FOX VALLEY LABORERS HEALTH AND WELFARE FUND
SUMMARY OF DENTAL BENEFITS
As of June 2011

Section 10.1 Definitions

(a) **"Course of Dental Treatment"** means a planned program of one or more services or supplies, whether rendered by one or more Dentists, for the treatment of a dental condition diagnosed by the attending Dentist as a result of an oral examination.

(b) **"Covered Dental Expense"** means the charges of a Dentist which an Eligible Participant or Dependent is required to pay for the services and supplies necessary for treatment of a dental condition, but only to the extent that such charges are Allowable Charges for services and supplies customarily employed for treatment of that condition, and only if provided in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the dental services which are recommended and performed by a licensed Dentist and described in this Article.

(c) **"Dentist"** means a duly licensed dentist or Physician licensed to furnish certain dental services, acting within the scope of his license to perform the particular dental services he has rendered.

Section 10.2 Coverage Provided

This Article shall provide Eligible Participants and Dependents who meet the eligibility requirements in Article III, with a Dental Benefits Program structured to include five types of Covered Dental Expenses: Type A Services, Type B Services, Type C Services, Type D Services and Type E Services. The extent of an Eligible Participant's or Dependent's Coverage hereunder shall be determined by the type of services rendered as illustrated below.

Preventive Services General and Replacement Services (Types A, B and C)	$50 deductible per individual per Calendar Year
Preventive Services (Type A)	100% of covered expenses
General Replacement Services (Types B and C)	85% of covered expenses
Orthodontic Services (Type D)	85% of covered expenses
Implant Services Type E	85% of covered expenses
Maximum Benefit for Types A, B and C	$1,500 per individual per Calendar Year
Maximum Benefit for Type D	$2,000 per individual per lifetime
Maximum Benefit for Type E	$3,500 per individual per lifetime

The Calendar Year maximum benefit limitation for Types A, B and C Services will not apply to essential pediatric benefits for eligible children under the age of 18.

The type of services rendered to the Eligible Participant or Dependent shall establish the Deductible Amounts, coinsurance rates and maximum benefits payable:

(a) Type A Services

Allowable Charges for the following types of Covered Dental Expenses shall be subject to the deductible and paid up to the maximum benefit:

(1) Routine oral examinations and prophylaxis (scaling and cleaning of the teeth) but not more than twice in a Calendar Year;
(2) Topical application of fluoride for children up to nineteen (19) years of age, but not more than one application in a Calendar Year;
(3) Sealants for children up to age 19. This benefit is limited to one application each calendar year.
(4) Space maintainers that replace prematurely lost deciduous teeth; and
(5) Emergency palliative treatment (treatment of pain-toothache).

(b) Type B and C Services

Allowable Charges for some or all of the following types of Covered Dental Expenses shall be subject to the deductible and paid up to the maximum benefit:

(1) Dental X-rays, including full mouth X-rays (but not more than once in any period of 36 consecutive months), supplementary bitewing X-rays (but not more than once in any period of six (6) consecutive months) and such other dental X- rays as are required in connection with the diagnosis of a specific condition requiring treatment;
(2) Extractions;
(3) Oral surgery;
(4) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
(5) General anesthetics when Medically Necessary and administered in connection with oral or dental surgery;
(6) Treatment of periodontal and other disease of the gums and tissues of the mouth;
(7) Endodontic treatment, including root canal therapy;
(8) Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months;
(9) Inlays, onlays, gold fillings, or crown restorations, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration; and
(10) Treatment for temporomandibular joint syndrome.
(11) Initial installation of fixed bridgework (including inlays and crowns as abutments); initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation); and replacement of an existing partial or full removable dentures or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing

partial, removable denture or bridgework, or to replace extracted natural teeth only if --

(A) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while eligible and after the existing denture or bridgework was installed;
(B) the existing denture or bridgework was installed at least five (5) years prior to its replacement and cannot be made serviceable; or
(C) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

(c) Type D Services (Orthodontic)

Allowable Charges for some or all of the following types of Covered Dental Expenses shall be paid up to the maximum benefit:

(1) Orthodontic diagnostic procedures.
(2) Initial and subsequent, if any, installations of orthodontic appliances.
(3) Surgical therapy and functional therapy, including related oral examinations and surgery.

(d) Type E Services (Implants)

Allowable Charges for some or all of the following types of covered Dental Expenses shall be subject to the Deductible and paid up to the maximum benefit:

(1) Placement of implants. The implant must be FDA approved and ADA acceptable and provisionally acceptable.
(2) Related examinations.

However, no benefits are payable unless the procedure is pre-approved by the Fund.

Section 10.3 Coverage Not Provided by the Dental Benefit Portion of the Plan

In addition to any limitations stated elsewhere in the Plan or any Supplements or Amendments hereto, no benefit will be payable under this Article for expenses incurred for:

(a) Expenses that exceed Allowable Charges;
(b) Treatment by other than a licensed Dentist, except for cleaning of teeth performed by a licensed dental hygienist, under the supervision and direction of a Dentist;
(c) Dental care which is included as a covered expense under any medical or comprehensive major medical expense benefit;
(d) Dental Expense which is due to Illness or Injury that is related to any occupation or employment for wages or profit;
(e) Courses of Dental Treatment which are received or started prior to the date the Participant becomes entitled to dental care benefits pursuant to the eligibility rules as set forth in Article III, or the date dental coverage begins for such Participant's Participating Union. Treatment is considered started --
    (1) for restorative services and endodontic services, when the tooth is prepared, or
    (2) for fixed or removable prosthodontics, when the impression for the appliance is taken;

(f) Treatment of any condition caused by war, or by any act of war, declared or undeclared, or by participating in a criminal enterprise or unlawful behavior;
(g) Replacement of a lost or stolen prosthetic device;
(h) Charges for failure to keep a scheduled appointment with a Dentist;
(i) Charges for porcelain or plastic pontics or facings on crowns posterior to the second bicuspid;
(j) Extraction of exfoliating deciduous teeth;
(k) Service with respect to congenital or development malformations or dentistry for purely cosmetic reasons including (but not limited to) cleft palate, maxillary and mandibular malformation, enamel hypoplasia, fluorosis, and anadonia except for Type D;
(l) Charges for the completion of dental care claim forms;
(m) Orthodontia or correction of malocclusion, except as specifically provided herein;
(n) Replacement of an existing prosthodontic appliance unless evidence satisfactory to the Trustees is presented that --
    (1) the existing appliance was installed at least five years prior to its replacement and the existing appliance cannot be made serviceable, or
    (2) the existing appliance is a temporary appliance.
(o) Charges for implants except as specifically provided herein.

Section 10.4 Alternate Courses of Dental Treatment

Due to the element of choice involved in the utilization of many dental services, situations frequently arise where there are two or more alternate methods of treatment for a particular dental condition.

If alternate services may be used to treat a dental condition, Covered Dental Expenses will be limited to the Allowable Charges for that service which --

(a) is customarily employed nationwide in the treatment of the condition; and
(b) is recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice taking into account the total current oral condition of the Eligible Participant or Dependent.

The purpose of this provision is to define the level of dental care upon which benefits are based when alternative methods of treatment may be used. The Eligible Participant or Dependent or such Eligible Participant's or Dependent's Dentist may choose a more expense level of care, but benefits will be payable in accordance with the above provision regardless of the method of treatment used.

Section 10.5 No Extension of Dental Benefits

All dental treatment must be performed while the individual being treated is eligible for benefits. There shall be no extended benefits payable for any Course of Dental Treatment or any other services if the individual receiving treatment is not eligible for benefits when the treatment is performed.

Section 10.6 Predetermination of Benefits

In order to maximize the dental benefits to which the Eligible Participant or Dependent is entitled, the Eligible Participant or Dependent must follow the predetermination procedure.

The predetermination procedure suggests that, before performing any needed dental services, the Eligible Participant's or Dependent's Dentist may submit to the Fund Office his proposed course of treatment for dental work for the Eligible Participant or Dependent, if the charges for the treatment will be

more than $500. The Course of Treatment must be submitted on a form provided by the Fund Office. The treatment course must give complete details, including full-mouth X- rays, concerning the services the Dentist proposes to complete and the charges the Dentist proposes to make for those services.

The Fund Office will review the Course of Treatment and the proposed fees and will advise the Eligible Participant or Dependent and such Eligible Participant's or Dependent's Dentist of the amount that will be payable by the Fund.

Section 10.7 Dental Network

The Fund may enter into agreements with a Dental Network offering access to a range of participating network dental providers who have agreed to charge lower fees for their services. Eligible Participants and Dependents may choose dental care services provided by providers that have negotiated service agreements with the Dental Network. Covered Dental Expenses remain the same whether Eligible Participants and Dependents choose to use a network Dentist or choose to see an out-of-network Dentist. However, by using a network provider, they can take advantage of the savings provided through the negotiated discount.