DENTAL BENEFITS

Individual Calendar Year Deductible: $50

Before Plan benefits are paid for many dental expenses, you must pay a **deductible**, which is the first $50 of eligible charges incurred each calendar year. The **deductible** does not apply to preventive services.

Maximum Family Calendar Year Deductible: **$150**

The calendar year **deductible** will be limited to $150 for members of any one family. The family calendar year **deductible** amount can be accumulated through charges incurred by any combination of family members.

Benefit Percentages

The Plan will pay the following percentages of usual, customary and reasonable charges for covered services:

Preventive Services	100%
Basic Services	80%*
Major Services	50%*
Orthodontic Services	50%*

*After satisfaction of the **deductible**

Maximum Benefits

Calendar Year Maximum $1,200 per individual

Dental benefits for preventive, basic and major dental care combined are limited to $1,200 payable per covered individual in a calendar year.

Orthodontic **Lifetime** Maximum $1,500 per individual

The **lifetime** maximum payable for orthodontic expenses is $1,500 per covered individual. Payments for orthodontic expenses are not included in calculating the calendar year maximum benefit.

<u>Predetermination of Benefits</u>

If the proposed dental treatment plan will cost over $200, you or your **dentist** may contact the **claim administrator** to voluntarily predetermine the necessity of services and the allowable amount. This will enable you to estimate in advance, the amount that will be paid by the Plan and the amount for which you

may be responsible. When the post-service claim is received by the **claim administrator**, benefits will be determined without giving deference to the predetermination.

Covered Expenses

The following are covered expenses under this plan. Benefits for these covered expenses are payable at the applicable **benefit percentage** and are subject to the **deductibles** and maximums shown above.

Preventive Services

- Preventive cleaning and scaling of teeth (above the gum line), but not more than twice in any calendar year;

- Fluoride application for individuals under age 19, but not more than twice in any calendar year;

- Space maintainers and their fitting for children age 13 and under;

- Diagnostic services to determine necessary care limited to:

  - Full mouth x-rays, not more than once in any three calendar year period, or more frequently if required in connection with the diagnosis of specific conditions;
  - Bitewing x-rays, but not more than twice in any calendar year;
  - Diagnostic oral examinations, but not more than twice in any calendar year;
  - X-rays and exams for emergency office visits, provided that charges for other dental services are not incurred during the same visit.

Basic Services

- Extracting one or more teeth, cutting procedures in the mouth, treating fractures and dislocations of the jaw;

- Treating gums and the supporting structure of the teeth;

- Periodontal scaling of teeth (below the gum line);

- Root canals and other endodontic treatment;

- General anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations;

- Antibiotics injected by a **dentist** or **physician** in conjunction with treatment of a covered dental expense;

- Fillings other than gold fillings (for gold fillings, see Major Services);

- Repairing existing dentures and fixed bridges (replacing such dentures and fixed bridges is described under Major Services);

- Adding teeth to an existing denture or fixed bridge, if required by the loss of natural teeth;

- Tooth sealants for children age six through 13. Coverage will be provided for the treatment of each permanent molar no more often than once every three calendar years;

Major Services

- One full or partial denture or fixed bridge. Replacing an existing device is covered if two conditions are met:

  - The existing device cannot be made serviceable; and

  - The device is more than five years old.

- Implants as an alternative to a bridge or other covered service. Benefits for implants will be limited to the amount payable under the Plan for the other service.

- Gold fillings and crowns necessary to restore the structure of teeth broken down by decay, injury, or severe attrition;

- Replacing a crown or gold filling (if the covered individual is charged for both temporary and permanent crowns or dentures, only the permanent charge is covered).

Orthodontic Services

- Orthodontic care includes treatment necessary for the proper alignment of teeth.

- Orthodontic coverage is provided only to individuals who are under age 19 at the time services are rendered.

Dental Exclusions and Limitations

Benefits are not payable for or in connection with:

1. Services or supplies partially or wholly **cosmetic** in nature;

2. Facings on pontics or crowns behind the second bicuspid. The cost to improve the **cosmetic** appearance for rear teeth is not covered;

3. Services or supplies furnished or reimbursed by any government or government program or law, unless payment is legally required;

4. Injuries arising out of or in the course of any occupation for wage or profit, or an **illness** for which **you** or **your dependent** is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law;

5. Specialized or personalized services;

6. Services or supplies not furnished by a **dentist** except x-rays ordered by a **dentist** and services of a Licensed Dental Hygienist under the **dentist's** supervision;

7. Training in, or supplies used for, dietary counseling, oral hygiene or plaque control;

8. Procedures, restoration and appliances to increase vertical dimension or restore occlusion, including treatment of Temporomandibular Joint dysfunction (TMJ);

9. Services or supplies due to war or act of war, declared or undeclared;

10. Services for which the covered individual would not be required to pay if there were no insurance;

11. Charges for removing stitches and post-operative examinations that have been included in the initial charge for a procedure listed in the Covered Expenses section;

12. Charges for adjusting dentures or bridges within six months of installation;

13. Failure to keep a scheduled visit with the **dentist**;

14. Services or supplies which do not meet accepted standards of dental practice, including those which are **experimental** in nature;

15. Orthodontic services for covered individuals other than **dependent** children;

16. Completion of insurance forms.

17. Expenses that are incurred while you are not covered under this plan. For this purpose, an expense is incurred at the time the service or supply.