

## VOLUNTARY DENTAL BENEFITS

The following Deductibles, Benefits, and Plan Maximums are per Plan Participant, per Plan Year:

Dental Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant – Deductible waived for Class 1 Services	\$25
Annual Deductible per Family – Deductible waived for Class 1 Services	\$50
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	\$1,000
Maximum Lifetime Benefit Limit for Class 4 Services – Orthodontia	Not Covered

Dental Benefit Coinsurance Levels Based Upon Class:	Benefit Coverage	Benefit Type
Class 1 Services	100% One Hundred Percent ☺	*Preventive Care
Class 2 Services	90% Ninety Percent	Repair and Restoration
Class 3 Services	60% Sixty Percent	Major Dental Repair
Class 4 Services	Not Covered	Orthodontics
<i>*All charges except preventive care are limited to Usual and Customary Fees calculated at the 90<sup>th</sup> percentile.</i>		

**Dental PPO Network:** The dental program includes the **Aetna Dental Signature Administrators PPO** Network. Use of network providers are optional.

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Plan Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section.

### Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a Participant chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the Participant and the Dentist decide to use a gold filling, the Plan will base its reimbursement on Maximum Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

### Pre-Determination of Dental Benefits

If a planned dental service or Participant's proposed course of treatment can be reasonably expected to involve dental charges of \$300 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges to the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.**

### Dental Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to the Maximum Allowable Charge.

### ***Class 1 Services (Preventive Care)***

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than once in any period of 6 consecutive months.
2. Periapical x-rays, as required, and bitewing x-rays once in any period of 6 consecutive months.
3. Full mouth x-rays, but not more than once in any period of 60 consecutive months, or
4. Panoramic x-rays, but not more than once in any period of 60 consecutive months (only Panoramic or Full mouth x-rays, but not both).
5. Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children under age 16, but not more than once in any period of 36 consecutive months.
6. Topical application of fluoride for Dependent Children under age 14, but not more than once in any period of 6 consecutive months.
7. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 16. No payment will be made for duplicate space maintainers.
8. Palliative emergency treatment of an acute condition requiring immediate care.

### ***Class 2 Services (Repair and Restoration)***

1. All Medically Necessary x-rays not covered under another class.
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.
3. Simple extractions.
4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant upon demonstration of Medical Necessity.
6. Periodontal examinations, treatment and Surgery.
7. Consultations.

### ***Class 3 Services (Major Dental Repair)***

Prosthetic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures.
3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
  - a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable.
  - b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.
4. Osseous Surgery.
5. Periodontal scaling.
6. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.
7. Post and core.
8. Relines.
9. Stainless steel crowns.

### ***Class 4 Services (Orthodontics) Only available if depicted in the Benefit Summary***

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. Orthodontic services will be eligible only when provided to covered Dependents who are under age 19 when treatment is received.

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan.
2. Interceptive, interventional or preventive orthodontic services.

3. Fixed and removable appliance placement, and active treatment per month after the first month.
4. Extractions in connection with orthodontic services.

### **Dental Exclusions and Limitations**

The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits".

**Adjustments.** Charges arising from alteration of dimension or occlusion; to address damage arising from abrasion or attrition; splinting and/or temporomandibular joint disturbances.

**Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records.

**After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates. Predetermination of an allowable course of treatment and eligible services (claims for which coverage would be in effect had coverage not terminated) will not extend coverage beyond termination. The Plan will pay for a prosthetic device, crown, such as full or partial dentures, if the preparatory steps (such as an impression) had already initiated and/or been prepared for said device or crown, while the patient was a Participant in the Plan; so long as the device or crown is delivered and installed within two months following termination of coverage, as well as root canal therapy if the Dentist opened the tooth while the patient was a Participant, and treatment is completed within two months of coverage termination.

**Anesthetic.** Local infiltration anesthetic when billed for separately by a Dentist.

**Cosmetic.** Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations.

This exclusion will not apply to cosmetic work needed as a result of Accidental Injury. Damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered orthodontic treatment.

**Crowns.** For crowns for the purpose of periodontal splinting.

**Duplicate X-Rays.** Charges for duplicate copies or replication of x-ray or other imaging.

**Education.** Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program.

**Experimental.** Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association.

**Hygiene.** For oral hygiene, plaque control programs or dietary instructions.

**Implants.** For implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except first-time non-cosmetic dental implants.

**Late Enrollee.** Charges Incurred during the first 24 months of coverage applicable to a late enrollee. This Exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Participant. "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

**Medical Benefits.** For charges covered under the "Medical Benefits" section of the Plan.

**Miscellaneous.** The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

**Missing Appliances.** The cost of replacing lost, missing or stolen supplies, including implants, appliances, and prosthetics.

**More Expensive Course of Treatment.** The aforementioned rules regarding Medical Necessity, Maximum Allowable Charge, and the least costly yet equally effective treatments shall apply here as well.

If a Participant chooses a more expensive treatment than is needed according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment at the most cost-effective level.

**Mouth Guards.** For athletic guards and/or occlusal guards.

**Not Recommended.** Charges for services or supplies which are not recommended and approved by a Dentist or Physician.

**Orthognathic Surgery.** For Surgery to correct malpositions in the bones of the jaw.

**Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

**Replacements.** Charges for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Participant, resulting in damages that are beyond repair. Damage resulting from biting or chewing is not considered an Accidental Injury.

**Single Provider Care.** Charges arising from solely the transfer from one Provider's care to another, that would not have been Incurred had one Provider been utilized, and thereby in accordance with the Maximum Allowable Charge.

**Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

**TMJ.** Treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint, and appliances.