EXTENSION OF DENTAL BENEFITS:

No payment will be made under the Plan for dental services or supplies furnished on or after the date of termination of Your or Your Dependent's coverage, except under the following specified circumstances:

1. In the case of appliances or modification of appliances not related to orthodontic treatment; if the master impression was taken by a Dentist while coverage was in effect under this Plan**,** benefits will be payable if the appliance was delivered or installed within sixty (60) days after the termination of coverage.

2. In the case of a crown, bridge or inlay or onlay restoration; if the tooth or teeth were prepared while coverage was in effect under this Plan**,** benefits will be payable if such crown, bridge or cast restoration was installed within sixty (6) days after the termination of coverage.

3. In the case of root canal therapy; if the pulp chamber was opened while coverage was in effect under this Plan, benefits will be payable if such root canal therapy is completed within sixty (60) days after the termination of coverage.

4. In the case of orthodontic treatment commencing while coverage was in effect under this Plan; benefits will be payable through the end of the month in which coverage terminated, based on a proration of the applicable quarterly installment.

The above benefits are subject to all other conditions, limitations, and exclusions contained in this Plan.

DENTAL SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. DENTAL CARE BENEFITS

COVERED SERVICES AND PROVISIONS	
	Coverage
Calendar Year Deductible	$50 per person $150 per family
Calendar Year Benefit Maximum (Preventive, Basic and Major Services)	$1,500 per person
Lifetime Orthodontic Benefit Maximum	$1,500 per person
Deductible Carry-Over	N/A.
Claims Filing Limit	All charges and corresponding requested documentation must be submitted within 180 days of the date incurred.
All benefits are limited to Usual and Customary Charges.	
ALTERNATE TREATMENT If more than one method of treatment is possible, the Covered Dental Charges will be limited to the Usual and Customary charges appropriate for those services and supplies which are customarily employed nationwide in the treatment of such condition and which are recognized by the dental profession to be appropriate methods of treatment, taking into account the total oral condition of the family member.	
TREATMENT PLAN You may wish to have an estimate of benefits payable before beginning treatment for extensive dental work. To receive this estimate, please have Your Dentist submit a Treatment Plan to the Plan Administrator before beginning a course of treatment which can reasonably be expected to involve Covered Services of $500 or more.	

II. PREVENTIVE CARE SERVICES

COVERED SERVICES AND PROVISIONS	Coverage
Routine oral examinations *Limited to 1 exams per six (6) months per Covered Person.*	100% Deductible waived.
Prophylaxis *Includes cleaning, scaling and polishing.* *Limited to 1 per six (6) months per Covered Person.* *Does not include periodontal cleanings (please see Section III for additional benefit coverage).*	100% Deductible waived.
Palliative emergency treatment and emergency oral examinations *Limited to reduction of fractures, stopping of bleeding and providing relief from pain.*	100% Deductible waived.
Dental X-rays • Entire denture series consisting of at least 14 films, including bitewings, if necessary. • Single film - initial. • Additional films (up to 12) each. • Intraoral, occlusal view, maxillary or mandibular, each. • Superior or inferior maxillary, extraoral, one film bitewing films. • Panoramic survey, maxillary and mandibular, single film (considered an entire denture series)..	100% Deductible waived.
Topical fluoride applications *Limited to 1 treatment per six (6) months for Covered Persons age 14 and under.*	100% Deductible waived.
Space maintainers *Fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to Dependent children under the age of sixteen (16). This does not include space maintainers used in orthodontics to create a space between teeth.*	100% Deductible waived.

Expenses Deemed Incurred for Preventive Care Services
Preventive Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed.

III. BASIC CARE SERVICES

COVERED SERVICES AND PROVISIONS	Coverage
Non-Routine Visits • *Consultation by other than practitioner providing treatment.* • *Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures).* • *Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).*	80%
Pathology – *Except for injuries, covered charge includes examination and diagnosis* • *Bacteriologic studies.* • *Carries susceptibility tests.* • *Biopsy and examination of oral tissue pulp vitality tests.* • *Diagnostic casts.*	80%
Oral Surgery – *including customary postoperative treatment furnished in connection with oral surgery, as follows:* • *Simple extraction of one (1) or more teeth.* • *Surgical extraction of erupted teeth (including tissue flap and bone removal).* • *Post-operative visit (sutures and complications) after multiple extractions of impactions.* • *Removal of impacted teeth (soft tissue, partially or completely bony).* • *Incision and drainage of a tumor or a cyst.* • *Alveolectomy (in addition to removal of teeth) per quadrant, alveolectomy (endentulous) per quadrant, alveoloplasty (with ridge extension, per arch), and frenectomy.* • *Excision of pericorneal gingiva, per tooth.* • *Removal of palatal torus.* • *Removal of mandibular tori, per quadrant.* • *Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.* • *General anesthesia, only when provided in conjunction with a surgical procedure.*	80%
Other Surgical Procedures • *Closure of oral fistula of maxillary sinus.* • *Replantation of tooth or tooth bud.* • *Crown exposure for orthodontia.* • *Incision and drainage for abscess.* • *Removal of foreign body from soft tissue.* • *Removal of foreign body from bone (independent procedure).* • *Sequestrectomy for osteomyelitis for bone abscess, superficial.* • *Maxillary sinusotomy for removal of tooth fragment or foreign body.* • *Suture of soft tissue injury.* • *Sialolithotomy; removal of salivary calculus.* • *Closure of salivary fistula.* • *Dilation of salivary duct.*	80%
Endodontics, *as follows:* • *Pulp capping – direct, excluding final restoration.* • *Vital pulpotomy, excluding final restoration.* • *Apicoectomy (performed as a separate surgical procedures).* • *Apicoectomy (performed in conjunction with endodontic procedure).* • *Remineralization (calcium hydroxide, temporary restoration) as a separate procedure only.*	80%

III. BASIC CARE SERVICES

COVERED SERVICES AND PROVISIONS	Coverage
Root Canals – *Treatment of non-vital teeth. Allowances include necessary x-rays and cultures but exclude final restoration.*	80%
Anterior, bicuspid and molar teeth • *Medicated paste (N-2)* • *Traditional canal therapy*	80%
Amalgam Restorations – *Primary/Permanent Teeth* • *Cavities involving one surface* • *Cavities involving two surfaces* • *Cavities involving three or more surfaces*	80%
Synthetic Restorations • *Silicate cement filling* • *Acrylic or Plastic filling* • *Composite resin involving one surface* • *Composite resin involving three or more surfaces*	80%
Periodontics (gum treatments) limited to: • Periodontics as follows (includes post-surgical visits): • Gingivectomy (including post-surgical visits) per quadrant. • Gingivectomy, treatment per tooth (fewer than six teeth). • Subgingival curettage, root planning, per quadrant, maximum of four quadrants within twelve consecutive months (not prophylaxis). • Osseous surgery (including post-surgical visits) per quadrant. • Muco gingival surgery (pedicle soft tissue graft, sliding horizontal flap) • Occlusal adjustment, performed in conjunction with periodontal surgery, per quadrant, maximum of four quadrants within twelve consecutive months.	80%

Expenses Deemed Incurred for Basic Care Services

Basic Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed. Exception: Expenses in the case of root canal therapy shall incur when work is begun on the tooth.

IV. MAJOR CARE SERVICES

COVERED SERVICES AND PROVISIONS	Coverage
Pin retention – *exclusive of restorative material (used in lieu of cast restoration) – indicate number of pins.*	50%
Onlays • *One surface* • *Two surface* • *Three or more surfaces.* • *Onlay, in addition to inlay allowance*	50%
Crowns • *Acrylic, acrylic with gold* • *Acrylic with semi-precious metal.* • *Porcelain.* • *Porcelain with gold.* • *Porcelain with semi-precious metal.* • *Gold (full cast).* • *Full cast with semi-precious metal* • *Gold (3/4 cast)* • *Cast post and core (in addition to crown), separate* • *Steel post and composite or amalgam (in addition to crown)* • *Cast dowel pin (one-piece casting with crown) Indicate type of crown* • *stainless steel (when tooth cannot be restored with a filling material).*	50%
Re-cementation • *Inlay* • *Crown* • *Bridge*	50%
Restorative – *Cast restorations and crowns are covered only by decay or traumatic injury and the tooth cannot be restored with routine filling material.*	50%
Prosthodontics – *Bridge abutments (see Inlays and Crowns)*	50%
Pontics • *Cast gold (sanitary)* • *Cast with semi-precious metal (sanitary)* • *Slotted facing* • *Slotted pontic* • *Porcelain fused to gold* • *Porcelain fused to semi-precious metal* • *Plastic processed to gold* • *Plastic processed to semi-precious metal*	50%
Repairs, Crown and Bridges *Repairs (covered charge based upon extent and nature of damage and type of materials involved).*	50%
Initial dentures, full or partial, and bridgework, fixed and removable *Subject to the following: Initial placement to replace natural teeth which were missing prior to the effective date of this Plan. (Exception: the limitation is not applicable if the full or partial dentures or fixed and removable bridgework also includes replacement of a natural tooth extracted while covered under this Plan).*	50%
Replacement of or addition of teeth to full or partial dentures or fixed bridgework *Subject to the following: Replacement or alteration will be covered only if one of the following conditions exists:* *a) Replacement or addition of teeth is required to replace one or more teeth extracted while covered under this Plan, or*	50%

IV. MAJOR CARE SERVICES

COVERED SERVICES AND PROVISIONS	Coverage
b) The existing full or partial denture is an immediate temporary denture which must be replaced with a permanent one, or **c)** *The original full or partial dentures or fixed bridgework cannot be made serviceable, and 5 Calendar Years have elapsed since the last placement.*	
Denture Relinings and Rebastings – *Allowable after six months from installation of appliance* • *Upper denture duplication (jump Case) per denture (limited to once in a period of 36 consecutive months).* • *Lower denture duplication (jump Case) per denture (limited to once in a period of 36 consecutive months).* • *Upper dentures reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months).* • *Lower dentures reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months).* • *Upper dentures reline (includes full and partial), laboratory (limited to once in a period of 12 consecutive months).* • *Lower dentures reline (includes full and partial), laboratory (limited to once in a period of 12 consecutive months).* • *Tissue conditioning, per denture (maximum of two treatments per arch) (limited to once in a period of 12 consecutive months). Indicate whether upper or lower.*	50%
Denture Adjustments – *Adjustment to denture more than six months after installation of it by other than dentist providing appliance.*	50%
Prosthodontics – *Bridge abutments (see Inlays and Crowns)*	50%

Expenses Deemed Incurred for Major Care Services

Except as provided in (1), (2) and (3) below, any expense or charge for Major Care Services will be deemed to be incurred as of the date the particular procedure is performed.

1. *Expenses for crowns, inlays, onlays or restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided You (or Your Dependent) remain continuously insured during the course of treatment.*
2. *Expenses for full or partial dentures or fixed bridgework will be deemed incurred on the date the final impression is taken provided You (or Your Dependent) remain continuously insured during the course of treatment.*
3. *Expenses for rebase of an existing partial or complete denture will be deemed incurred on the first day of preparation of the rebase of such denture provided You (or Your Dependent) remain continuously insured during the course of treatment.*

V. ORTHODONTIC CARE SERVICES

COVERED SERVICES AND PROVISIONS	
	Coverage
Orthodontic Care Services - *Limited to* ***Covered Persons age 18 and under*** *consisting of installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.*	
Preventive Treatment Procedures • *Radiographs* • *Cephalometric film* • *Minor treatment for tooth guidance* • *Interceptive Orthodontic Treatment* • *Removal appliance therapy* • *Fixed appliance therapy*	50% Deductible waived.
Treatment of the Transitional Dentition • *Class I Malocclusion* • *Class II Malocclusion* • *Class III Malocclusion*	50% Deductible waived.
Treatment of the Permanent Dentition • *Class I Malocclusion* • *Class II Malocclusion* • *Class III Malocclusion*	50% Deductible waived.

Expenses Deemed Incurred for Orthodontic Care Services	*Orthodontic Care Services expenses are deemed to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained, except with respect to charges for Orthodontic Treatment.* 1. *Charges incurred for diagnosis and evaluation or pre-orthodontic care preliminary to the Course of Orthodontic Treatment are limited to 25% of the total amount of Covered Services for the Course of Orthodontic Treatment.* 2. *With respect to each month of the Course of Orthodontic Treatment, a maximum monthly amount equal to the quotient of the total amount of Covered Services incurred for the Course Of Orthodontic Treatment (less the amount calculated above), divided by the maximum number of months necessary upon the installation of the first appliance to complete the Course of Orthodontic Treatment.*

VISION SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. VISION CARE BENEFITS

COVERED EXPENSES AND PROVISIONS	Coverage
Upon receipt of satisfactory proof that a Covered Person has incurred charges for services rendered by an ophthalmologist, optometrist or a dispensing optician in connection with routine eye care, the Plan will pay the allowances as listed within this Schedule of Covered Expenses and Provisions. The balance is not covered under any medical plan offered by the Employer.	
Maximum Benefit per Covered Person per Calendar Year	$200
Claims Filing Limit	All charges and corresponding requested documentation must be submitted within 180 days of the date incurred.
All benefits are limited to Usual and Customary Charges.	

II. VISION CARE SERVICES

COVERED EXPENSES AND PROVISIONS	Coverage
Complete Visual Analysis/Refraction *Limited to 1 exam and refraction during any twelve (12) consecutive months per Covered Person.*	$20 copay, then 100%
Eyeglass lenses **Includes:** Single vision lenses Bifocal lenses Trifocal lenses Lenticular lenses Contact lenses Prescription sunglasses *Limited to one pair of lenses (or contact lenses) during any twelve (12) consecutive months per Covered Person. Benefits are available only when recommended and approved by a licensed optometrist or ophthalmologist.*	$20 copay, then 100%
Frames *Limited to one set of frames during any twenty-four (24) consecutive months per Covered Person.*	$20 copay, then 100%

Expenses Deemed Incurred for Vision Care Services
Vision Care Services expenses are deemed to be incurred: (1) By the person receiving the vision care and (2) as of the date vision care is performed. Exception: Expenses in the case of lenses shall incur the date on which the lenses are ordered.

EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Expenses and Provisions*):

1. for services and treatment unless they were prescribed by a Dentist or Physician, except for scaling or cleaning of teeth and topical application by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the Dentist or Physician;
2. for or in connection with an Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law;
3. for care and treatment of an Injury arising out of, or in the course of, any employment for wage or profit;
4. for charges incurred on account of services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;
5. for charges payable under any federal, state or local government program (unless legally required);
6. for services, supplies or treatment received in any government owned facility (unless legally required or when due to an emergency);
7. for charges which the Covered Person is not legally required to pay, or for charges which would not have been made if no coverage had existed;
8. for services, supplies or treatment for which no charge is applied or under this Plan is prohibited by any law to which the Covered Person is subject at the time expenses are incurred;
9. which are not Reasonable and/or in excess of Usual and Customary Charges;
10. for services or treatment which do not meet the standard of dental practice accepted by the American Dental Association;
11. which are for care or treatment which is experimental or investigational, according to accepted standards of practice,
12. which are for care or treatment which is not Dentally or Medically Necessary;
13. due to accidental Injury resulting from participation in the commission of an assault or felony;
14. for training, educational instructions or materials, even if they are performed or prescribed by a Dentist or Physician;
15. for charges in connection with dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
16. for charges incurred on account of war, declared or undeclared, including armed aggression;
17. for expenses incurred on account of loss or theft of dentures, bridgework or appliances;
18. for installation, replacement or alteration of, or additions to, dentures or fixed bridgework, except as provided in the Schedule of Covered Services and Provisions;

19. for charges incurred for:
    a. all services in connection with implants;
    b. myofunctional therapy;
    c. sealants, oral hygiene instruction, a plaque control program or dietary instructions;
    d. mouth guards;
    e. oral hygiene, dietary or plaque control programs or other educational programs;
    f. duplicate prosthetic devices or appliances;
    g. porcelain veneered crowns or pontics placed on or replacing a tooth posterior to the second bicuspid, to the extent the charges exceed the charge that would have been covered under the Schedule of Covered Services and Provisions for acrylic veneered crowns or pontics; or
    h. crowns, appliances or restorations for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion (except as covered under orthodontic treatment);
20. for services, supplies or treatment which were ordered or started before coverage began, or after coverage ended, other than orthodontic treatment;
21. for charges incurred by telephone consultation, failing to keep a scheduled visit, failing to complete a claim form or failing to provide medical records;
22. for supplies or appliances of the type normally intended for sport use;
23. for treatment of Temporomandibular Joint (TMJ) disorders;
24. for non-related charges such as:
    a. preparing medical reports;
    b. itemized bills or charges for mailing;
    c. for training, educational instructions or materials, even if they are performed or prescribed by a Physician, ophthalmologist, optometrist or dispensing optician; and
    d. for legal fees and expenses in obtaining medical treatment;
25. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical or vision services, drugs or supplies;
26. for the replacement of lost, stolen, or broken lenses and/or frames;
27. for surgical and/or medical treatment of the eyes;
28. for charges incurred for orthoptics (eye muscle exercises);
29. for charges incurred for vision training;
30. for goggles or safety lenses;
31. for sunglasses, unless prescribed by a Physician;
32. for additional cost of tinting and coating lenses;
33. for any lenses not prescribed by a legally licensed Physician, optometrist or dispensing optician.