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

<table>
<thead>
<tr>
<th></th>
<th>NON-ORTHODONTICS</th>
<th>ORTHODONTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Individual Annual Calendar Year Deductible</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Family Annual Calendar Year Deductible</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Maximum (the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)</td>
<td>$1500 per person per Calendar Year</td>
<td>$1000 per person per Calendar Year</td>
</tr>
</tbody>
</table>

**Annual deductible applies to preventive and diagnostic services**
- No (In Network)
- No (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 Plan Pays*</th>
<th>Out-of-Network Plan Pays**</th>
<th>Benefit Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Oral Evaluation</td>
<td>100%</td>
<td>90%</td>
<td>Limited to two (2) times per consecutive twelve (12) months.</td>
</tr>
<tr>
<td>Routine Radiographs</td>
<td>100%</td>
<td>90%</td>
<td>Biteviews: 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>90%</td>
<td>Complete Series/Panorac: Limited to one (1) time per consecutive thirty-six (36) months.</td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>90%</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>90%</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>90%</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>90%</td>
<td>Limited to Covered Persons under the age of sixteen (16) years, one (1) time per per periodontal only (60) months. Benefits includes all adjustments within six (6) months of installation.</td>
</tr>
<tr>
<td>Palliative Treatment</td>
<td>100%</td>
<td>90%</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

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Plan Pays*</th>
<th>Out-of-Network Plan Pays**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorations (Amalgam or Composite)</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Major Services

**6-Month Waiting Period**

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Plan Pays*</th>
<th>Out-of-Network Plan Pays**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Anesthetics</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Adjunctive Services</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Orthodontic Services**

**12-Month Waiting Period**

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Plan Pays*</th>
<th>Out-of-Network Plan Pays**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnose or correct misalignment of the teeth or bite</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

**Out of Network benefits are based on the Usual and Customary Charge.

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 broad, 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 benefits 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.
Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – Four dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan limits reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan is based, you will be responsible for the difference between the two 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 a single filling. LUSTERING RADIOGRAPHS are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANORAMS RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANING) are limited to two (2) prophylaxises in any twelve (12) consecutive calendar months, to a maximum of four (4) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRORADIAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

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

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

GENERAAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons: toxicity to local anesthesia, mental retardation, Alzheimer’s, or acute muscular disorders.

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

OCCLUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control grinding habit.

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 prorated over the course of the treatment.

PATIENT 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 periodontal 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 – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

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

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

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

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

REPLACEMENT of 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.

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

SCALEING AND ROOT PLANING are limited to one (1) time per quadrant or 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 cleaning and scaling.

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

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments where 5-6 or more millimeters of interdental space maintained.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Hospital or other facility charges.
3. Reconstructive surgery to the mouth or jaw.
4. Any Procedures not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological 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 pharmacological 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.

7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
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 removal.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed removable prosthesis.
12. If damage or breakage was directly related to provider error, replacements of: (a) incomplete or partial dentures, (b) fixed bridgework, or (c) crowns. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
14. Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hour notice.
15. Expenses for dental procedures begun before enrollment under the plan.
16. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient’s current vertical dimension of occlusion (VDO).
17. Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
19. Occlusal guards used as safety items or for sports-related activities.
20. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
21. Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
22. Acupuncture, acupressure, and other forms of alternative treatment, whether, or not.
23. Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
24. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/restoration is not restored with an esthetic or composite resin filling.
25. Sedation, restorations, or other laboratory prepared restorations when used primarily for the purpose of anesthetic.
26. Any charges related to histologic review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
27. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
28. Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

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

1. Ehlers, accident, treatment or medical condition arising out of:
   a. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
   b. service in the Armed Forces or units auxiliary thereto;
   c. suicide, attempted suicide or intentionally self-inflicted injury;
   d. aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline, and;
   e. with respect to blanket insurance, interdisciplinary sports.
2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental 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 government hospital; benefits provided under Medicare or other governmental program (except Medicare), any State or Federal workers’ 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 recovered or recovered; 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 possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
5. ILEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission 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.