SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS, THE MAXIMUM ELIGIBLE EXPENSE (MEE) OR PROCEDURE BASED LIMIT

THE BENEFIT PERIOD IS A CALENDAR YEAR

DEDUCTIBLE

Deductible Per Covered Person per Benefit Period $50

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses
- Deductible . . . . Waived
- Benefit Percentage 80%

Type B (Basic Care) Dental Expenses
- Deductible . . . . Applies
- Benefit Percentage 80%

Type C (Major Restorative) Dental Expenses
- Deductible . . . . Applies
- Benefit Percentage 50%

ORTHODONTIC TREATMENT BENEFIT
(For Dependent Children less than nineteen (19) years of age)

Deductible . . . . Applies
Benefit Percentage 50%
Maximum Lifetime Benefit $1,250

PLAN MAXIMUMS

Type A, B, and C Dental Expenses
- Maximum Benefit per Benefit Period $1,250

Orthodontic Treatment
- Maximum Lifetime Benefit $1,250

WAITING PERIODS

Major Restorative Services are covered after 12 months of continuous coverage under this Plan.

Orthodontic Treatment are covered after 12 months of continuous coverage under this Plan.

DENTAL BENEFITS

TYPE A (PREVENTIVE CARE) EXPENSES

The following general dental expenses will be considered “Type A” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Oral Examination (including prophylaxis--scaling and cleaning of teeth), but not more than twice in any Benefit Period.

2. Topical application of sodium fluoride or stannous fluoride for dependent children under fourteen (14) years of age. Benefits for topical application of sodium fluoride or stannous fluoride will be provided only once every Benefit Period.

3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one full mouth x-ray or series in any three Benefit Periods and not more than two sets of supplementary bitewing x-rays in any Benefit Period.

4. Sealants for Dependents under age nineteen (19) but not more than one treatment per permanent tooth every three (3) Benefit Periods.

5. Space maintainers for Dependents under age nineteen (19).

TYPE B (BASIC CARE) EXPENSES

The following general dental expenses will be considered “Type B” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Emergency palliative care to relieve dental pain.

2. Extractions, except for orthodontic extractions.

3. Oral surgery.

4. Fillings.

5. Nitrous Oxide when administered in connection with covered dental services.

6. General anesthesia when Medically Necessary and administered in connection with oral surgery or other Covered Dental Benefits. Administration of intravenous “IV” sedation for bony impacted extractions only.

7. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures, limited to scaling and root planning once per quadrant every three Benefit Periods.

8. Endodontic treatment, including root canal therapy.

9. Injection of antibiotic drugs.

10. Prophylaxis for periodontal treatment.

11. Non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

12. X-rays other than preventive to diagnose a dental condition.

TYPE C (MAJOR RESTORATIVE) EXPENSES

Major Restorative Services are eligible following twelve (12) consecutive months of coverage.

The following general dental expenses will be considered "Type C" for reimbursement purposes:

1. Gold fillings, inlays, onlays or crowns (including precision attachments for dentures).

2. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted.

3. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework. However, this item will apply only to replacements and additions that meet the "Prosthesis Replacement Rule" below.

4. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted.

5. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture. However, this item applies only to replacements and additions that meet the "Prosthesis Replacement Rule" below.

6. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures.

7. Dental implants.

8. Gingivectomy and gingivoplasty.

9. Management of acute infection and oral lesions.

ORTHODONTIC TREATMENT

(For Covered Dependent Children less than nineteen (19) years of age only)

Orthodontic Treatment is eligible following twelve (12) consecutive months of coverage.

The following expenses will be considered "Orthodontic" for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to any separate Deductible or Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.

2. Cephalometric X-ray once in any twenty-four (24) consecutive month period.

3. One set of study models per Covered Person.

4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.

5. Orthodontic extractions.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

PROSTHESIS REPLACEMENT RULE

Replacement of or additions to existing dentures or bridgework as described under Type C Expenses will be covered only if evidence satisfactory to the Plan Supervisor is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.

3. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

DENTAL BENEFIT LIMITATIONS

The following examples describe limitations in coverage under the Plan.

1. Restorative:

   A. Gold, baked porcelain restorations, crowns, jackets: The Eligible Expense for the dental procedure actually performed will be limited to the Eligible Expense appropriate to the procedure.

   B. Reconstruction. Benefits will include only the appropriate Eligible Expense for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are eligible only under the Orthodontic Treatment Benefit, if provided by this Plan.

2. Prosthodontics:

   A. Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, Eligible Expenses for the covered dental service performed will be limited to the Eligible Expense appropriate to the cast chrome or acrylic denture.

   B. Complete Dentures. The Eligible Expense for the dental procedure actually performed will be limited to the Eligible Expense appropriate to the standard procedure.

   C. Replacement of existing dentures or removable or fixed bridgework. Charges for the replacement of existing dentures or removable or fixed bridgework will be considered only if the existing appliance is not serviceable and cannot be repaired. The Eligible Expense for the procedure performed will be limited to the Eligible Expense appropriate for those services which would be necessary to render such appliances serviceable.

3. Facility, Ambulatory Surgery Center and Hospital expenses will include only services provided for any of the following reasons:

   A. If services are Dentally Necessary;

   B. If the Plan Administrator determines that for other than Dentally Necessary reasons, the services or treatment cannot be performed in the dental service provider’s office;

   C. For children less than 5 years of age;

   D. Covered Persons who are mentally or physically handicapped/challenged.

DENTAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Dental Benefits in addition to the following Dental Benefit Exclusions:

1. Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.

2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.

3. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. Charges for veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not Dentally Necessary. Only the charge for a corresponding restoration will be covered.

4. Charges for facility, Ambulatory Surgery Center and Hospital charges, except as specifically provided for under Dental Benefit Limitations.

5. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.

6. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.

7. Charges for any services or supplies which are for Orthodontic Treatment, except as specifically provided for by the Plan.

8. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.

9. Charges for oral hygiene and dietary instructions.

10. Charges for temporary dentures.

11. Charges for extracoronal and other periodontal splinting.

12. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.

13. Broken or missed appointments.

14. Charges for infection control (OSHA) fees or claim filing.

15. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.

16. Hypnosis, prescribed drugs, premedications or any euphoric drugs, with the exception of nitrous oxide.

17. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.

18. Appliances or restorations used for periodontal splinting; to increase vertical dimensions; to restore occlusions; or to correct habits including, but not limited to, tongue thrusting and bruxism.

19. Athletic mouth guards.

20. Bone grafting.

21. Myofunctional therapy.

22. Periodontal night guard.