

**ALTERNATE DENTAL PLAN
SCHEDULE OF BENEFITS**

Effective 1/1/2007, The Current Dental Plan uses the PPO network that is indicated on the membership identification card. The PPO Directory includes a list of participating providers. The directory is also available on line at: www.NCAS.com.

Payments to Out-of Network providers are based on the Reasonable and Customary allowance (see DEFINITIONS), in the amounts specified in the schedule shown below. In-Network payments are based on the allowable amount as contracted between the provider and the PPO Network in the amounts specified in the schedule shown below.

| Individual Maximums: | |
|---------------------------------------|------------------|
| Plan Year Maximums: Levels I-III | \$1,000 |
| Lifetime Maximum Level IV | \$750 |
| Calendar Year Deductible: | |
| Deductible: Individual | \$25 |
| Family (aggregate) | \$75 |
| Covered Services: | |
| Level I – Preventive | 100% |
| Level II – Diagnostic and Restorative | 80% ¹ |
| Level III – Major | 50% ¹ |
| Level IV - Orthodontics | 50% ¹ |
| ¹ Subject to deductible | |

ELIGIBILITY The eligibility, enrollment, and effective date of coverage provisions described in Section I also pertain to Dental Care Benefits.

DENTAL PLAN PROVISIONS

Plan Year – The Dental Plan Year is from January 1st to December 31st.

Individual Deductible Each Participants deductible is \$25. The deductible must be met once each Plan Year and applies to Level II, III and IV Dental Covered Services.

Family Deductible Under Family Coverage, when the combined covered expenses of

three or more family members reach \$75 in a Plan Year, then all covered family members are eligible to receive Dental benefits for that year without any additional deductibles. The deductible applies to Level II, III and IV Dental Covered Services.

Dental Care Covered Services –the Plan will pay the percentage indicated in the Schedule of Benefits based on the Reasonable and Customary allowances for the services rendered.

Maximum Dental Care Benefit The Plan Year maximum payable is \$1,000 per person for Covered Services in Levels I through III. The lifetime maximum payable is \$750 per person for Covered Services in Level IV. Amounts paid under Level IV do not apply toward the Plan Year maximum.

DENTAL COVERED SERVICES FOR THE ALTERNATE DENTAL PLAN

A Participant is entitled to benefits for the following services. All benefits are subject to the exclusions, limitations, and provisions of this Plan. Payments are based on the Reasonable and Customary allowance.

LEVEL I

Oral Examinations – One oral examination per six month period.

Oral Prophylaxis – Cleaning of teeth, including scaling and polishing, one per six consecutive month period.

Palliative Treatment – Emergency treatment for the relief of pain.

Sealants – For dependent children under age 15, limited to one application per permanent molar.

Space Maintainers – Fixed or removable appliances used to replace the premature loss of extracted teeth for Participants under age 19.

Topical Fluoride Applications – Not more than one topical fluoride application (used to reduce susceptibility to decay) per six consecutive month period for participants under age 19.

X-rays – A complete series of full-mouth x-rays every 3 consecutive years and one set of bitewing x-rays per six consecutive month period.

LEVEL II

Anesthesia – Anesthesia in conjunction with oral surgery and covered dental procedures.

Endodontic Services – Diagnosis and treatment of the pulp chambers and pulp canals. Covered endodontic services include pulpotomies, pulp capping, root canal therapy (includes any x-rays and cultures but not the final restoration) and apicoectomies.

Extractions – Removal of teeth including wisdom teeth.

Fillings or Restorations – Fillings or restorations consisting of amalgam or composite material once per year per tooth surface.

Injection of Antibiotic Drugs

Oral Surgery (including post-operative care) – Alveoplasties, stomatoplasties, the excision and drainage of abscesses involving the teeth and/or support structures of the teeth, and the removal of exostosis and hyperplastic tissues.

Periodontic Services – Prevention, detection and treatment of diseases of the tissues and bones supporting the teeth including splinting, gingival curettage, root planning and scaling (limited to once per year per quadrant), gingivectomy or gingivoplasty and osseous surgery and grafts.

Repair of Crowns and Dentures – Recementation for any crown, bridge, facing or inlay. Repair of facings of a removable denture; repairs are limited to a maximum of 1 repair of each removable denture per plan year and denture adjustments and relinings.

LEVEL III

Prosthodontic Services include the following:

- a. Inlays and onlays;
- b. Crowns including cast gold, porcelain, acrylic, steel, porcelain-faced crowns and temporary crowns. Crown build-ups will also be covered for permanent teeth, limited to 1 crown build-up per tooth every 5 years;
- c. Pontics, including cast gold, cast non-precious metal, porcelain fused to gold, porcelain fused to non-precious metal, plastic processed to gold, and plastic processed to non-precious metal;
- d. Full or partial dentures or bridgework and crowns; and if such denture or bridgework is a replacement for another denture or bridge, the replacement occurs more than 5 years after the installation of the denture or bridge being replaced and the old denture or bridge cannot be made serviceable and was not lost or stolen;

LEVEL IV

Orthodontic Services for Dependents under age 19

- a. Diagnosis, photographs, cephalometric x-rays and tracings;
- b. Active treatment including appliances and progress x-rays;
- c. All other orthodontic treatments including diagnostic and related services.

Covered Services are reimbursed as they are incurred, except that banding and related services are prorated over the duration of the treatment plan.

PRE-TREATMENT AUTHORIZATION

In order to determine appropriateness of treatment and reasonable and customary fees, a pre-treatment authorization is recommended from the Claims Administrator for any non-emergency treatment plan which exceeds \$200. An authorization with estimated benefits payable will be released after the dentist submits the treatment plan to the Claims Administrator (including the list of services to be performed) with dental codes, the itemized cost of each service, and the estimated duration of treatment.

Actual benefits are determined according to the Reasonable and Customary allowance which exists at the time the services are actually performed. Dental expenses may be denied if the treatment is not appropriate for the Participant's condition or any portion of fees charged may be denied which are in excess of Reasonable and Customary allowances for such procedures.

LIMITATIONS AND EXCLUSIONS ON YOUR DENTAL COVERAGE

Change of Dentist – If a Participant transfers from the care of a dentist to that of another dentist during the course of treatment, or if more than 1 dentist provides services for a dental procedure, benefits will be provided for no more than the amount allowed had only a single dentist provided the service.

Optional Techniques – Some dental conditions may be treated by 1 or more methods. This Plan will pay for the procedure that provides the proper treatment, according to accepted standards of dental practice, for the lowest Reasonable and Customary allowance.

Services Rendered Prior to Coverage – Under your dental coverage, the plan will exclude any dental services rendered prior to the effective date of coverage. Certain services which are begun before the effective date will be considered as occurring prior to the effective date of coverage even if completed after the effective date. This applies to the following services:

- a. Fixed bridgework and full or partial dentures if the first impressions are taken and/or abutment teeth fully prepared prior to the effective date;
- b. A crown, inlay or onlay if the tooth is prepared prior to the effective date;
- c. Root canal therapy if the pulp chamber of the tooth is opened prior to the effective date.

Exclusions – In addition to the General Limitations and Exclusions, benefits will not be provided under your Dental Care Benefits for:

1. **Alterations** – Charges for altering vertical dimension, or restoring occlusion;
2. **Analgesia**;
3. **Cosmetic or Aesthetic** – Dental services for cosmetic or aesthetic purposes. However, charges are payable if the cosmetic dental work is needed because of an accidental injury received while covered if the cosmetic dental work is completed within 1 year from the date of the accident. The charges for the correction of a birth abnormality of a Participant are **not** considered to be cosmetic;
4. **Educational** – Charges for educational, research, or training programs, such as training in plaque control, dietary counseling or oral hygiene;
5. **Experimental** – Experimental services or services which do not meet the standards

- of dental practice accepted by the American Dental Association;
6. **Implants;**
 7. **Infection Control;**
 8. **Missed Appointments** – Charges made by a dentist for missed appointments or for completion of claim forms or filing of claims;
 9. **Nightguards;**
 10. **Not Listed** – Charges for services not listed under Dental Covered Services;
 11. **Not Necessary** – Dental services which are not necessary for the diagnosis or treatment of any dental disease, defect, or injury;
 12. **Periodontal services** – Except in areas where natural teeth are present;
 13. **Relative** – Charges incurred for services or supplies rendered by the Employee, Employee's Spouse and the children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse.
 14. **Replacement of Appliance** – Replacement of lost missing, or stolen appliances and any appliance to be used as a spare;
 15. **Replacement of Tooth** – Charges for treatment to replace tooth structure lost due to abrasion or attrition;
 16. **Temporomandibular Joint Disorder** – treatment by orthodontic means of temporomandibular joint dysfunction (TMJ) syndrome, internal derangement of the mandible, Costen-Syndrome or similar disorder;
 17. **Timely Filing** – Charges for services received by the Claims Administrator later than 1 year from the date the services were rendered;
 18. **Veneers** – Charges for veneers on crowns or pontics other than the ten upper and lower anterior teeth;
 19. **Workers' Compensation** – Dental services for which coverage is available to the Participant, in whole or in part, under any Workman's Compensation Law or similar legislation whether or not the Participant claims compensation or receives such benefits.