DENTAL SCHEDULE OF BENEFITS

INDIVIDUAL DEDUCTIBLE Per calendar year. Waived for preventive services.	$75
FAMILY DEDUCTIBLE Per calendar year. Waived for preventive services.	$225
MAXIMUM PAYABLE Per Participant, per calendar year.	$1,000
	Coinsurance
TYPE I - PREVENTIVE Oral Exam, Cleaning, X-rays, Fluoride, and Sealants. Deductible waived.	80%
TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Endodontic Treatment, Periodontal Services, Pathology, Repairs, Adjustments, Tissue Conditioning, Anesthesia, and Injectables.	70%

If you are covered under this section, the Plan will pay the dental benefits listed herein. Benefits are subject to the limitations shown in the Schedule of Benefits in addition to limitations shown in this section. Charges in excess of the maximum allowable charge are not eligible under this Plan.

OPTIONAL PREDETERMINATION OF BENEFITS

Before beginning a course of treatment for which your dentist's charges are expected to be $250 or more, you are encouraged to send a description of the proposed course of treatment and charges to the Plan Supervisor. This information may be transmitted on a standard dental claim form available from your dentist. The Plan Supervisor will then determine the estimated benefits payable for the proposed treatment and advise you and your dentist before treatment begins.

The estimate will allow both you and your dentist to know in advance what benefits will be payable by the Plan. If desired, the estimate will also allow you to discuss the proposed treatment with another dentist and obtain a competitive opinion of needed treatment and the price for the treatment.

Please note that the estimate from the Plan Supervisor will be based on the coverage available at the time the estimate is given and will always be subject to the annual dental maximum benefit shown in the Schedule of Benefits.

DESCRIPTION OF BENEFITS

The Plan pays for covered dental expenses that are incurred during a calendar year on your behalf for preventive dental care, treatment of dental disease, failing dental restorations and for injury to teeth not otherwise covered under a medical benefit. Plan benefits are subject to the applicable deductible, coinsurance percentage, maximum allowable charge and payable up to the calendar year dental maximum shown in the Schedule of Benefits.

DEDUCTIBLE

The deductible for covered dental expenses is shown in the Schedule of Benefits. This amount must be satisfied (unless waived for certain expenses as shown in the Schedule of Benefits) before benefits are payable.

COVERED DENTAL EXPENSES

Covered dental expenses include your dentist's charges for the services and supplies listed below which meet all of the following tests:

- They are necessary and customarily employed nationwide for the treatment of the dental condition.

- They are appropriate and meet professionally recognized national standards of quality.
- They are the least costly dental care that will provide adequate treatment based upon national standards of the dental profession.

Benefits are determined by American Dental Association (ADA) codes submitted on the itemized bills. The correct ADA code must be used to ensure the benefit is paid at the correct coinsurance level.

The Plan pays only for covered charges incurred by you while you are insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is seated. A covered charge for any other prosthetic device is incurred on the date the prosthetic device is placed. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are rendered.

ALTERNATE TREATMENT

If alternate services or supplies are used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the dental condition and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account your total current oral condition.

TYPE I - PREVENTIVE

The following services and supplies are payable at the coinsurance amount as shown in the Schedule of Benefits and are not subject to the deductible:

- Preventive oral examinations during regular business hours limited to two treatment(s) every calendar year.
- Prophylaxis (preventive teeth cleaning) limited to two treatment(s) every calendar year.
- Topical application of fluoride limited to two treatment(s) every calendar year to age 20.
- Dental x-rays:
  - Full mouth series limited to once every 36 months.
  - Charges for bitewing x-rays are covered twice every calendar year.
- Sealants for permanent posterior teeth (bicuspids and molars only) to prevent crevice decay, limited to one treatment(s) every three calendar years.
- Oral hygiene instruction, lifetime maximum three sessions.
- Space maintainers limited to participants under age 12 and limited to initial appliance only. Allowance includes all adjustments in the first six months after installation: fixed, unilateral, band or stainless steel crown type or removal bilateral type.

TYPE II - BASIC AND RESTORATIVE

The following services and supplies are payable after the deductible at the coinsurance amount shown in the Schedule of Benefits.

- Fillings of silver amalgam, composite, plastic, porcelain, silicate, and synthetic restoration.
- Stainless steel crowns, the existing crown(s), limited to one crown per tooth every two calendar years.
- Palliative (alleviation of pain) emergency treatment.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment.
- Oral surgery, including surgical extractions and general anesthetic (when necessary).

- Apicoectomy (including retrograde filling).
- Periodontic services (treatment of the supporting tooth structures).
  - Periodontal examination, limited to once per calendar year.
  - Periodontal osseous/mucogingival surgery, limited to four quadrant(s) every 60 months.
  - Periodontal prophylaxis/maintenance, limited to two treatment(s) every calendar year.
  - Periodontal scaling and root planing, limited to four quadrant(s) every calendar year.
- Denture adjustments.
- Denture tissue conditioning. Lifetime maximum of three treatments per arch.
- Consultations.
- Alveoloplasty.
- Frenectomy.
- Bonded fillings and laminates.
- Veneers.
- Repairs of dentures and bridges; including recementing of crowns, inlays, onlays, and bridgework.
- Occlusal adjustments, limited to four quadrants every six months.

TYPE III - MAJOR AND PROSTHETICS

The following services and supplies are payable after the deductible at the coinsurance amount shown in the Schedule of Benefits:

- Crowns and crown build up.
- Post and core.
- Inlays and onlays.
- Bridges, fixed and removable.
- Dentures, full and partial.
- Rebasing of dentures, limited to once every 60 months.
- Relining of dentures, limited to once every 36 months.
- Addition of teeth to partial denture or bridgework to replace extracted natural teeth.

PROSTHESIS REPLACEMENT RULE

The Prosthesis Replacement Rule states that replacements or additions to existing restorations provided under Type III Major and Prosthetics of the Plan, (including but not limited to crown, denture, bridgework, inlay, or onlay), will be covered only if one of the following applies:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing crown, denture, bridgework, inlay, or onlay was installed, and while you were covered.

- The existing crown, denture, bridgework, inlay, or onlay cannot be made serviceable and was installed at least 5 years prior to its replacement.

- The existing crown, denture, bridgework, inlay, or onlay is an immediate temporary, and replacement by a permanent crown, denture, bridgework, inlay, or onlay is required within 12 months from the date of initial installation of the immediate temporary restoration.