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e. Modify Appendix A. (Dental Plan Specifications) Section IV to indicate orthodontia is an *included* rather than excluded benefit.

APPENDIX A - DENTAL PLAN SPECIFICATIONS
Employee Only Coverage

I.	Type I Expenses	
	A. Deductible	None
	B. Reimbursement	80%
I.	Type II and III Expenses	
	A. Deductible	$25 per calendar year
	B. Type II Expenses Reimbursement	80%
	C. Type III Expenses Reimbursement	50%
III.	Calendar Year Individual Maximum	$1500.00
IV.	Orthodontia	Included ~~Excluded~~
V.	Service Waiting Period	First of the month following date of hire
VI.	Employee Contribution	None

General Schedule of Dental Services (Reimbursable Expenses)

A. Type I Expenses (Diagnostic and Preventive)
* Oral examinations
* X-Rays
* Prophylaxis (cleaning)
* Emergency treatment for pain
* Fluoride treatments
* Space maintainers

B. Type II Expenses (Basic Services)
* Anesthesia

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* Restorations (Fillings other than gold). Effective 1-1-08, coverage includes composite (white) resin restorations for anterior (front) and posterior (back) teeth.
* Endodontics (such as pulp capping and root canal therapy)
* Periodontics
* Maintenance and repair to dentures, fixed bridges * Extractions

C. Type III Expenses (Major Services) * Gold inlay, crowns, etc.
* Prosthodontics (removable and fixed)
  - Complete dentures
  - Partial dentures

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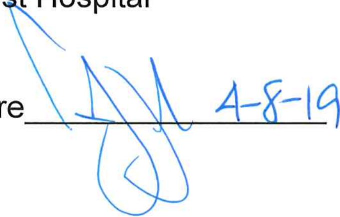
Signature 

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Signature