SUPERIOR DENTAL CARE

Schedule of Benefits – Plan #1624	In Network	Out of Network
Preventive	**100%**	**100%**
Basic	**80%**	**80%**
Major	**50%**	**50%**
Contract Maximum	**$1,500.00**	**$1,500.00**
Deductible *(applies to Basic and Major services)*	**$25/$50**	**$25/$50**
Orthodontia	**50%**	**50%**
Lifetime Ortho Deductible	**$100 per child**	**$100 per child**
Lifetime Ortho Max	**$1,500.00**	**$1,500.00**
Copay *(applies to eligible oral evaluations)*	**None**	**None**

Contract Period – The defined time during which your benefits will apply. This is typically a 12 month period of time; however please check with your employer to be sure.
Contract Maximum – The amount of dental expenses allotted to each member per Contract Period. Typically includes all benefits paid under the Preventive, Basic, Major categories.
Deductible – The amount of dental expense, which you are responsible for before SDC begins calculations of benefits. Deductibles follow the contract period and have individual and family maximums.
Lifetime Ortho Maximum – The amount of orthodontia benefit, per member per lifetime, while enrolled with SDC. Any orthodontia payments made by SDC are applied toward the Lifetime Maximum. The orthodontia Lifetime Maximum is separate from the Contract Maximum and does not refresh. Timely submission of ortho claims is necessary for prompt consideration of benefit.
Copay - This amount is applied to eligible oral evaluations in the Preventive Category only and is to be paid per Covered Person per occurrence, at the time of the visit.

PREVENTIVE SERVICES

ORAL EVALUATIONS *2x contract period;* **LIMITED, DETAILED/EXTENSIVE PROBLEM FOCUSED ORAL EVALUATIONS** *2x contract period;* **PROPHYLAXIS** (cleaning) *2x contract period;* **TOPICAL APPLICATION OF FLUORIDE** *1 treatment per contract period for children under 19;* **BITEWING X-RAYS** *2x per contract period;* **FULL MOUTH X-RAYS OR PANORAMIC SURVEY** *1x 3 years;* **INTRAORAL PERIAPICAL X-RAYS** *4 per contract period;* **SEALANTS/PREVENTIVE RESINS** (permanent molars only) *1x 5 years per tooth for children under 19*

BASIC SERVICES

SPECIALIST EXAMINATION *for endodontics, periodontics, or oral surgery; or* **CONSULTATION** *1x per contract period*; **PERIODONTICS/SURGICAL PERIODONTICS** (includes local anesthesia and postop care); Periodontal Scaling and Root Planing *1x 2 years each quadrant;* Periodontal Maintenance (root planing followed by osseous surgery - a single course of treatment) *2x per contract period during a course of full mouth periodontal treatment;* Full Mouth Debridement *1 per lifetime*; Localized Delivery of Antimicrobial Agents *1x per year per tooth;* Complete Occlusal Adjustment *1x 3 years following periodontal surgery;* Gingivectomy *each quadrant/area 1x 3 years;* Gingival Grafts *1x 3 years each quadrant/area;* Osseous Surgery *1x 3 years each quadrant/area;* Bone Replacement Graft (for natural retained tooth only) 1x per 3 years; Guided Tissue Regeneration *1x per 3 years per tooth/site;* Crown Lengthening; **SPACE MAINTAINERS** *1x lifetime per area for children under 15;* **ORAL SURGERY** (includes local anesthesia/routine postop care); Extractions; Removal of Periapical and Follicular Cysts; Intraoral Incision and Drainage; Biopsy; Frenectomy; General Anesthesia or IV Sedation - in connection with oral surgery (excluding simple extractions); Alveoplasty, Vestibuloplasty *1x 5 years;* Removal of Exostosis or Tori; **ENDODONTICS** (includes local anesthesia, x-rays and routine postop care); Root Canal Treatment *1x lifetime;* Surgical Endodontics *1x lifetime per tooth; Pulp Cap 1x per lifetime per tooth;* **RESTORATIVE** (includes local anesthesia); Restorations (amalgam and composite) - to restore teeth damaged by decay or traumatic injury *1x 2 years per surface;* Pins *1x 5 years per tooth;* **BRUSH BIOPSY** *1x per contract period;* **MINOR EMERGENCY TREATMENT** *for the temporary relief of pain, bleeding or swelling*

MAJOR SERVICES

PROSTHODONTICS *(replaceable after 5 years in place)* Bridge Abutments (See Crowns and Onlays); Pontics (See Crowns and Onlays); Removable Partial Dentures; Complete Dentures; Rebasing and Relining *1x 2 years;* Tissue Conditioning *1x 2 years per arch;* **CROWNS, INLAYS AND ONLAYS** *(replaceable after 5 years in place);* (treatment for decay or traumatic injury and when teeth cannot be restored with a filling material or when the tooth is an abutment. Applies interchangeably to onlays, inlays, veneers, crowns, abutments, and pontics for the same tooth); Crowns, Onlays, Inlays, Veneers, Post and Core; Prefabricated Crowns *(replaceable after 5 years in place);* Recementation (onlays, inlays, veneers, crowns and bridges) *1 per year more than six months after installation;* **REPAIRS** (includes repairs to crowns, bridges, and complete or partial dentures) *more than six months after installation 1x per contract period;* Denture Adjustments *more than six months after installation 2x per contract period*; **OCCLUSAL GUARDS** *1x 2 years*; **IMPLANTS** *1x 5 years per tooth;* Surgical placement of implant, Implant supported prosthetics, Repair of an implant, Removal of an implant

ORTHODONTIC SERVICES

Superior Dental Care's (SDC) orthodontia benefits are limited to dependent children under 19. Coverage is for a "Treatment Plan" evaluated through a pre-determination of benefits. Treating dentists providing this service must supply SDC with films and study models upon request. The one-time Record/Diagnosis fee consists of initial exam, diagnosis and consultation, x-rays, and study models. This fee can be submitted for payment separately and will apply to the member's

lifetime maximum. Ortho payments for members will be made monthly beginning after the first month of treatment, and continue for the estimated duration of the treatment plan, as long as the patient is in active treatment. Retention is not covered. For treatment in progress at the time of eligibility, SDC will review the initial treatment months and total cost to determine benefit eligibility. All calculations are based on the appropriate plan percentage, up to the plan's allowable orthodontic lifetime maximum, and for the remaining months of estimated treatment. Benefits will automatically terminate when the patient ceases to be eligible. **HARMFUL HABIT APPLIANCE** (fixed and removeable) *for children under 19;* **EXPOSURE OF TOOTH TO AID ERUPTION**

EXCLUSIONS

The following items are not covered under SDC dental plans unless your plan indicates otherwise on the reverse side of this document.
1. Services performed for cosmetic reasons, including personalization or characterization of dentures **2.** Services or supplies that are considered experimental according to standard dental practice **3.** Services or procedures started prior to the effective date of coverage. Prosthetic devices and crowns will not be covered if impressions are taken before the effective date of coverage **4.** Services or procedures completed after the date of termination, unless stated elsewhere in this Evidence of Coverage **5.** Missed appointment charge **6.** Replacement of lost or stolen prosthetic devices unless it is after the limitation date **7.** Dental Services or health care services not specifically listed in the Covered Services section of this Plan (including any hospital charges, prescription drug charges) **8.** Services of anesthesiologists **9.** Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a Dentist or an employee of the Dentist who is certified in their profession to provide anesthesia services. **10.** Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. **11.** Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings. **12.** Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants. **13.** Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed. **14.** A permanent appliance or restoration (such as a partial, denture, bridge or crown) that has not been permanently cemented. **15.** Services performed for which no payment would normally be required. **16.** Services covered under Workers Compensation, Federal or State agencies **17.** Services performed by other than a licensed dentist, except for legally delegated services to a licensed dental hygienist or licensed expanded functions auxiliary **18.** Surgery, treatment and x-rays for Craniomandibular disorders (TMJ) **19.** Orthognathic surgery **20.** Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan. **21**. Laboratory charges **22.** Services performed on a tooth with poor prognosis **23.** Athletic mouth guards, enamel microabrasion and odontoplasty **24.** Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Plan. **25.** Bacteriologic tests. **26.** Separate services billed when they are an inherent component of a Dental Service. **27.** Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges). **28.** Services for the replacement of an existing partial denture with a bridge. **29.** Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments. **30.** Provisional splinting, temporary procedures or interim stabilization. **31.** Placement or removal of sedative filling, base or liner used under a restoration. **32.** Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital. **33.** Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids. **34.** Implant maintenance or repair to an implant or implant abutment. **35.** Pulp vitality tests. **36.** Secondary diagnostic tests in addition to the primary therapy. **37.** Diagnostic casts. **38.** Incomplete root canals. **39.** Cone beam images. **40.** Anatomical crown exposure. **41.** Temporary anchorage devices. **42.** Amalgam or composite restorations placed for preventive or cosmetic purposes.

NATIONAL NETWORK

While SDC is licensed to sell to groups domiciled in Ohio, Kentucky and Indiana, our network of participating dentists and specialists offers coverage across the country with **over half a million access points nationwide**. SDC members are encouraged to seek service from a Participating Dentist or Specialist. **You may access our directory of Participating Dentists on our website superiordental.com. Participating dentists are prohibited from collecting any amount beyond the assigned member responsibility and SDC's reimbursement**. Unless otherwise contracted, SDC's payments for out of network services will be directed to the Enrollee. Members receiving SDC payment for services performed by a non-participating dentist will be responsible for the full payment to that dentist. Any out of network service may be subject to a "balance bill" for any amount that the dentist's charge exceeds SDC's then current allowable amount for an eligible service.

PLAN SPECIFICS

Pre-determination of Benefits Pre-determination of Benefits is necessary for services $400.00 or more and for periodontal services. Alternate benefits may be received when there is more than one acceptable course of treatment.
Coordination of Benefits SDC coordinates benefits with other carriers and with other SDC plans. SDC follows the rules established by state law for Coordination of Benefits to decide which plan pays first. The birthday rule applies for covered dependents – the parent's birthday first in the calendar year is considered the primary carrier. If a divorce has occurred, the plan follows the divorce decree.
Evidence of Coverage Your Evidence of Coverage is on file with your employer or you may call our office to request a copy. Additional access is provided on our website at: superiordental.com. Important information addressed in the Evidence of Coverage includes: claims appeal procedures, exclusions, coordination of benefit rules, contact information for SDC's Member Services Team, for State Departments of Insurance, for State Dental Associations and more.
Claim Submission All claims must be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status.

VALUE-ADDED BENEFITS

SMILE*RIDER*® Dentists who participate in our Smilerider program offer a 15% discount for elective services such as teeth whitening, veneers, bonding and porcelain facings. This discount comes with the SDC dental plan at no additional charge.
EyeMed Vision Care® Discount Plan SDC offers a vision discount plan through EyeMed Vision Care at eyemed.com. This program offers significant savings and there are no limitations on the frequency of use. Please contact your employer to confirm this benefit is available to you. After confirming this benefit, be sure to mention to your eyecare provider that you are a member of Superior Dental Care. This plan is not vision insurance.
Free Second Opinion SDC will provide a Free Second Opinion by a participating dentist for extensive treatment plans. This is provided at no cost and without utilizing any portion of the individual's Contract Maximum. This benefit is required to be coordinated, in advance, through SDC's Dentist and Member Services team.
General SDC Information Warning: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.