Dental Care Benefits
Administered by HealthSCOPE Benefits

Rates Effective 1/1/2017

<table>
<thead>
<tr>
<th></th>
<th>Monthly Employee Cost</th>
<th>Weekly Employee Cost</th>
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<tbody>
<tr>
<td><strong>Pro One</strong> (Low Plan)</td>
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<td></td>
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<tr>
<td>Single Dental</td>
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<td>Single + 1 Dental</td>
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<tr>
<td>Family Dental</td>
<td>$ 69.98</td>
<td>$ 16.15</td>
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<tr>
<th></th>
<th>Monthly Employee Cost</th>
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<tbody>
<tr>
<td><strong>Pro Two</strong> (Hi Plan)</td>
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<td>Single Dental</td>
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<td>Single + 1 Dental</td>
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<td>Family Dental</td>
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<td>$ 18.25</td>
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</table>

**DENTAL PLAN 1**

| Deductible per Participant (for Class 2 Services) | $50 |
| Maximum benefit per calendar year for Class 1 and 2 Services | $1,000 |

**Covered Dental Expenses:**

| Class 1 Services (Preventive Care) | 100% |
| Class 2 Services (Repair and Restoration) | 80% |

**DENTAL PLAN 2**

| Deductible per Participant (for Class 2 and 3 Services) | $50 |
| Maximum benefit per calendar year for Class 1, 2 and 3 Services | $1,000 |

**Covered Dental Expenses:**

| Class 1 Services (Preventive Care) | 100% |
| Class 2 Services (Repair and Restoration) | 80% |
| Class 3 Services (Major Dental Repair) | 50% |

*Charges are limited to Usual and Customary Fees.*

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each calendar year toward covered expenses. Once the Deductible is satisfied, additional covered expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this Article.
**Covered Expenses** The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees.

**Class 1 Services (Preventive Care)** The limits on Class 1 Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

a. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of one exam and cleaning per 6 consecutive months (frequencies combined with periodontal maintenance);
b. One bitewing x-ray series every 12 consecutive months;
c. One fluoride treatment for covered Dependent children under age 14 per 12 consecutive months;
d. Space maintainers for covered Dependent children under age 16 to replace primary teeth. This includes all adjustments made, or recementing done, within 6 months of installation;
e. Harmful habit appliances for Dependent children up to age 16. Not covered if orthodontic related;
f. Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 16, once per tooth. Limit of 1 sealant per tooth per lifetime.

**Class 2 Services (Repair and Restoration)**

a. Dental x-rays not included in Class 1. This includes one full mouth x-ray or panoramic x-ray every 60 consecutive months. Also covered are:
   1. Periapical – no more than 4 x-rays in 12 consecutive months;
   2. Occlusal films – no more than 2 films in any 12 consecutive months;
   3. Extraoral – no more than 2 films in any 12 consecutive months;
   4. Sialography;

b. Oral surgery. This includes local anesthesia and post-op care. Oral surgery is limited to extractions, surgical incision and drainage of abscess and root removal of exposed roots;

c. Periodontics (gum treatments). This service includes:
   1. Provisional splinting by resin (composite) restoration only;
   2. Scale and root planing, limited to 1 quadrant per 24 consecutive months. If 3 or more quadrants are done at the same appointment, benefits will be limited to a full mouth debridement. If a prophylaxis (cleaning) and scaling and root planing are done at the same appointment, benefits will be limited to a prophylaxis. If a periodontal maintenance procedure and scaling are performed at the same appointment, benefits will be limited to a periodontal maintenance procedure;
   3. No more than 1 full mouth treatment in any 12 consecutive months. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service.
   4. Periodontal maintenance including exam, charting and oral hygiene instructions is limited to 1 in any 6 consecutive months, to be combined with routine prophylaxis (cleaning);
   5. Occlusal adjustment;

d. Bacteriologic studies for determination of pathologic agents;

e. Palliative treatment, only if no other treatment is rendered during the visit, except x-rays;

f. Pin retention. This service is limited to 1 time per restoration, payable only if performed with a restoration.

g. Fillings, other than gold. This service includes local anesthesia. Multiple restorations performed on one surface of the same tooth are deemed to be single surface restorations. Mesial-lingual, distal-lingual, mesial-facial and distal-facial resin (composite) restorations on anterior teeth are deemed to be single surface restorations;

h. Histopathologic examinations;

i. Therapeutic drug injections.

**Class 3 Services (Major Dental Repair) *Covered for Dental Plan 2 only***

a. Complex oral surgery includes the following:
   1. Surgical extractions;
   2. Oroantral fistula closure;
   3. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;
4. Tooth transplantation;
5. Surgical exposure of impacted or unerupted tooth to aid eruption;
6. Biopsy of oral tissue;
7. Transseptal fiberotomy;
8. Alveoplasty;
9. Vestibuloplasty;
10. Removal of exostosis;
11. Removal of foreign body, skin or subcutaneous areolar tissue;
12. Removal of reaction-producing foreign bodies musculoskeletal system;
13. Maxillary sinusotomy for removal of tooth fragment or foreign body;
14. Frenulectomy (frenectomy or fremotomy) separate procedure;
15. Excision of hyperplastic tissue – per arch;
16. Excision of pericornal gingiva;
17. Sialolithotomy;
18. Excision of salivary gland;
19. Sialodochoplasty;
20. Closure of salivary fistula;

If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

b. General anesthesia, when medically necessary;

c. Endodontics;
1. Pulpotomy (only for deciduous teeth);
2. Root canal;
3. Root canal retreatments, covered only if original root canal was performed at least 24 months prior;
4. Apexification/recalcification procedures;
5. Apicoectomy;
6. Periradicular services;
7. Retrograde filling;
8. Root amputation;
9. Hemisection, including any root removal, not including root canal therapy; this does not include fixed partial dentures replacing the extracted part of the hemisected tooth;

d. Periodontics
1. Provisional splinting by resin (composite) restoration only;
2. Scale and root planing, limited to 1 quadrant per 24 consecutive months. If 3 or more quadrants are done at the same appointment, benefits will be limited to a full mouth debridement. If a prophylaxis (cleaning) and scaling and root planing are done at the same appointment, benefits will be limited to a prophylaxis. If a periodontal maintenance procedure and scaling are performed at the same appointment, benefits will be limited to a periodontal maintenance procedure;
3. No more than 1 full mouth treatment in any 12 consecutive months and only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service);
4. Periodontal maintenance including exam, charting and oral hygiene instructions is limited to 1 in any 6 consecutive months, to be combined with routine prophylaxis (cleaning);
5. Gingivectomy or gingivoplasty;
6. Gingival flap procedure;
7. Mucogingival surgery;
8. Osseous surgery;
9. Only if more than 36 consecutive months have passed since gingivectomy, flap surgery, mucogingival surgery or osseous surgery was performed in that same area of the mouth;
10. Clinical crown lengthening;
11. Guided tissue regeneration;
12. Soft tissue graft;
13. Subepithelial connective tissue graft;
14. Distal or proximal wedge;
15. Occlusal adjustments;
16. Occlusal guards – NO MORE THAN 1 IN ANY 24 CONSECUTIVE MONTHS;

e. Major restorations – Initial (new) or Replacement
1. Inlay/onlay (charges are based on the allowable charge of a metallic inlay or onlay);
2. Crowns (charges are based on the allowable charge for predominately base metal);
3. For children under age 16, covered dental services for crowns on vital teeth are limited to prefabricated stainless steel or prefabricated resin crowns;
4. Labial veneers (anterior teeth only);
5. Core build-up, including any pins;
6. Cast post and core;
7. Prefabricated post and core;
8. Complete dentures;
9. Partial dentures;
10. Fixed partial dentures (bridges);
11. Tissue conditioning;

f. Major restorations – Maintenance
   1. Recement or repair of inlays, onlays, crowns or fixed dentures;
   2. Repairs to fixed, partial or complete dentures (repairs and recements covered only if more than 6 months have passed since initial insertion);
   3. Adjustments to dentures (no more than 1 adjustment in any 12 consecutive months and more than 6 months have passed since initial insertion);
   4. Denture rebase;
   5. Denture reline (no more than 1 in any 36 consecutive months and if more than 12 months have passed since initial insertion);
   6. Diagnostic casts, no more than 1 per 36 consecutive months and only if required for extensive prosthetic dentistry, other than dentures.

g. Major restoration limits - Replacement of one or more natural teeth which are lost while dental expense benefits for the Covered Person are in effect for:
   i. Installation of fixed bridgework done for the first time; installation for the first time for: a partial removable denture, or a full removable denture;
   ii. Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed; or it is needed because the existing denture or bridgework can no longer be used and was installed at least 7 years prior to its replacement;
   iii. Replacing an existing immediate temporary full denture by a new permanent full denture when: the existing denture can not be made permanent; and the permanent denture is installed within 12 months after the existing denture was installed;
   iv. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

Waiting Periods.
The following services have a 6 month waiting period:
   a. Endodontics
   b. Denture reline or rebase
   c. Adjustment to dentures or other removable prosthetic services
   d. Prefabricated stainless steel crowns
   e. Prefabricated resin crowns

The following services have a 12 month waiting period:
   a. Complex oral surgery
   b. Periodontics

The following services have a 24 month waiting period:
   a. Labial veneers (anterior teeth only), crowns, inlays, onlays
   b. Core build-ups and cast post and core’s
   c. Complete and partial and fixed (bridges) dentures
   d. Addition of teeth to existing dentures
   e. Tissue conditioning
   f. Fixed Partial Dentures or diagnostic casts

These Waiting Periods for Class 3 Dental Services do not apply to Covered Dental Services Necessary for treatment of an Accidental Non-Chewing Injury sustained while insured; or Recementing of, or repairs to, inlays, onlays, crowns, or fixed partial dentures.