Peoni
PLANS ADMINISTERED BY VERDEGARD™

Navigator Dental Benefits

These benefits only apply to employee's that have enrolled for Dental Coverage.

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

Individual Deductible
Deductible Amount - This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a benefit year, a member must meet the deductible shown in the Schedule of Benefits.

Family Deductible
When the dollar amount showing in the Schedule of Benefits has been incurred by members of a Family toward their benefit year deductibles, the deductibles of all members of the Family will be considered satisfied for that year.

Benefit Payment
Each benefit year benefits will be paid for covered dental charges in excess of the deductible up to the Maximum Dental Benefit Amount as shown in the Schedule of Dental Benefits. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount. Any charges that exceed the Benefit Year Maximum as shown in the Dental Schedule of Benefits will not be paid by the Plan.

Funding Status
This plan is a self-funded plan that requires the employer to pay for Covered Dental Services in excess of the deductible, up to the Benefit Year Maximum as shown in the Schedule of Benefits. Covered Dental Services are reimbursed at the Usual, Customary, and Reasonable Charges (UCR) as described under Dental Charges. This plan does not carry secondary insurance coverage to pay for the costs for Covered Dental Services therefore, funding the costs of Covered Dental Services is solely the responsibility of the employer.

Dental Charges
This plan does not utilize a network. The plan benefits are available to any provider of your choice. Dental charges are reimbursed at the Usual, Customary, and Reasonable Charges (UCR) made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service. The Plan considers the 90th percentile National Dental Advisory Service (NDAS) as the Usual, Customary, and Reasonable rate. The plan will not pay for any charges that exceed the UCR.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion the overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

DENTAL SCHEDULE OF BENEFITS

The following benefits apply to any provider of your choice.

PLAN PROVISIONS	
Benefit Year Deductible (Applies to Basic and Major Services Only) Per Individual Per Family	 $50 $150
Benefit Year Maximum Applies to Class A Services (Preventive), Class B Services (Basic), and Class C Services (Major)	$1,000
Covered Services	**Plan Liability**

Class A Services – Preventive	100% (deductible waived)
Class B Services – Basic	80% after deductible
Class C Services – Major	50% after deductible

COVERED DENTAL SERVICES

CLASS A SERVICES: PREVENTIVE AND DIAGNOSTIC DENTAL PROCEDURES

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per Member per benefit year.
2. One bitewing x-ray series, limited to 1 every 6 months.
3. One full mouth x-ray every 36 months.
4. One fluoride treatment for covered Dependent children under age 19 per benefit year.
5. Space maintainers for covered Dependent children under age 19 to replace primary teeth.
6. Emergency palliative treatment for pain.
7. Topical sealants for covered Dependent children under age 16, limited to one application per permanent tooth.

CLASS B SERVICES: BASIC DENTAL PROCEDURES

1. Dental x-rays not included in Class A.
2. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
3. Periodontics (gum treatments).
4. Endodontics (root canals).
5. Extractions. This service includes local anesthesia and routine post-operative care.
6. Re-cementing bridges, crowns, or inlays.
7. Fillings, other than gold.
8. General anesthetics, upon demonstration of Medical Necessity.
9. Antibiotic drugs.

CLASS C SERVICES: MAJOR DENTAL PROCEDURES

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be resorted with gold.
2. Installation of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of fixed bridgework to replace one or more natural teeth, which were extracted while the

person was covered for these benefits.
7. Repair of crowns, bridgework and removable dentures.
8. Re-basing or relining of removable dentures.
9. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this time will apply only if one of these tests is met;
    a. The replacement or addition of teeth is required because of one of more natural teeth being extracted after the person is covered under these benefits.
    b. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
    c. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

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 standard of dental practice, the benefits payment will be based on the cost of the treatment, which provides professionally 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 Usual, Customary and Reasonable charge for an amalgam filling. The patient will pay the difference in cost.

DENTAL EXCLUSIONS

1. Services that are excluded under the Medical Plan Exclusions.
2. Services that, to any extent, are payable under any medical expense benefits of the Plan.
3. Services, which are not included in the list of covered dental services.
4. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
5. Crowns, filings 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.
6. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
7. Replacement of lost or stolen appliances.
8. Orthognathic surgery.
9. Personalization of dentures.
10. Oral hygiene, plaque control programs or dietary instructions.
11. During the first six months of coverage under this Plan, for denture replacement, unless the replacement is required due to the initial placement of an opposing full denture.
12. Services, which are covered under any other Plan or policy of the Employer.
13. For space maintainers unless they are replacing permanent teeth of a child under age 19.
14. For any treatment for cosmetic purposes, or to correct congenital malformations, except congenital malformations of newborn children. Facing on crowns and pontics, beyond the second bicuspid are considered cosmetic.
15. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, except when placement is required due to an accident sustained while covered under this Plan.
16. For initial placement of any prosthetic appliance or fixed bridge, unless such placement is needed because of the extraction of one or more natural teeth (except wisdom teeth) while covered under this Plan. Any such appliance or fixed bridge must include replacement of the extracted teeth or tooth.
17. For charges incurred prior to the effective date of participation coverage under this Plan.
18. For charges incurred after an individual's coverage terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after an individual's coverage ends.
19. For orthodontic treatment including appliances, restorations or procedures that alter vertical dimension, alignment and occlusion, restore or maintain occlusion, splint or replace tooth structure lost due to abrasion

or attrition, or to treat conditions of the tempormandibular joint.

20. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
21. For completion of claim forms.
22. For orthodontic treatment, except as may be indicated in the Schedule of Benefits and Covered Dental Services.
23. For topical sealants, which are not applied to permanent molar, or are applied after the age of 15.
24. For sub gingival curettage or root planning, unless periodontal disease is confirmed.

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