SCHEDULE OF BENEFITS, EXCLUSIONSAND LIMITATIONS - HIGH

A. BENEFITS

Annual Deductible Per Insured Person	$100 Per Calendar Year	
Annual Deductible Per Insured Family	$300 Per Calendar Year	
Annual Maximum Per Insured Person	$1,000	
Covered Services:	**Policy Pays**	**Waiting Period**
Oral Evaluations (Exams)	100%	None
Radiographs (Bitewings, Full mouth, Occlusal and Periapical Films)	100%	None
Prophylaxis (Cleanings)	100%	None
Fluoride Treatments	100%	None
Palliative Treatment (Emergency)	100%	None
Sealants	100%	None
Space Maintainers	100%	None
Repairs of Crowns, Inlays, Onlays, Fixed atrial Dentures and Dentures	50%	6 months
Resin Based Composite –Anterior (White Fillings)	50%	None
Resin Based Composite-Posterior (White Filling)	50%	None
Amalgam Restorations	50%	None
Simple Extractions	50%	6 months
Surgical Extractions	30%	12 months
Complex Oral Surgery	30%	12 months
Endodontics (Root canals, etc.)	30%	12 months
General Anesthesia and/or Nitrous Oxide and/or IV Sedation	50%	12 months
Nonsurgical Periodontics	30%	12 months
Periodontal Maintenance	30%	12 months
Surgical Periodontics	30%	12 months
Crowns, Inlays, Onlays	30%	12 months
Prosthetics (Fixed Partial Dentures, Dentures)	30%	12 months
Adjustments and Repairs of Prosthetics	50%	6 months
Implant Services	0%	None
Consultations	100%	None
Orthodontics	0%	None

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist. Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

Subsections B (Exclusions) and C (Limitations) describes services, supplies or charges that are excluded (Exclusions), or for which coverage is limited by age or frequency (Limitations), subject to any other applicable provisions of this Policy. Only American Dental Association procedure codes may be billed under this Policy.

B. EXCLUSIONS - The following services, supplies or charges are excluded:

1. Subject to Subsection B. TIME LIMIT ON CERTAIN DEFENSES of SECTION GP - GENERAL PROVISIONS of the Policy, for Services, including multi-visit procedures started prior to a Policyholder's or Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken.

2. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).

3. That are covered by Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member(s) is entitled to payment under an automobile insurance policy. The Plan's benefits would be in excess to the third-party benefits and therefore, the Plan would have right of recovery for any benefits paid in excess.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

6. Which are Cosmetic in nature as determined by the Plan (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

7. Elective procedures (e.g. the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn Dependent child.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated on the Schedule of Benefits.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Policy. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

11. For treatment of fractures and dislocations of the jaw.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which, in the absence of insurance, the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

21. For treatment and appliances for bruxism (e.g. night grinding of teeth).

22. For any claims submitted to the Plan by the Member or on behalf of the Member in excess of twelve (12) months after the date of service, unless such claims are submitted to the Plan as soon as reasonably possible.

23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

24. Procedures that are:

    a. part of a service but are reported as separate services
    b. reported in a treatment sequence that is not appropriate
    c. misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply.

28. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".

C. LIMITATIONS - Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the Member reaches any stated age:

1. X-rays and films (full mouth, bitewing, periapical and occlusal):

   a. Full mouth x-rays - one (1) every 5 years.

   b. Bitewing x-rays - one (1) set every twelve (12) months under age nineteen (19) and one (1) set every eighteen (18) months age nineteen (19) and older.

   c. Periapical x-rays - four (4) every twelve (12) months.

   d. Occlusal films - two (2) every 24 months under age eight (8).

2. Oral Evaluations (Comprehensive, periodic and other covered evaluations):

   a. Comprehensive and periodic - two (2) of these services every twelve (12) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more years.

   b. Other Evaluations (limited or detailed dental problems and consultations) - one (1) limited problem (specific dental problem or complaint) per dentist per patient every twelve (12) months and one (1) detailed problem focuses (extensive complex problem requiring extensive diagnostic) per dentist per patient every twelve (12) months per eligible diagnosis.

3. Prophylaxis - two (2) every twelve (12) months. One (1) additional for Member under the care of a medical professional during pregnancy
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4. Fluoride Treatments – one (1) per 12 months under age fourteen (14).

5. Space Maintainers - one (1) per five (5) year period for Members under age fourteen (14)

when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

6. Sealants - one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.

7. Prefabricated Stainless Steel Crowns – one (1) per tooth per lifetime for Members under age fourteen (14).

8. Periodontal Services:

    a. Full mouth debridement - one (1) per lifetime.

    b. Periodontal maintenance following active periodontal therapy - two (2) every twelve (12) months in addition to routine prophylaxis.

    c. Periodontal scaling and root planing - one (1) per thirty-six (36) months per area of the mouth.

    d. Surgical periodontal procedures - one (1) per thirty-six (36) months per area of the mouth.

    e. Guided tissue regeneration - one (1) per tooth per lifetime.

9. Replacement of restorative services only when they are not, and cannot be made, serviceable:

    a. Basic restorations - not within twenty-four (24) months of previous placement.

    b. Single crowns, inlays, onlays - not within five (5) years of previous placement.

    c. Buildups and post and cores - not within five (5) years of previous placement.

    d. Replacement of natural tooth/teeth in an arch - not within five (5) years of a fixed partial denture, full denture or partial removable denture.

10. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

11. Pulpal therapy - one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth.

12. Root canal retreatment - one (1) per tooth per lifetime.

13. Recementation - one (1) every thirty-six (36) months. Recementation during the first twelve (12) months following insertion of the crown or fixed partial dentures by the same dentist is included in the crown or fixed partial dentures benefit.

14. General anesthesia and IV sedation limited to sixty (60) minutes per session.

15. Payment for orthodontic services, if covered, cease at the end of the month after termination of the contract.

16. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under the ABP.