DENTAL PLAN

SCHEDULE OF BENEFITS

If you or one of your Dependents receives dental treatment or service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled benefits are based on your class and the status of your Dependents:

Classes of Coverage

Employees/Dependent Spouses…….. Covered Charges under Dental Care Parts 1, 2, and 3
Dependent Children …….....Covered Charges under Dental Care Parts 1, 2, 3, and 4

Individual Calendar Year Deductible

Part 1…….……..…None
Parts 2, 3, and 4 (combined)……..…. $50
Part 4……...$50

In place of individual Deductibles, a family maximum Deductible may be applied. The family maximum Deductible will be a combined family total of $150 per Calendar Year for Covered Charges under Dental Care Parts 2, 3 and 4 (but not counting more than $50 per Calendar Year for any one person in your family). When the family maximum Deductible is satisfied for a Calendar Year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family.

Maximum Payment Limits

Parts 1, 2, and 3 (combined)……..$ 1,250 Per calendar year
Orthodontia……$ 1,250 Per Lifetime

Dental Care Co-insurance

Part 1 - Diagnostic and Preventive Services……...100% Deductible waived
Part 2 - Basic Restoration Services……. 80% After Deductible
Part 3 - Major Restoration Services…… 50% After Deductible
Part 4 – Orthodontia…… 50% After Deductible
In excess of any applicable Deductible amounts, up to the Dental Maximum Payment Limits.

Deferred Coverage Provision

Benefits for Covered Charges under Dental Care Parts 2, 3, and 4 will be limited if you or if any of your Dependents become covered under the Deferred Coverage provision described in the HOW TO BE COVERED UNDER THE PLAN Section on page 22.

BENEFIT DESCRIPTION

Payment of Benefits

Each Calendar Year benefits will be paid to a Covered Person for the Dental Charges in excess of the Deductible. Payment will be made at the rate shown under Dental Care Co-insurance in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be **$300** or more, a predetermination of benefits form must be submitted. A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form. The Dentist should send the form to the Claims Administrator at this address:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601
(319) 752-3200 or (800) 373-1327

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the Benefit Payment will be based on the cost of the treatment, which provides professional, satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Prevailing Charge for an amalgam filling. The patient will pay the difference in cost.

BENEFIT DESCRIPTION (CONTINUED)

Payment Conditions

If you or one of your Dependents receives any treatment or service that is listed in the Schedule of Dental Procedures, the Claims Administrator will pay Dental benefits for Covered Charges:

- in excess of the Deductible amount(s); and
- at the payment percentage(s) indicated; and
- To the Maximum Allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits; as described in the Schedule of Benefits Section.

Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for treatment or service, but not more than the Maximum Allowances shown in the Schedule of Dental Procedures. Also:

- If the Claims Administrator determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Maximum Allowance for the least expensive of the procedures that would provide professionally acceptable results.

- Covered Charges will include only those charges for treatment or service that begins (see below) while you and your Dependents are covered under this plan.

- Covered Charges will include only those charges for treatment or service that is completed while you and your Dependents are covered under the plan (except when the treatment or service is covered under the Extended Benefits provision).

- Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a non-listed procedure is accepted, the Claims Administrator will determine its Maximum Allowance based on the Maximum Allowance for a listed procedure of comparable nature.

Beginning Date for Treatment or Service

Treatment or service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for full or partial dentures, on the date the master impression is made; and
- for orthodontia, on the date the appliances or bands are first set; and
- for all other, on the date the treatment or service is performed.

A temporary dental treatment will be considered an integral part of the final treatment rather than a separate treatment.

BENEFIT DESCRIPTION (CONTINUED)

Extended Benefits (After Dental Coverage Terminates)

If Dental Expense Coverage under your plan ceases and if you or your Dependents qualify, the Planholder will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent was covered under this plan; and

- crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent was covered under this plan; and

- full or partial dentures, but only if the master impression was made while you or a Dependent was covered under this plan; and

- orthodontia, but only if the appliance or bands were first set while the Dependent child was covered under this plan. The amount payable will be the part of the quarterly payment that would have been payable had coverage remained in force during the period extended benefits are payable;

provided the treatment or service is received within the lesser of two months or the duration of the treatment plan.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under this plan had coverage remained in force; and

- the treatment or service began while you or a Dependent was covered under this plan; and

- this plan is in force at the time treatment or service is received.

However, no Extended Benefits will be paid for treatment or service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

SCHEDULE OF DENTAL PROCEDURES

Covered Charges will include only charges for procedures listed below:

Part 1 Services - Preventive and Diagnostic Dental Procedures

Examinations

Oral examination

Only one oral examination (other than emergency examination) will be covered each six-month period.

Radiographs

Intraoral x-rays (complete series)
Covered once each three-year period.

Bitewing
Only one set will be covered each six-month period.

Occlusal

Periapical

Extraoral x-rays

Panoramic
Sialography
TMJ
Cephalometric film
Posterior/anterior and lateral skull and facial bone survey
Other extraoral

Only one of the listed extraoral procedures will be covered each six- month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Part 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth including scaling and polishing)

Covered once each six- month period.

SCHEDULE OF DENTAL PROCEDURES (CONTINUED)

Topical application of fluoride

Applicable only to Dependent children. Only one application will be covered each 12-month period.

Space maintainers
Applicable only to Dependent children under age 14.

Topical application of sealants
Applicable only to Dependent children under age 14. Covered once each quadrant in each four-year period.

Other Services

Biopsy of oral tissue
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Bacteriologic culture
Histopathologic examinations
Pulp vitality test
Diagnostic cast

Covered once each two-year period.

Part 2 Services - Basic Restoration Services

Restorations

Fillings (amalgam, silicate, plastic or composite, including pin retention when necessary)

Stainless steel crown

Oral Surgery

Extraction of teeth
Alveoloplasty
Removal of dental cysts and tumors
Incision and drainage of dental abscess
Tooth replantation
Surgical exposure to aid eruption
Surgical repositioning of teeth
Excision of hyperplastic tissue

SCHEDULE OF DENTAL PROCEDURES (CONTINUED)

Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant each six-month period.

Periodontal appliance

One appliance is covered in each three-year period.

Periodontal prophylaxis

Gingivectomy
Gingival curettage
Osseous surgery
Osseous graft

Only one of these procedures is covered per quadrant each 12-month period.

Endodontic Services

Pulp cap
Pulpotomy
Root canal therapy- including treatment plan, diagnostic x-rays, clinical procedures and follow-up care

Apicoectomy and retrograde fillings- covered as a separate procedure only if performed more than one year after the root canal therapy is completed ear after the root canal therapy is completed.

Apexification
Apical curettage
Root resection
Hemisection

Anesthesia

General anesthesia

Covered as a separate procedure only when required for complex oral surgical procedures covered under this plan and only when not performed in a Hospital.

SCHEDULE OF DENTAL PROCEDURES (CONTINUED)

Other Services

Repairs to bridges and full or partial dentures

Relining dentures

Covered only if relining is done more than one year after the initial installation and then not more than once each two-year period.

Recementing bridges, inlays, crowns and space maintainers
Adding additional teeth to partial denture
Consultation with specialist
Antibiotic drug injection

Part 3 Services - Major Restoration Services

All procedures listed include one year of follow-up care.

Restorations

Gold foil
Gold inlays and onlays

Gold restorations are covered only if the tooth cannot be restored by a silver filling and (for replacements) at least five years have elapsed since the last placement.

Porcelain inlays

Crowns - Single Restorations

Plastic or porcelain crowns (with gold, semiprecious metal or nonprecious metal)

Full cast crowns (gold, semiprecious metal, or nonprecious metal)

Crowns are covered only if the tooth cannot be restored by a filling, and (for replacements) at least five years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimension or restoring vertical occlusion are not covered.

Cast post and core

Covered only for teeth that have had root canal therapy

Steel post and composite or amalgam

SCHEDULE OF DENTAL PROCEDURES (CONTINUED)

Prosthodontics - Fixed

Fixed bridges

Initial placement of fixed bridges or full or partial dentures to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this plan for 24 consecutive months, unless the bridge or denture also includes replacement of a natural tooth extracted while covered. Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable and (a) the person has been covered under this plan for at least 12 consecutive months; and (b) at least five years have elapsed since the last placement.

Prosthodontics - Removable

Full or partial dentures

Initial placement of full or partial dentures to replace teeth which were missing prior the effective date of the person's coverage will be covered only after the person has been covered under the plan for 24 consecutive months, unless the dentures also includes replacement of a natural tooth extracted while covered. Replacement of full or partial dentures is covered only if the existing denture cannot be made serviceable and (a) the person has been covered under this plan for at least 12 consecutive months (not applicable if replacement of a denture is made necessary by the initial placement of an opposing full denture); and (b) at least five years have elapsed since the last placement. Covered Charges for removable prosthodontics do not include any additional charges for overdentures or for precision or semi-precision attachments.

Part 4 Services - Orthodontia (Applicable to Dependent Children Only)

Comprehensive Orthodontic Treatment:

Fixed appliances, including x-rays and other diagnostic procedures--formal, full-banded treatment and retention.

Removable appliances, including x-rays and other diagnostic procedures, and retention.

Appliances for tooth guidance, removable and fixed.

Appliances for control of oral habits harmful to dental health, removable and fixed.

Retention appliances, removable and fixed.

PLAN LIMITATIONS

Dental Covered Charges will not include and no benefits will be paid for:

- treatment, service, or material that is not for Necessary Dental Care; or
- any part of a charge for treatment or service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- any instructions for plaque control, oral hygiene, or diet control; or
- any treatment or service which does not have uniform professional endorsement, including (but not limited to) implants or other Experimental procedures; or
- any treatment or service primarily for cosmetic purposes, including (but not limited to) personalization or characterization of dentures and facings on crowns or pontics posterior to the second bicuspid; or
- drugs and medicines (other than antibiotic injections); or
- treatment or service to alter or maintain vertical dimension or restore occlusion; or
- treatment or service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
- Orthodontic Treatment, service, appliance, or bands received within 12 months after your Dependent child's Dental Expense Coverage is effective, unless the appliance or bands were first inserted on or after the effective date; or
- treatment or service for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or
- treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- treatment or service that results from war or act of war; or
- treatment or service that results from voluntary participation in criminal activities; or
- treatment or service that is covered by a Workers' Compensation Act or other similar law; or
- treatment or service that results from an injury arising out of or in the course of any employment for wage or profit.