

Group Dental Plan

AREA RATING 1 – AL, AR, IA, ID, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NM, OH, OK, SC, SD, TN, VA, WI, WV, WY

We understand that today's employees demand choice. That's why we offer a voluntary dental program that allows you to choose between a basic and deluxe plan. The High-Low Choice provides you with the freedom to choose a dental plan that best fits your individual needs. Compare the cost and benefits of each plan, then determine which plan will work best for you and your family.

BOTH PLANS FEATURE

- Freedom of choice of dentists, including specialists
- Nationwide coverage
- Benefits are underwritten by Lincoln National Life Insurance Company
- Fast and accurate claims service

The Choice is Yours

Plan 1 (Low) provides coverage for the most common dental procedures. Plan 2 (High) also offers valuable protection, and provides increased benefits over Plan 1.

Your plan pays the indicated percentages of Allowable Charges for covered services that are listed here and described in your Group Certificate. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum. Allowable Charges are based on the usual and customary charges being made by providers in the area where the dental services are performed.

Eligibility

Employees working an average of 24 hours per week, spouse and unmarried dependent children under age 19 (age 19 through 24 if full-time student).

DENTAL PLAN 1 (Low) Services

Benefit Maximum, Per Person, Per Calendar Year	\$1,000									
Insured Percentage Allowable Charge Per Person, Per Calendar Year										
	<table border="0"> <tr> <td></td> <td align="center">Type I</td> <td align="center">Type II</td> </tr> <tr> <td>During 1st Year</td> <td align="center">80%</td> <td align="center">*50%</td> </tr> <tr> <td>During 2nd Year & thereafter</td> <td align="center">100%</td> <td align="center">80%</td> </tr> </table>		Type I	Type II	During 1st Year	80%	*50%	During 2nd Year & thereafter	100%	80%
	Type I	Type II								
During 1st Year	80%	*50%								
During 2nd Year & thereafter	100%	80%								
Deductible, Per Person, Per Calendar Year	\$50									
Family Deductible	\$150									

*Initial benefits subject to 2 month waiting period after the effective date

DENTAL PLAN 2 (High) Services

Benefit Maximum, Per Person, Per Calendar Year	\$1,000																
Insured Percentage Allowable Charge Per Person, Per Calendar Year																	
	<table border="0"> <tr> <td></td> <td align="center">Type I</td> <td align="center">Type II</td> <td align="center">Type III</td> </tr> <tr> <td>During 1st Year</td> <td align="center">80%</td> <td align="center">*50%</td> <td align="center">*10%</td> </tr> <tr> <td>During 2nd Year</td> <td align="center">100%</td> <td align="center">80%</td> <td align="center">25%</td> </tr> <tr> <td>During 3rd Year & thereafter</td> <td align="center">100%</td> <td align="center">80%</td> <td align="center">50%</td> </tr> </table>		Type I	Type II	Type III	During 1st Year	80%	*50%	*10%	During 2nd Year	100%	80%	25%	During 3rd Year & thereafter	100%	80%	50%
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Deductible, Per Person, Per Calendar Year	\$50																
Family Deductible	\$150																

*Initial benefits subject to 2 month waiting period after the effective date

MONTHLY RATES

Employee Only	\$26.97
Employee & Spouse	\$45.44
Employee & Children	\$56.65
Employee & Family	\$78.92

MONTHLY RATES

Employee Only	\$41.43
Employee & Spouse	\$81.59
Employee & Children	\$84.07
Employee & Family	\$124.22

See reverse side for dental service types, limitations and exclusions

DENTAL PLAN 1 (Low) Services

Type I Diagnostic & Preventative Dental Services, including:

- Routine Oral Examinations – up to 2 per Calendar Year
- Prophylaxis (routine cleanings) – up to 2 per Calendar Year
- Fluoride Treatment – one treatment per Calendar Year
Only for insured dependent children through age 15
- Space Maintainers – *Only for children through age 15*
(includes adjustments within 6 months of installation)
- X-Rays:
 - Bitewing films – up to 4 per Calendar Year
 - Panoramic or Full Mouth X-Rays – one complete full mouth series or panoramic film in any 5 consecutive years.
 - Other Dental X-Rays (needed to diagnose a specific dental condition) – Maximum of 6 per Calendar Year.

Type II Basic Dental Services, including:

- Sealants – once per permanent molar in any 3 Calendar Years
Only for insured dependent children through age 17
- Fillings
 - Benefits for composite fillings of posterior (back) teeth limited to amount payable for an equivalent amalgam filling.
 - Multiple restorations on one surface will be treated as a single filling
 - Replacement fillings for a tooth or tooth surface which was filled within the last 12 months are not covered
- Pin retention – included in addition to restoration
- Prefabricated stainless steel or resin crowns - one per tooth in any 5 consecutive years. *Only for insured dependent children through age 15*
- Emergency exams; treatment; injections of antibiotics
- Pathology – biopsy and examination of oral tissue
- Oral Surgery (*see policy for complete list of procedures*)
 - Simple extractions & Surgical removal of erupted teeth
 - Removal of impacted tooth (soft tissue or bony)
- Reimplantation of tooth or tooth bud due to accident
- Incision & drainage of abscess
- General Anesthesia or I.V. Sedation - in connection with a Necessary complex oral surgery or when medical condition or health factors render anesthesia a medical necessity
- Repair or recementation of inlays, crowns and bridges; Repair of partial dentures.
- Endodontics – including root canal therapy; pulpotomy; root amputation, hemisection; apexification; apicoectomy

Exclusions

General Exclusions

The plan does not cover services started before the coverage begins or after it ends. Services must be necessary and appropriate for the claimant's condition. Benefits are limited to services specifically shown on the List of Procedures, included in the policy, unless coverage for additional services is required by state law. Benefits are not payable for duplication of services or for treatment by a practitioner who lives with or is related to the employee.

Benefits are not payable for the initial placement of a prosthetic appliance or fixed bridge unless it is replacing teeth extracted or accidentally lost while covered. The policy does not cover the cost of implants, cosmetic procedures, athletic mouth guards, orthodontics, appliances to correct harmful habits or the replacement cost of lost or stolen dental appliances. The policy excludes the treatment of TMJ or congenital malformities, except as required by state law.

Benefits are not payable for services provided by an ambulatory surgical facility, hospital, any other facility; an anesthesiologist; for medications administered outside the dentist's office; for prescription drugs; or for analgesia, sedation, hypnosis or acupuncture administered for the purpose of alleviating anxiety or apprehension.

Plan benefits are not payable for a condition for which the claimant is eligible for benefits under Worker's Compensation or a similar law; or for a condition that is attributed to employment or military service. Coverage is not available for dental conditions caused by an act of war, self-inflicted injury, involvement in an illegal occupation, attempt to commit a felony, or active participation in a riot.

Benefit Adjustments

Benefits will be coordinated with any other dental coverage. Under the Optional Services provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted to the insurance company for an estimate of benefits payable.

This is not a Certificate of Coverage. This is a merely a summary of benefits. To review a more detailed explanation of benefits and limitations, you may request a copy of the full text benefit information from Leslie & Associates.

DENTAL PLAN 2 (High) Services

Type I Preventative Dental Services – Same as Plan 1

Type II Basic Dental Services – Same as Plan 1

Type III Major Dental Restorative Services, including:

- Periodontics (*see policy for complete list of procedures*)
 - Gingivectomy or gingivoplasty – one per site in each 36 consecutive months
 - Osseous Surgery - one per site in each 36 consecutive months
 - Soft Tissue Graft - one per site in each 36 consecutive months
 - Subepithelial connective tissue graft – one per site in each 36 consecutive months
 - Guided Tissue Regeneration
 - Crown Lengthening
 - Debridement – one treatment in each 24 consecutive months
 - Scaling and Root Planing – one treatment in each 24 consecutive months (not covered if performed in less than 3 months following periodontal surgery)
 - Periodontal Maintenance Cleanings - limited to 4 per Calendar Year (not covered if performed in less than 3 months following periodontal surgery)
 - Chemotherapeutics
- Major Restorations
 - Inlays and onlays
 - Crowns and posts (for claimants age 16 or older)
 - Crown Build-Up
 - Cast post and core
- Oral Surgery – Alveolar or Gingival Reconstruction
 - Alveolectomy
 - Vestibuloplasty
 - Removal of exostosis of the maxilla or mandible
 - Excision of hyperplastic tissue
- Prosthodontics – fixed or removable
 - Bridge abutment and pontics - limited to one time in any 8 consecutive years
 - Dentures, including adjustments made within 6 months of placement; replacement is limited to one time in any 5 consecutive years
 - Complete or partial denture - upper or lower
 - Special tissue conditioning
 - Reline of complete or partial denture
 - Rebase of complete or partial denture