

**SCHEDULE OF DENTAL BENEFITS  
DN1 Program**

COVERED EXPENSES	DEDUCTIBLE	COPAYMENT	MAXIMUM BENEFITS
<p><b><i>Preventive and Diagnostic Dental Care</i></b></p> <ul style="list-style-type: none"> <li>• Periodic oral exams - twice in any calendar year</li> <li>• Emergency treatment for pain</li> <li>• Routine cleaning and scaling - twice in any calendar year</li> <li>• Topical fluoride application - twice in any calendar year, up to age 19</li> <li>• X-rays               <ul style="list-style-type: none"> <li>○ Bitewing series - one set each in any calendar year</li> <li>○ Full mouth or panoramic series - one set each in any 36-month period</li> </ul> </li> <li>• Space maintainers (nonorthodontic) for Covered Dependents up to age 14</li> <li>• Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19</li> <li>• Consultations</li> <li>• X-rays of individual teeth - as necessary</li> </ul>	NONE	The Plan pays 100% of the Usual and Customary Charge up to the maximum benefits shown on Dental Fee Schedule.	UNLIMITED
<p><b><i>Basic Dental Care</i></b></p> <ul style="list-style-type: none"> <li>• Fillings</li> <li>• Routine extraction</li> <li>• Oral surgery, including general anesthesia when medically necessary               <ul style="list-style-type: none"> <li>○ surgical removal of erupted teeth or impacted or unerupted teeth</li> <li>○ incision and drainage of abscess</li> <li>○ alveolectomy</li> <li>○ alveoplasty with ridge extension</li> </ul> </li> <li>• Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure</li> <li>• Endodontics - pulp capping; root canal treatment; apicoectomy</li> <li>• Stainless steel crowns - for Covered Dependents up to age 12</li> </ul>	\$25 per individual per calendar year (including basic and major care), subject to a maximum of \$50 per family. The family Deductible may be satisfied by any combination of covered family members.	Benefits are paid up to the maximum shown on the Dental Fee Schedule, less the applicable dental plan deductible.	Calendar year maximums apply to the following benefits: <b><i>Periodontics</i></b> \$1,000 per individual <b><i>Prosthodontics</i></b> \$1,000 per individual.

**SCHEDULE OF DENTAL BENEFITS  
DN1 Program**

COVERED EXPENSES	DEDUCTIBLE	COPAYMENT	MAXIMUM BENEFITS
<p><b>Major Dental Care</b></p> <ul style="list-style-type: none"> <li>• Inlays</li> <li>• Onlays</li> <li>• Crowns</li> <li>• Pontics</li> <li>• Fixed or removable bridgework</li> <li>• Full and partial dentures</li> <li>• Denture repairs (including the addition of a tooth or teeth to an existing denture.)</li> <li>• Recement bridge</li> </ul>	<p>\$25 per individual per calendar year (including basic and major care), subject to a maximum of \$50 per family. The family Deductible may be satisfied by any combination of covered family members.</p>	<p>Benefits are paid up to the maximum shown on the Dental Fee Schedule, less the applicable dental plan deductible.</p>	<p>Calendar year maximums apply to the following benefits:  <b>Periodontics</b>            \$1,000 per individual  <b>Prosthodontics</b>            \$1,000 per individual.</p>
<p><b>Orthodontic Care</b></p> <ul style="list-style-type: none"> <li>• Comprehensive full-banded treatment</li> <li>• Appliances for tooth guidance - one appliance per individual</li> <li>• Retention appliances - one appliance per individual</li> <li>• Benefits are payable at the time treatment begins. The full orthodontic benefit will be paid at the time of banding</li> </ul>	<p>NONE</p>	<p>The Plan pays 75% up to the \$1,500 lifetime maximum</p>	<p>Separate \$1,500 lifetime maximum benefit per individual</p>

**IMPORTANT NOTES:**

1. Any non-emergency prosthodontic, periodontic or orthodontic 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. Members must be covered for at least six consecutive months to be eligible for Orthodontic Care.
4. Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage.