DENTAL SCHEDULE OF BENEFITS (Optional)

Calendar Year Maximum Benefit For Preventive, Basic and Major Services	$1,500
Calendar Year Deductible	
Individual	$50
Family	$150
For Basic and Major Services. The Deductible does not apply to Preventive and Orthodontic Services .	
Note: *The Family Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined.*	
Co-Insurance Factor	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia*	
Deductible	N/A
Co-Insurance	50%
Lifetime Maximum	$1,500
*Limited to Dependent Children under age 19	

VISION SCHEDULE OF BENEFITS (Optional)

CALENDAR YEAR MAXIMUM-ALL SERVICES	$200
VISION EXAMINATION	100% After $20 Co-Pay
LENSES	100% After $20 Co-Pay
FRAMES	100% After $20 Co-Pay

DENTAL EXPENSE BENEFIT

The Dental Expense Benefit has been designed to help you pay for your family's dental expenses and orthodontic treatment. This benefit covers only those dental expenses which are performed by a licensed Dentist or by a licensed Dental Hygienist if
rendered under the supervision and guidance of a Dentist.

Covered dental expenses are further limited to those services and supplies customarily employed for treatment of dental conditions only if rendered in accordance with accepted standards of dental practice.

This benefit covers the services included in the List of Covered Services, appearing on later pages. The list is divided into Preventive, Basic, Major and Orthodontic services.

If a dental service is performed that is not on the list and the service is not excluded by this Plan, but the list contains a similar service that is suitable for the condition being treated, then benefits will be payable as if the listed service was the one actually performed.

A charge will be considered to be incurred:

- For dentures or partials - on the date the impression is taken;
- For fixed bridgework, crowns, inlays or onlays - on the date the tooth or teeth are prepared and the final impressions are made;
- For root canal therapy - on the date the pulp chamber is opened and explored; and
- For all other services - on the date the service is performed.

DEDUCTIBLE AMOUNT

The Dental Deductible, if applicable, is the amount of Covered Dental Expenses which you must pay before benefits are payable by the Plan. The Dental Deductible is shown on the Schedule of Benefits and must be satisfied each Calendar Year.

FAMILY DEDUCTIBLE

When Covered Family Members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Dental Deductibles to the remaining Covered Dental Expenses for all Covered Family Members for that Calendar Year.

CO-INSURANCE FACTOR

After the Calendar Year Deductible is satisfied, the Plan will pay benefits at the applicable co-insurance percentage shown on the Schedule of Benefits for all eligible Dental Expenses incurred by that individual during the remainder of that Calendar Year.

CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to you and to each of your Covered Dependents for all dental services, not including orthodontic services, received in any one Calendar Year.

ALTERNATE TREATMENT PLANS

In all cases in which there are alternate plans of treatment carrying different treatment costs, payment will be made only for the least expensive procedure which will produce a professionally satisfactory result, with the balance of the treatment cost remaining the responsibility of the patient.

TREATMENT PLAN

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $500 or more, a description of the procedures to be performed and an estimate of the Dentist's charges should be filed with the Claims Administrator before beginning dental care.

Many Dentists require that you agree to the proposed treatment and charges before treatment begins. Therefore, it is valuable for you to know what the Dental benefit will pay before you make a financial commitment.

Have the Dentist complete the dental claim form including a written description of the proposed treatment, the estimated cost and x-rays. This process allows the Claims Administrator the opportunity to review Plan specifications such as deductibles, co-insurance percentages, benefit maximums, limitations and exclusions.

The Claims Administrator will notify the Dentist of the benefits payable. Consideration will be given to alternate procedures, services or courses of treatment that may be performed in order to accomplish the desired result.

If a Treatment Plan is not submitted in advance, the Claims Administrator reserves the right to make a determination of benefits payable considering alternate procedures, services, or courses of treatment, based on accepted standards of dental practice.

This Treatment Plan requirement will not apply to courses of treatment under $500 or to emergency treatment, routine oral examination x-rays, prophylaxis and fluoride treatments.

ORTHODONTIC EXPENSE BENEFIT

DEPENDENT CHILD COVERAGE ONLY (Under age 19)

When your Covered Dependent Child incurs expenses on the accompanying "List of Covered Orthodontic Services" and such expense is incurred while this coverage is in force for your Dependent Child and treatment is rendered by a Dentist as defined herein, the Plan will pay the benefits as determined for the reasonable charges actually incurred.

ORTHODONTIC PROCEDURE

Orthodontic procedures means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

ORTHODONTIC TREATMENT PLAN

The charges must be a part of an Orthodontic Treatment Plan which, prior to the performance of the procedures, has been (a) submitted to the Claims Administrator and (b) reviewed and returned to the Dentist showing estimated benefits. Submission of an Orthodontic Treatment Plan is not required if charges made or to be made total $500 or less. Such Treatment Plan must:

1. Provide a classification of the malocclusion,
2. Recommend and describe necessary treatment by orthodontic procedures,
3. Estimate the duration over which treatment will be completed,
4. Estimate the total charge for such treatment, and
5. Be accompanied by cephalometric x-rays, study models and such other supporting evidence as the Claims Administrator may reasonably require.

COVERED CHARGES

The total covered charges scheduled to be made in accordance with an Orthodontic Treatment Plan shall be payable in equal quarterly installments over a period of time equal to the estimated duration of the Orthodontic Treatment Plan; however, the number of quarterly installments shall not exceed eight (8). The first installment shall become payable on the date on which the orthodontic appliances were first installed, and subsequent installments shall become payable at the end of each three- month period thereafter.

Charges are covered only to the extent that they are made in connection with an orthodontic procedure which is required by one or more of the following conditions:

1. Overbite or overjet of at least four (4) millimeters.
2. Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp.
3. Cross-bite.
4. An arch length discrepancy of more than four (4) millimeters in either the upper or lower arch.

LIFETIME ORTHODONTIC MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to each of your covered dependents for all Orthodontic benefits received in a lifetime.

LIMITATION

Orthodontic procedures must commence prior to a Covered Dependent child attaining age nineteen (19) and the first active appliance must be installed while the child is covered under this Plan.

COVERED SERVICES

PREVENTIVE SERVICES

Oral Examinations
Initial
Periodic
Initial and periodic exams are limited to one (1) per six (6) months
Emergency Oral Examination for the relief of dental pain
Prophylaxis with or without oral examination (limited to one (1) per six (6) months)
Topical application of stannous fluoride for individuals under age fourteen (14) (limited to one (1) in any six (6) month period)

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)

Space Maintainers
Limited to dependent children under the age of 16.

BASIC SERVICES

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)

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

Oral Surgery -- Includes local anesthesia and routine post -operative care

Extractions
Uncomplicated (single)
Surgical removal of erupted tooth (including tissue flap and bone removal)
Post-operative visit (sutures and complications) after multiple extractions of impactions

Impacted Teeth
Removal of tooth (soft tissue)
Removal of tooth (partially bony)
Removal of tooth (completely bony)

Alveolar Or Gingival Reconstructions
Alveolectomy (in addition to removal of teeth) per quadrant
Alveolectomy (edentulous) per quadrant
Alveoloplasty with ridge extension, per arch
Excision of pericorneal gingiva, per tooth
Removal of palatal torus
Removal of mandibular tori, per quadrant
Excision of hyperplastic tissue, per arch

Cysts And Neoplasms
Removal of cyst or tumor

Other Surgical Procedures
Closure of oral fistula of maxillary sinus
Replantation of tooth or tooth bud
Crown exposure for orthodontia
Incision and drainage of 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

Anesthesia
General, in conjunction with surgical procedures only

Periodontics -- 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

Endodontics
Pulp capping - direct, excluding final restoration
Vital pulpotomy, excluding final restoration
Apicoectomy (performed as a separate surgical procedure)
Apicoectomy (performed in conjunction with endodontic procedure)
Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only

Root Canals -- Treatment of non-vital teeth. Allowances include necessary x-rays and cultures but exclude final restoration

Anterior Teeth
Medicated paste - (N-2)
Traditional canal therapy

Bicuspid Teeth
Medicated paste - (N-2)
Traditional canal therapy

Molar Teeth
Medicated paste - (N-2)
Traditional canal therapy

Amalgam Restorations – Primary Teeth
Cavities involving one surface
Cavities involving two surfaces
Cavities involving three or more surfaces

Amalgam Restorations - Permanent Teeth
Cavities involving one surface
Cavities involving two surfaces
Cavities involving three or more surfaces

Synthetic Restorations
Silicate cement filling
Acrylic or Plastic filling
Composite resin involving one surface
Composite resin involving three or more surfaces

MAJOR SERVICES

Pins
Pin retention – exclusive of restorative material (used in lieu of cast restoration) -- indicate number of pins

Crown
Stainless steel (when tooth cannot be restored with a filling material)

Full And Partial Denture Repairs
Broken dentures, no teeth involved
Partial denture repairs (metal) Covered charge based upon extent and nature of damage and type of materials involved. Replacing missing or broken teeth, each tooth

Repairs, Crown And Bridges
Repairs (Covered charge based upon extent and nature of damage and type of materials involved)

Adding Teeth To Partial Denture To Replace Extracted Natural Teeth
First tooth
Each additional tooth and clasp

Recementation
Inlay
Crown
Bridge

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 denture reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months)
Lower denture reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months)
Upper denture reline (includes full and partial), laboratory (limited to once in a period of 12 consecutive months)
Lower denture 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

Denture Adjustments
Adjustment to denture more than six months after installation of it by other than Dentist providing appliance

Restorative –Cast restorations and crowns are covered only by decay or traumatic injury and the tooth cannot be restored with routine filling material

Inlays
One surface
Two surfaces
Three or more surfaces
Onlay, in addition to inlay allowance

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

Prosthodontics
Bridge Abutments (See Inlays and Crowns)

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

Removable Bridge (unilateral)
One piece chrome casting clasp attachment (all types), per unit including pontics

Dentures And Partial Dentures-- Covered charges for dentures and partial dentures include adjustments and relines within six months after installation. Specialized techniques and characterizations are not covered.
Complete maxillary denture
Complete mandibular denture
Upper partial, with two chrome claps with rests, acrylic base
Lower partial with two chrome claps with rests, acrylic base
Lower partial with chrome lingual bar and clasps, acrylic base
Upper partial with chrome lingual bar and clasps, acrylic base
Stayplate base, temporary denture (anterior teeth only) Indicate whether upper or lower)
Simple stress breakers, extra per unit

ORTHODONTIC SERVICES

Preventive Treatment Procedures
Radiographs
Cephalometric film
Minor treatment for tooth guidance
Interceptive Orthodontic Treatment
Removal appliance therapy
Fixed appliance therapy

Treatment of the Transitional Dentition
Class I Malocclusion
Class II Malocclusion
Class III Malocclusion

Treatment of the Permanent Dentition
Class I Malocclusion
Class II Malocclusion
Class III Malocclusion

DENTAL EXPENSE EXCLUSIONS AND LIMITATIONS

The Dental Benefit provisions of this Plan do not cover any loss caused by, incurred for, or resulting from:

1. A service furnished a Covered Person for:

   a. Cosmetic purposes, unless necessitated as a result of accidental injuries sustained while such person was covered under this Plan and for the repair of which the service is furnished within one (1) year of the date of the accident and while the individual remains a Covered Person. For purposes of this limitation, facings on crowns or pontics posterior to the second bicuspid and the personalization and characterization of dentures shall always be considered cosmetic;

   b. Dental care of a congenital or developmental malformation (unless an Orthodontic Benefit provision is specifically included and made a part of this Plan).

2. An orthodontic service, unless specifically provided by an Orthodontic Benefit provision included in and made a part of this Plan.

3. Replacement of lost, missing or stolen prosthetic device or any other device or appliance.

4. Replacement of lost, missing or stolen orthodontic appliances.

5. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, replacing tooth structure lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint.

6. A service not reasonably necessary or not customarily performed for the dental care of the Covered Person.

7. A service not furnished by a Dentist, unless the service is performed by a licensed Dental Hygienist under the supervision of a Dentist or an x-ray ordered by a Dentist.

8. Sealants, oral hygiene instruction, a plaque control program or dietary instructions.

9. Implantology.

10. The initial placement of a partial or full removable denture or fixed bridgework, including crowns and inlays forming the abutments, if involving the replacement of one or more natural teeth extracted prior to the Covered Person becoming covered under this Plan, unless the denture or fixed bridgework also includes the replacement of a natural tooth which is extracted while the Covered Person is covered under this Plan.

11. The replacement of a removable partial or denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, is covered only due to one of the following:

a. The replacement or addition of teeth is required to replace one or more natural teeth extracted while covered under this Plan.

b. The existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable.

c. An accidental bodily injury sustained while the Covered Person is covered under this Plan.

12. Any dental services or supplies which are included as covered expenses under any other provision in this Plan, or under any other group plan carried or sponsored by the Company.

13. Services or supplies that do not meet accepted standards of dental practice including, but not limited to, services which are investigational or experimental in nature.

14. Services or supplies of the type normally intended for sport or home use such as athletic mouth guards, toothpaste, toothbrushes, etc.

15. Any item shown in General Exclusions or Limitations.

EXTENSION OF 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 (60) 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.

VISION CARE EXPENSE BENEFIT

The Vision Expense Benefit has been designed to provide reimbursement for the expenses incurred for the cost of vision examinations, lenses, and frames prescribed by a legally qualified Ophthalmologist or Optometrist.

COVERED EXPENSES

Covered charges include the following services or supplies and are payable as shown on the Schedule of Benefits:

Vision Examination

- The examination may include an ocular case history, external examination, ophthalmoscopic examination, refraction, binocular measure, tonometry, or any other medically necessary vision test, prescription for corrective lenses when indicated, summary and findings, and inspection of any corrective lenses prescribed.

Lenses

- Single Vision Lenses
- Bifocal or equivalent progressive lenses
- Trifocal or equivalent progressive lenses
- Lenticular lenses
- Contact lenses
- Prescription Sunglasses

Frames

VISION CARE EXCLUSIONS AND LIMITATIONS

The Vision Benefit provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Vision care expenses incurred which were not recommended and approved by a licensed Optometrist or Ophthalmologist.

2. Any medical or surgical treatment or supplies (including prosthetic devices) furnished for surgical or medical care for the treatment of an eye disease and/or injury.

3. Sunglasses without a prescription, and charges for tinting and anti-reflective coatings.

4. Non-prescription lenses of any kind.

5. Replacement, at other than the normal policy period, of lenses or frames which were furnished under this Plan and which have been lost, stolen, or broken.

6. Duplicate or spare-eyeglasses or lenses or frames.

7. Orthoptics (eye muscle exercises).

8. Subnormal vision aids, such as ocular microscopes, ocular telescopes or hand-held magnifiers.

9. Any item shown in General Exclusions and Limitations.