## BENEFIT GUIDELINES

### NETWORK NON-NETWORK

<table>
<thead>
<tr>
<th>Individual Annual Deductible</th>
<th>$50</th>
<th>$50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Annual Deductible</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Annual Maximum Benefit (The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</td>
<td>$1500 per person per calendar year</td>
<td>$1500 per person per calendar year</td>
</tr>
<tr>
<td>Annual Deductible Applies to Preventive and Diagnostic Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Waiting Period</td>
<td>12 months for major services</td>
<td></td>
</tr>
</tbody>
</table>

### COVERED SERVICES*

#### DIAGNOSTIC SERVICES

- **Periodic Oral Evaluation**:
  - NETWORK: 100%
  - NON-NETWORK: 100%
  - Limited to 2 times per consecutive 12 months.
- **Radiographs**: 100%
- **Lab and Other Diagnostic Tests**: 100%

#### PREVENTIVE SERVICES

- **Dental Prophylaxis (Cleanings)**: 100%
- **Fluoride Treatments**: 100%
- **Sealants**: 100%
- **Space Maintainers**: 100%

#### BASIC DENTAL SERVICES

- **Restorations (Amalgam or Anterior Composite)**:
  - NETWORK: 80%
  - NON-NETWORK: 80%
  - Multiple restorations on one surface will be treated as a single filling.
- **General Services (including Emergency Treatment)**: 80%
- **Simple Extractions**: 80%
- **Oral Surgery (includes surgical extractions)**: 80%
- **Periodontics**: 80%
- **Endodontics**: 80%

#### MAJOR DENTAL SERVICES

- **Inlays/Onlays/Crowns**: 50%
- **Dentures and other Removable Prosthetics**: 50%
- **Fixed Partial Dentures (Bridges)**: 50%

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.

*** The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Preventive Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

GENERAL EXCLUSIONS
The following are not covered:
1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmaceutical regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmaceutical regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal identity as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been covered under the policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthetic replacement procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.