OPTIONAL VOLUNTARY DENTAL BENEFITS
(If elected by Participant)

The following Deductibles, Benefits, and plan maximums are per Plan Participant, per Plan year:

Dental Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant *(Deductible waived for Class 1 Services)*	**$25**
Maximum Number of Deductibles for Family	**x 2**
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	**$1,500**
Maximum Lifetime Benefit Limit for Class 4 Services *(Orthodontia)*	**$1,500**

Dental Benefit Coinsurance Levels Based Upon Class:	Benefits	Benefit Type
Class 1 Services	**100%**	**Preventive Care**
Class 2 Services	**90%**	**Repair and Restoration**
Class 3 Services	**60%**	**Major Dental Repair**
Class 4 Services	**60%**	**Orthodontics**
All charges except preventive care are limited to Usual and Customary Fees calculated at the 90th percentile.		

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.

16.01. 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.

A. Class 1 Services *(Preventive Care)*

1. Routine oral examinations and prophylaxis *(cleaning, scaling and polishing teeth)*, but not more than once each in any period of 6 consecutive months;

2. Periapical x-rays, as required, and bitewing x-rays once in any period of 6 consecutive months;

3. Full mouth x-rays, but not more than once in any period of 60 consecutive months or,

4. Panoramic x-rays, but not more than once in any period of 60 consecutive months *(only Panoramic or Full mouth x-rays – not both)*;

5. Sealants for Dependent Children under age 16, but not more than once in any period of 36 consecutive months;

6. Topical application of fluoride for Dependent Children under age 14, but not more than once in any period of 6 consecutive months;

7. Space maintainers *(not made of precious metals)* that replace prematurely lost teeth for Dependent Children under age 16. No payment will be made for duplicate space maintainers; and

8. Palliative Emergency treatment of an acute condition requiring immediate care.

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

1. All Medically Necessary x-rays;

2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;

3. Simple extractions;

4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;

5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;

6. Periodontal examinations, treatment and surgery; and

7. Consultations

C. Class 3 Services *(Major Dental Repair)*

Prosthodontic services *(initial installation or replacement of bridgework or dentures)* will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;

2. Repair or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures

3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:

    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;

4. Osseous Surgery;

5. Oral Surgery;

6. Periodontal scaling;

7. Post and core;

8. Re-lines;

9. Stainless steel crowns; and

D. Class 4 Services *(Orthodontics)* Only if allowed as depicted in benefit summary

Orthodontic services will be eligible only when provided to covered Dependents who are under age 19 when treatment is received.

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;

2. Interceptive, interventive or preventive orthodontic services;

3. Fixed and removable appliance placement, and active treatment per month after the first month; and

4. Extractions in connection with orthodontic services.

16.02. Exclusions and Limitations

The following exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Summary of Benefits."

A. Adjustments. Charges for services to alter vertical dimension *(work done or appliance used to increase the distance between nose and chin)*; to restore or maintain occlusion *(work done or appliance used to change the way the top and bottom teeth meet or mesh)*; to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;

B. After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses Incurred for the following procedures will be payable as though the coverage had continued in force:

1. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;

2. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and

3. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;

C. Cosmetic. Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations.

This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;

D. Education. Charges for instruction in oral hygiene, plaque control or diet;

E. Experimental. Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;

F. Late Enrollee. Charges for crowns, bridgework, dentures, periodontics and orthodontics Incurred during the first 24 months of coverage for a late enrollee, unless such services and supplies are needed as a result of Accidental Injury sustained by the Participant. *(Damage resulting from biting or chewing is not considered an Accidental Injury.)* "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period;

G. Miscellaneous. The Plan does not cover any charge, service or supply which is:

1. For treatment other than by a Dentist or Physician, except:
   a. Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and

b. Non-Experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;

2. For local infiltration anesthetic when billed for separately by a Dentist;

3. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;

4. For oral hygiene or dietary instruction;

5. For a plaque control program *(a series of instructions on the care of the teeth)*;

6. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;

7. For periodontal splinting;

8. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

9. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;

10. For replacement of a lost, missing or stolen prosthetic device;

11. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;

12. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;

13. Charges for missed appointments or completion of claim forms;

14. Covered under the "Medical Benefits" Article of the Plan; and

15. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

H. Missing Appliances. Charges for replacement of lost, missing or stolen appliances or prosthetic devices;

I. More Expensive Course of Treatment. In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure;

J. Not Recommended. Charges for services or supplies which are not recommended and approved by a Dentist or Physician;

K. Orthognathic Surgery. For Surgery to correct malpositions in the bones of the jaw;

L. Personalization. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

M. Replacements. Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Participant. *(Damage resulting from biting or chewing is not considered an Accidental Injury)*;

N. Single Provider Care. In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the services. An appropriate expense in this case will be the Usual and Customary fee;

O. Splinting. For crowns, fillings or appliances that are used to connect *(splint)* teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite *(occlusion)* or are cosmetic.

16.03. Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of $300 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is <u>not required</u> prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment.

In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.**

OPTIONAL VOLUNTARY VISION BENEFITS
(If elected by Participant)

The following Deductibles, Copayments, and Benefits are per Plan Participant, per Plan year:

Vision Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant	**$25**
Maximum Number of Deductibles for Family	**x 2**
Vision Coinsurance	**90%**
Maximum Annual Benefit Limit per Participant	**$600**

Vision Expense Benefit Descriptions:	Benefits	Limits[1]
Eye exam, per participant	**$100 Maximum**	**12 - month period**
Frame-type lenses, per pair – Single Vision	**$120 Maximum**	**12 - month period**
Frame-type lenses, per pair – Bi-focal	**$130 Maximum**	**12 - month period**
Frame-type lenses, per pair – Tri-focal	**$140 Maximum**	**12 - month period**
Frame-type lenses, per pair – Lenticular	**$150 Maximum**	**12 - month period**
Frames	**$130 Maximum**	**24 - month period**
Contact Lenses	**90 / 10 *(Plan Limit)***	**12 - month period**

17.01. Additional Covered Expenses
Subject to the limits in the Summary of Benefits, the Plan pays the Usual and Customary fees for vision care services, as follows:

A. Enrolled in a Training Program. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program;

B. Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses *(except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury)*;

C. Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;

D. Recommended. Recommended and approved by a Physician or optometrist;

17.02. Exclusions and Limitations

17.03. The following exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Summary of Benefits":

A. Benefit Limitation: A Participant can use the benefit to secure either eye glasses with frames or contact lenses (not both)

B. Missed Consultations. Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

C. Greater Coverage. Any charges that are covered under a medical or health plan that reimburses a greater amount than this Plan;

D. Non-Prescription Lenses. Charges for lenses ordered without a prescription;

E. Orthoptics. Charges for orthoptics *(eye muscle exercises)*

[1] These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan Document carefully to determine benefits available.

F. **Safety Goggles or Sunglasses.** Charges for safety goggles or sunglasses, including prescription type; and

Vision Training. Charges for vision training or subnormal vision aids.