) or one panoramic x-ray in any 60 consecutive month period
3. One set of bitewing x-rays and two periapical films in any 12 consecutive month period
4. One extraoral x-ray will be covered in any six consecutive month period
5. Two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any 12 consecutive month period
6. Topical fluoride treatment for dependent children under the age of 14 limited to one application in any 12 consecutive months

7. Sealants are covered for first and second permanent molars only for dependent children under the age of 16. Limited to once per tooth in any 36 consecutive month period
8. Space maintainers are limited to dependent children under the age of 16
9. Benefits for composite restorations on molar teeth will be based on the benefits for the corresponding amalgam restorations
10. Stainless steel and prefabricated resin crowns are covered for dependent children under the age of 19 only and limited to one in any 24 consecutive month period
11. Vital pulpotomy covered for deciduous (primary) teeth only
12. Retreatment of previous root canal therapy limited to once per tooth per lifetime
13. Periodontal scaling and root planing limited to once each quadrant in any 24 consecutive month period
14. General anesthesia and IV sedation is covered only when required for complex oral surgical procedures covered under this plan and only when performed in a dental office.
15. Consultation with a specialist limited to once in any 12 consecutive month period
16. Periodontal surgical procedures are limited to once per quadrant in any 36 consecutive month period
17. Bone replacement graft limited to once per site per lifetime
18. Recementing inlay, onlay, crown covered if done more than 12 months after initial insertion, limited to one time in any 24 consecutive month period
19. Repairs to complete or partial denture, bridge or crown; relining and rebasing of complete or partial dentures; tissue conditioning covered if done more than 12 months after initial insertion, limited to one time in any 24 consecutive month period
20. Denture adjustment covered only if at least 2 months have elapsed since the insertion, limited to once in any 12 consecutive month period
21. Inlay and onlay restorations covered only if tooth cannot be restored by a filling. Replacements – at least 60 months since the last placement. Not covered for persons under the age of 16
22. Crowns are covered only if the tooth cannot be restored by a filling. Replacements – at least 60 months since the last placement. Crowns for the replacement of inlay or onlay or bridge abutment are covered only if at least 60 consecutive months have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under age 16, the benefit for a crown on a vital tooth is limited to resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months has elapsed since placement of the pontic
23. Cast post and core and core buildup limited to once per tooth per 60 consecutive month period
24. Fixed bridges limited to persons over age 16. Benefits for fixed bridges are payable only for the replacement of those teeth which were extracted while insured under this Group Policy. Fixed bridge must be more than 60 consecutive months old and not serviceable for replacement to be covered.
25. Complete and partial dentures are covered only for the replacement of those teeth which were extracted while insured under this Group Policy. Appliance must be more than 60 consecutive months old and not serviceable for replacement to be covered.
26. If LIBERTY Dental Plan determines that more than one procedure could be performed to correct a dental condition, the covered benefit will be the least expensive of the procedures that would provide professionally acceptable results.
27. Covered charges will include only those charges for treatment or services that begins while the Member or Dependent is insured under this Group Policy

Claim Address:

LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110

Member Services:

(888) 703-6999
Monday – Friday
7:00 a.m. – 5:00 p.m.

This is only a brief summary of the Dental Plan. The Dental Plan contract and Summary Plan Description must be consulted to determine the exact terms, limitations, and exclusions of coverage.