## Dental PPO Summary of Benefits Effective: 1/1/2016

### Individual Annual Calendar Year Deductible
- **Network:** $50
- **Out-of-Network:** $100
- **Orthodontics:**
  - **Network:** $0
  - **Out-of-Network:** $0

### Family Annual Calendar Year Deductible
- **Network:** $150
- **Out-of-Network:** $300
- **Orthodontics:**
  - **Network:** $0
  - **Out-of-Network:** $0

### Maximum (the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)
- **Network:** $1000 per person per Calendar Year
- **Out-of-Network:** $1000 per person per Calendar Year
- **Orthodontics:**
  - **Network:** $1000 per person per Lifetime
  - **Out-of-Network:** $1000 per person per Lifetime

### Annual deductible applies to preventive and diagnostic services
- **Yes** (In Network)
- **Yes** (Out-of-Network)

### Solstice Benefits Booster Included (Increasing Calendar Year Maximum Benefit)
- **Yes**

### Orthodontic eligibility requirement
- **Children up to 19 Years Old**

### Preventive & Diagnostic Services

<table>
<thead>
<tr>
<th>Service</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>BENEFIT GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Oral Evaluation</td>
<td>100%</td>
<td>80%</td>
<td>Limited to two (2) times per consecutive twelve (12) months.</td>
</tr>
<tr>
<td>Routine Radiographs</td>
<td>100%</td>
<td>80%</td>
<td>Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.</td>
</tr>
<tr>
<td>Non-Routine - Complete Series Radiographs</td>
<td>100%</td>
<td>80%</td>
<td>Complete Series/Panor: Limited to one (1) time per consecutive thirty-six (36) months.</td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>80%</td>
<td>Limited to two (2) prophylaxis in any twelve (12) consecutive months, to a maximum of four (4) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.</td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td>100%</td>
<td>80%</td>
<td>Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>80%</td>
<td>Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unerupted permanent molar every consecutive thirty-six (36) months.</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100%</td>
<td>80%</td>
<td>Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.</td>
</tr>
<tr>
<td>Palliative Treatment</td>
<td>100%</td>
<td>80%</td>
<td>Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit</td>
</tr>
</tbody>
</table>

### Basic Services
- **Restorations (Amalgam or Composite):** 70% / 50%
  - Multiple restorations on one (1) surface will be treated as a single filling.
- **Simple Extractions:** 70% / 50%
  - Limited to one (1) time per tooth per lifetime.

### Major Services

**6-Month Waiting Period**

<table>
<thead>
<tr>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>40%</td>
<td>20%</td>
<td>Extractions: Limited to one (1) time per tooth per lifetime.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>40%</td>
<td>20%</td>
<td>Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>40%</td>
<td>20%</td>
<td>Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months.</td>
</tr>
<tr>
<td>Endodontics</td>
<td>40%</td>
<td>20%</td>
<td>Periodontal Maintenance: Limited to four (4) periodontal maintenance in any twelve (12) consecutive months, to a maximum of four (4) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns</td>
<td>40%</td>
<td>20%</td>
<td>Limited to one (1) time per tooth per consecutive sixty (60) months.</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>40%</td>
<td>20%</td>
<td>Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.</td>
</tr>
<tr>
<td>Anesthetics</td>
<td>40%</td>
<td>20%</td>
<td>General Anesthesia: When clinically necessary.</td>
</tr>
<tr>
<td>Adjunctive Services</td>
<td>40%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)</td>
<td>40%</td>
<td>20%</td>
<td>Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months.</td>
</tr>
</tbody>
</table>

### Orthodontic Services

**12-Month Waiting Period**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Diagnose or correct misalignment of the teeth or bite</td>
<td>50%</td>
<td>25%</td>
<td>Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.</td>
</tr>
</tbody>
</table>

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

**Out-of-Network benefits are based on the participating provider contracted fees.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table 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 benefit administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/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 Limitations

ALTERNATE BENEFIT—Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan team must determine the least costly treatment alternative. If you and your dentist agree on a treatment which is more costly than the treatment as 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.

BASIC RESTORATIONS—Multiple restorations on one (1) surface will be treated as one (1) restoration. X-RAYS are limited to one (1) series of films per two consecutive twelve (12) months.

COMPLETE SERIES OF PANORAMS X-RAYS are limited to one (1) per time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to one (1) per time per consecutive thirty-six (36) months. No additional allowances for precision or semi-precision attachments.

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FLUORIDE TREATMENTS are limited to Covered Persons under the age of eighteen (18) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DENTURE RENOVATION is limited to one (1) per time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IN SEDATION are covered when necessary for one of the following reasons: toxicity to local anesthesia, mental retardation, Alzheimer’s, spastic muscular disorders.

MAJOR RESTORATIONS—Replacement of complete dentures, fixed or removable partial dentures, crowns, and inlays or onlays, previously submitted for payment under the plan is limited to one (1) per time per consecutive sixty (60) months from initial or subsequent placement.

OCCLUSAL GUARDS are limited to one (1) per time per consecutive sixty (60) months and only if prescribed to control clenching or grinding.

ORAL EVALUATIONS—Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if in conjunction with other exams.

ORTHODONTIC SERVICES—When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at 20% and remaining payment provided over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to four (4) per year of maintenance in any twelve (12) consecutive months, to a maximum of four (4) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY—Hand tissue and soft tissue periodontal surgery is limited to one (1) per time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) per pin per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have root canal therapy.

RELINING, REBANDING AND TISSUE CONDITIONING DENTURES are limited to relining/rerebanding performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) per time per consecutive thirty-six (36) months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) per time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) consecutive months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12) consecutive months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first and second unerupted permanent molars every consecutive thirty-six (36) months.

SCALEING AND ROOT PLANING are limited to two (2) per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased periodontal tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEPTAL FILLINGS are covered as a separate benefit only if no other service, other than X-rays and surgery, were performed on the same tooth during the visit.

SPACE MAINTENANCE are limited to Covered Persons under the age of sixteen (16) years, (one (1) time per consecutive sixty (60) months. Benefit includes all adjustments made up to six (6) months of initial adjustments.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Reconstructive orthodontic treatment of a tooth or jaw.
3. Any Procedures not directly associated with dental disease.
4. Any Dental Procedure not performed in a dental setting.
5. Procedures that are considered 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 Experimental, Investigational or Unproven in the treatment of that particular condition.
6. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
7. Other fees related to infection control, denture duplication, oral hygiene procedures that are considered Experimental, Investigational or Unproven.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. Procedures that are considered Experimental, Investigational or Unproven (excluding surgical and nonoral). 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 Experimental, Investigational or Unproven in the treatment of that particular condition.
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Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

1. Rhinos, accident, treatment or medical condition arising out of: (i) war or act of war (further declared or undeclared); participation in a felony, riot or insurrection;
   (ii) service in the Armed Forces or units auxiliary thereto; or
   (iii) suicide, attempted suicide or intentionally self-inflicted injury;

2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incident to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

3. Treatment provided in a governmental hospital, benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal worker’s compensation, employers’ liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recoverable or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person’s immediate family; and services for which no charge is normally made;

4. Services provided while the Covered Person is outside the United States, its territories or possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.

5. ILLEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.

6. INTOXICANTS AND NARCOTICS: Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.