

SERVICES	DENTAL PLAN A	DENTAL PLAN B	DENTAL PLAN C	DENTAL PLAN D
<b>Contract Year Deductible</b>	N/A	N/A	N/A	\$50
<b>Per Individual Family Limit</b>				\$150
<b>Waived for Type I</b>				Yes
<b>Reimbursement Type:</b>				
<b>In-Network</b>	Negotiated PDP fee	Negotiated PDP fee	Negotiated PDP fee	Negotiated PDP fee
<b>Out-of-Network</b>	90th percentile of R&C	90th percentile of R&C	90th percentile of R&C	90th percentile of R&C
<b>Type I</b>	100%	100%	100%	100%
<b>Preventative Services</b>	oral exams (1 per 6 months), cleanings (1 per 6 months), bitewing x-rays (1 per 6 months for children; 1 per 12 months for all others), fluoride treatment (children under age 14)	oral exams (1 per 6 months), cleanings (1 per 6 months), bitewing x-rays (2 per 12 months), fluoride treatment (children under age 14), space maintainers (children under age 14), sealants (children under age 14)	oral exams (1 per 6 months), cleanings (1 per 6 months), bitewing x-rays (2 per 12 months), fluoride treatment (children under age 14), space maintainers (children under age 14), sealants (children under age 14), full mouth x-rays	oral exams (1 per 6 months), cleanings (1 per 6 months), bitewing x-rays (2 per 12 months), fluoride treatment (children under age 19), space maintainers (children under age 14), sealants (children under age 14), full mouth x-rays, periapical x-rays
<b>Type II</b>	80%	80%	80%	80%
<b>Basic Services</b>	space maintainers (children under age 14), fillings, sealants (children under age 14), full mouth x-rays, periodontal maintenance, periapical x-rays, injection of antibiotic drugs	fillings, full mouth x-rays, periodontal maintenance, periapical x-rays, injection of antibiotic drugs, endodontics	fillings, periodontal maintenance, periapical x-rays, injection of antibiotic drugs, endodontics, anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery	fillings, periodontal maintenance, injection of antibiotic drugs, endodontics, anesthesia, simple & surgical extractions, oral surgery, consultations
<b>Type III</b>	50%	50%	50%	50%
<b>Major Services</b>	endodontics, anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, consultations	anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, consultations	crowns, inlays, onlays, dentures, bridges, consultations	periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges
<b>Waiting Period</b>	12 months	12 months	12 months	12 months
<b>Contract Year Maximum</b>	\$1,000	\$1,250	\$1,500	\$1,500
<b>Type IV</b>	N/A	50%	50%	50%
<b>Child Orthodontia (Optional)</b>				
<b>Lifetime Maximum</b>		\$1,000	\$1,000	\$1,500
<b>Deductible</b>		None	None	None
<b>Waiting Period</b>		12 months	12 months	12 months
<b>Monthly Costs</b>				
<b>without Ortho</b>				
<b>Employee</b>	\$26.29	\$36.03	\$38.80	\$40.90
<b>Employee + One</b>	\$50.27	\$68.88	\$74.16	\$78.18
<b>Employee + Two</b>	\$63.04	\$86.36	\$93.03	\$98.02
<b>Employee + Family</b>	\$85.50	\$117.12	\$126.18	\$132.96
<b>with Ortho</b>				
<b>Employee</b>	N/A	\$36.03	\$38.80	\$40.90
<b>Employee + One</b>	N/A	\$68.88	\$74.16	\$78.18
<b>Employee + Two</b>	N/A	\$92.51	\$99.66	\$108.02
<b>Employee + Family</b>	N/A	\$126.10	\$135.94	\$147.66

## Limitations & Exclusions

The following expenses are not Covered Dental Expenses for any of the plans:

### Services and Supplies:

- Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
- Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments.
- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
  - Otherwise is a Covered Dental Expense; and
  - Is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
  - Is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child which has resulted in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
- Services or supplies which are covered by any employers' liability laws.
- Services or supplies which any employer is required by law to furnish in whole or in part.
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
- Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
- Services or supplies for which a Covered Person is not required to pay.
- Services or supplies which are deemed experimental in terms of generally accepted dental standards.
- Services or supplies received as result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
- Adjustment or a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Service or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
- Fixed or removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Implantology.
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.
- Charges for broken appointments.
- Charges by the Dentist for completing dental forms.
- Sterilization supplies.
- Services or supplies furnished by a family member.
- Treatment of temporomandibular joint disorders. This exclusion does not apply to residents of Minnesota.

The following expenses are not Covered Dental Expenses for any other plans with Ortho:

- Repair or replacement of an orthodontic appliance.

The following expenses are not Covered Dental Expenses for any of the plans without Ortho:

- Orthodontia.