



State of Wisconsin/Wisconsin Public Employees (WPE)
WEA Trust 2012 Preferred Provider Plan (PPP)
Dental Outline of Coverage

BENEFITS	NETWORK	NON-NETWORK
INDIVIDUAL ANNUAL MAXIMUM	\$1,000	\$1,000

PREVENTIVE AND DIAGNOSTIC BENEFITS		
Periodic Oral Examinations—twice per calendar year	Covered in full	Subject to WEA Trust’s maximum reimbursement amount based on reasonable and customary*
Bitewing X-rays—twice per calendar year	Covered in full	
Prophylaxes—twice per calendar year	Covered in full	
Fluoride Applications—twice per calendar year/ dependent children under age 19	Covered in full	
Sealants—every five years/dependent children under age 17	Covered in full	
Diagnostic X-rays—one panoramic or full series per 24-month period	Covered in full	
Pulp Vitality Tests	Covered in full	
Office Visits or Consultations	Covered in full	

BASIC BENEFITS		
Fillings	Covered at 80%	80% and subject to WEA Trust’s maximum reimbursement amount based on reasonable and customary*
Extractions of Teeth	Covered at 80%	
Oral Surgery	Covered at 80%	
Stainless Steel Crowns	Covered at 80%	
Space Maintainers	Covered at 80%	
Pulpotomies and Root Canal Treatment	Covered at 80%	
Periodontic Treatments	Covered at 80%	
Denture Repair	Covered at 80%	
Occlusal Adjustments (\$100 lifetime max)	Covered at 80%	
Bruxism Appliances	Covered at 80%	

ONLAYS & CROWNS		
Crowns, onlays, laminates, and veneers to restore teeth, but only if we determine that such teeth as a result of fracture, extensive caries, trauma, or attrition, cannot be restored by any other means. Porcelain (tooth colored) or similar facings are covered on any tooth except a molar.	Covered at 50%	50% and subject to WEA Trust’s maximum reimbursement amount based on reasonable and customary*

ORTHODONTIC SERVICES		
Orthodontic services for covered dependent children under the age of 19	Covered at 50% with \$1,500 lifetime maximum	Covered at 50% with \$1,500 lifetime maximum

* We reimburse charges that we consider to be reasonable and customary. When we receive a claim, we compare the charge for each covered service with our schedule of reasonable and customary fees. If a charge exceeds the scheduled amount, we will reimburse less than the billed charge. You are responsible for any amount that exceeds the reasonable and customary fee.

Note: This is only a general outline of the WEA Trust PPP Dental Benefit—State benefits, limitations, and exclusions. A more detailed description of the WEA Trust PPP Dental Benefit—State coverage—is available to each plan member.

General Exclusions and Limitations

The plan's benefits are subject to the exclusions and limitations listed in Section 7 of the WEA Trust PPP Dental Benefit—State. Other exclusions and limitations appear under the specific categories of benefits to which they apply.

1. We will not reimburse for any service that is not specifically listed as a covered service in this plan document.
2. We will not reimburse the cost of services that fall outside the plan's General Provisions to cover only medically necessary and medically appropriate treatment. (See Section 2 of the WEA Trust PPP Dental Benefit—State.) For example, we will never cover services that we determine are wholly or primarily for cosmetic purposes.
3. We will not pay for any costs you incur in establishing or substantiating proof of a covered loss. For example, we do not reimburse charges for completing forms, expenses for copying and providing dental or medical records, or other information in support of a claim.
4. All reimbursements are subject to the "Factors That Affect the Reimbursement Amount" in Section 2.
5. We will not reimburse for the necessary replacement of crowns, onlays, laminates, and veneers that are less than five years old. However, if we determine they are unserviceable, their reimbursement will be prorated as described in Section 5 under "Five-Year Proration."
6. We will not reimburse expenses for or in connection with any of the following:
 - Services for the diagnosis or treatment of temporomandibular joint (TMJ) dysfunction and temporomandibular disorders (TMD).
 - Services in connection with the alteration or change of the vertical dimensions of the jaw or occlusion of the teeth except for the \$100 lifetime benefit maximum for occlusal adjustment for each covered individual.
 - Appliances for increasing vertical dimension or restoring occlusion.
 - Hospital, ambulatory surgery center, or physician charges.
 - Hospital calls made by Dentists.
 - Therapeutic drug injections and prescription or non-prescription drugs of any kind.
 - Take-home dental or oral hygiene supplies.
 - Behavior management.
 - Expenses for services that are reimbursable under a surgical, medical, or comprehensive health insurance policy.
 - Services performed outside the scope of the license of the individual providing the services.
 - Replacement of orthodontic appliances, retainers, prosthetics, or other oral appliances that have been lost, stolen, damaged, misplaced, missing, or otherwise compromised.
7. We do not reimburse any expenses, even if medically necessary and medically appropriate, for the following:
 - Services furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.
 - Services furnished or paid for by a governmental entity, facility, or program other than Medicaid or as required by law.
 - Services eligible for worker's compensation benefits, or benefits from any other payment program established by similar law, whether or not you apply for or receive them. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.
 - Services for a condition resulting from service in the armed forces of any country or from an act of war, whether declared or undeclared.
 - Services received while you are not covered by this plan.
 - Services for a condition resulting from participation in a crime.

