

SCHEDULE OF DENTAL BENEFITS
DNO Program / Minimum 150 Hours per Month

COVERED EXPENSES	DEDUCTIBLE	COPAYMENT	MAXIMUM BENEFITS
<p><i>Preventive and Diagnostic Dental Care</i></p> <ul style="list-style-type: none"> • Periodic oral exams - twice in any calendar year • Emergency treatment for pain • Routine cleaning and scaling - twice in any calendar year • Topical fluoride application - twice in any calendar year, up to age 19 • X-rays <ul style="list-style-type: none"> ○ Bitewing series - one set each in any calendar year ○ Full mouth or panoramic series - one set each in any 36-month period • Space maintainers (nonorthodontic) for Covered Dependents up to age 14 • Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19 • Consultations • X-rays of individual teeth - as necessary 	NONE	The Plan pays 100% of the Usual and Customary Charge up to the maximum benefits shown on Dental Fee Schedule.	UNLIMITED
<p><i>Basic Dental Care</i></p> <ul style="list-style-type: none"> • Fillings • Routine extraction • Oral surgery, including general anesthesia when medically necessary <ul style="list-style-type: none"> ○ surgical removal of erupted teeth or impacted or unerupted teeth ○ incision and drainage of abscess ○ alveolectomy ○ alveoplasty with ridge extension • Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure • Endodontics - pulp capping; root canal treatment; apicoectomy • Stainless steel crowns - for Covered Dependents up to age 12 			<p>Calendar year maximums apply to the following benefits:</p> <p><i>Periodontics</i> \$1,000 per individual</p> <p><i>Prosthodontics</i> \$1,000 per individual.</p>

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COVERED EXPENSES	DEDUCTIBLE	COPAYMENT	MAXIMUM BENEFITS
Major Dental Care <ul style="list-style-type: none"> • Inlays • Onlays • Crowns • Pontics • Fixed or removable bridgework • Full and partial dentures • Denture repairs (including the addition of a tooth or teeth to an existing denture.) • Recement bridge • Implant abutments 	NONE	The Plan pays 100% of the Usual and Customary Charge up to the maximum benefits shown on Dental Fee Schedule.	Calendar year maximums apply to the following benefits: Periodontics \$1,000 per individual Prosthodontics \$1,000 per individual.
Orthodontic Care <ul style="list-style-type: none"> • Comprehensive full-banded treatment • Appliances for tooth guidance - one appliance per individual • Retention appliances - one appliance per individual • Benefits are payable at the time treatment begins. The full orthodontic benefit will be paid at the time of banding 		The Plan pays 75% up to the \$3,000 lifetime maximum.	Separate \$3,000 lifetime maximum benefit per individual.
Dental Implant <ul style="list-style-type: none"> • Prior authorization is required • Surgical placement of implant body only is covered with prior authorization 		The Plan pays up to \$1,000 per implant.	Lifetime Implant maximum Of \$2,000 per Individual.

IMPORTANT NOTES:

1. Any non-emergency prosthodontic or periodontic treatment in excess of \$250 should be submitted for pre-determination of benefits.
2. Gold restorations (fillings, inlays, onlays and crowns) are covered only if teeth cannot be restored with a less expensive filling material or if the tooth is an abutment to a covered partial denture or fixed bridge.
3. Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage.
4. Members must be covered for at least six consecutive months to be eligible for Orthodontic Care.

SCHEDULE OF DENTAL BENEFITS
DN4 Program / Minimum 80 Hours per Month

COVERED EXPENSES	DEDUCTIBLE	CO-PAYMENT	MAXIMUM BENEFITS
<p><i>Preventive and Diagnostic Dental Care</i></p> <ul style="list-style-type: none"> • Periodic oral exams - twice in any calendar year • Emergency treatment for pain • Routine cleaning and scaling - twice in any calendar year • Topical fluoride application - twice in any calendar year, up to age 19 • X-rays <ul style="list-style-type: none"> ○ Bitewing series - one set each in any calendar year ○ Full mouth or panoramic series - one set each in any 36-month period • Space maintainers (nonorthodontic) for Covered Dependents up to age 14 • Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19 • Consultations • X-rays of individual teeth - as necessary 	None	The Plan pays 100% of the Usual and Customary Charge up to the maximum benefit shown on Dental Fee Schedule.	Subject to a \$1,000 all inclusive (preventive, basic and major care) calendar year maximum per individual.
<p><i>Basic Dental Care</i></p> <ul style="list-style-type: none"> • Fillings • Routine extraction • Oral surgery, including general anesthesia when medically necessary <ul style="list-style-type: none"> ○ surgical removal of erupted teeth or impacted or unerupted teeth ○ incision and drainage of abscess ○ alveolectomy ○ alveoplasty with ridge extension • Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure • Endodontics - pulp capping; root canal treatment; apicoectomy • Stainless steel crowns - for Covered Dependents up to age 12 			

SCHEDULE OF DENTAL BENEFITS
DN4 Program / Minimum 80 Hours per Month

COVERED EXPENSES	DEDUCTIBLE	CO-PAYMENT	MAXIMUM BENEFITS
<i>Major Dental Care</i> <ul style="list-style-type: none"> • Inlays • Onlays • Crowns • Pontics • Fixed or removable bridgework • Full and partial dentures • Denture repairs (including the addition of a tooth or teeth to an existing denture.) • Recement bridge 	None	The Plan pays 100% of the Usual and Customary Charge up to the maximum benefit shown on Dental Fee Schedule.	Subject to a \$1,000 all inclusive (preventive, basic and major care) calendar year maximum per individual.
<i>Orthodontic Care</i>	There is no Orthodontic Care Coverage For the D4 plan.		
<i>Dental Implant</i>	There is no Dental Implant Coverage For the D4 plan.		

IMPORTANT NOTES:

1. Any non-emergency prosthodontic or periodontic treatment in excess of \$250 should be submitted for pre-determination of benefits.
2. Gold restorations (fillings, inlays, onlays and crowns) are covered only if teeth cannot be restored with a less expensive filling material or if the tooth is an abutment to a covered partial denture or fixed bridge.
3. Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage