

SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

BASIC DENTAL PPO PLAN

Non-Network Annual Deductible: \$50 Individual

\$150 Family

Annual Benefit Maximum: \$1,500 Individual

The following schedule summarizes amounts you will pay for covered services. Please refer to the “What’s Covered” sections of this Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COPAYMENT AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network 0%	N/A	Not subject to the annual benefit maximum. Includes: oral exams (2 per calendar year), cleanings (2 per calendar year), full mouth x-rays (1 complete set every 3 calendar years), bitewing x-ray (2 per calendar year), panoramic x-ray (1 every 3 calendar years), fluoride application (2 per calendar year for participants under 19 years old), sealants (limited to posterior teeth for participants under 14 years old; 1 treatment per tooth every 3 calendar years), space maintainers (limited to non-orthodontic treatment), and emergency care to relieve pain.
	Non-Network 0%	No	
Basic Restorative Services	Network 15%	N/A	Subject to annual benefit maximum. Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics.
	Non-Network 15%	Yes	
Major Restorative Services	Network 50%	N/A	Subject to annual benefit maximum. Includes crowns, dentures, oral surgery, osseous surgery, and bridges.
	Non-Network 50%	Yes	
Orthodontia	Not covered under this plan.		

NOTES: Non-network services are subject to reduction for reasonable and customary (R&C) charges. **You are responsible** for any difference between R&C charges and the actual billed charges, as well as any noncovered expenses.

Network providers are not subject to reduction for R&C charges, since they have agreed to accept a contracted rate for their services.

A pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

DENTAL & ORTHODONTIA PPO PLAN

Non-Network Annual Deductible: \$25 Individual

\$75 Family

Annual Benefit Maximum: \$1,500 Individual

Lifetime Orthodontic Maximum: \$1,500 Individual

The following schedule summarizes amounts you will pay for covered services. Please refer to the “What’s Covered” sections of this Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COPAYMENT AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network 0%	N/A	Not subject to the annual benefit maximum. Includes: oral exams (2 per calendar year), cleanings (2 per calendar year), full mouth x-rays (1 complete set every 3 calendar years), bitewing x-ray (2 per calendar year), panoramic x-ray (1 every 3 calendar years), fluoride application (2 per calendar year for participants under 19 years old), sealants (limited to posterior teeth for participants under 14 years old; 1 treatment per tooth every 3 calendar years), space maintainers (limited to non-orthodontic treatment), and emergency care to relieve pain.
	Non-Network 0%	No	
Basic Restorative Services	Network 15%	N/A	Subject to annual benefit maximum. Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics.
	Non-Network 15%	Yes	
Major Restorative Services	Network 15%	N/A	Subject to annual benefit maximum. Includes crowns, dentures, oral surgery, osseous surgery, and bridges.
	Non-Network 15%	Yes	
Orthodontia	Network 50%	N/A	Subject to the lifetime orthodontic maximum. Orthodontic expenses do not apply to the annual benefit maximum.
	Non-Network 50%	Yes	

NOTES: Non-network services are subject to reduction for reasonable and customary (R&C) charges. **You are responsible** for any difference between R&C charges and the actual billed charges, as well as any noncovered expenses.

Network providers are not subject to reduction for R&C charges, since they have agreed to accept a contracted rate for their services.

The word “lifetime” refers to the period of time you or your eligible dependents participate in this Plan or any other plan sponsored by the Medical Trust.

A pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

PREVENTIVE DENTAL PPO PLAN

Non-Network Annual Deductible: \$0 Individual
\$0 Family

Annual Benefit Maximum: n/a

The following schedule summarizes amounts you will pay for covered services. Please refer to the “What’s Covered” section of this Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COPAYMENT AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network & Non-Network 0%	N/A	Includes oral exams (2 per calendar year), cleanings (2 per calendar year), full mouth x-rays (1 complete set every 3 calendar years), bitewing x-ray (2 per calendar year), panoramic x-ray (1 every 3 calendar years), fluoride application (2 per calendar year for participants under 19 years old), and emergency care to relieve pain.
Basic Restorative Services	Network & Non-Network 99%	N/A	Includes fillings, denture adjustments and repairs.
Major Restorative Services	Network & Non-Network 99%	N/A	Includes crowns, dentures, bridges, root canal therapy, oral surgery, and osseous surgery.
Orthodontia	Network & Non-Network 99%	N/A	

NOTES: Non-network services are subject to reduction for reasonable and customary (R&C) charges. **You are responsible** for any difference between R&C charges and the actual billed charges, as well as any noncovered expenses.

Network providers are not subject to reduction for R&C charges, since they have agreed to accept a contracted rate for their services.

A pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.