SCHEDULE OF DENTAL BENEFITS

Annual Deductible	**Annual Dental Plan Maximum**	**General Overall (Lifetime) Maximum Plan Benefit**	**Coinsurance**
What you must **pay each plan year before** The Dental Plan pays benefits	The most the Dental Plan will pay for covered dental expenses in one year	The most this Dental Plan will pay for all covered dental expenses for one person	How you and the Dental Plan will split the cost of covered dental expenses
Individual: $50 Family $100	$1,500 per person per Plan year	$1,500 for Orthodontia benefit only for dependant children through age 26 (Lifetime)	Preventive: Plan pays 100% Basic: Plan pays 80% Major: Plan pays 50% Orthodontia: Plan pays 50% (All services are subject to The deductible except Preventive)

All annual deductibles & annual maximum plan benefits are determined during the Plan year beginning July 1 and ending June 30.

Dental Network

You may choose **any dentist in the USA or Mexico.** Some dentist will bill directly to Plan / Summit but some might require payment in full at time of services. You need to contact dentist prior to services being performed to see what payment is required. If Dentist bills Member (requires payment in full), member will need itemized statement and copy of payment receipt from dentist for reimbursement. You can fax copies to: Summit 480-505-0406, make sure your name and ID number is enclosed with fax statements.

Plan / Summit will reimburse covered person subject to; Deductible / Co-insurance and subject to all terms of the Dental Plan as noted in Plan Document.

Dental Expense Benefit

*Subject to all the terms of the **Plan,** the **Plan** will pay a dental benefit for covered dental expenses **incurred** by a **covered person.** The dental benefits a percentage of the **customary and reasonable amount** for **incurred** covered dental expenses**,** as shown on the Schedule of Benefits.*

COVERED EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Preventive Dental Services (Diagnostic)

1. Routine oral examinations: Initial or periodic, limited to twice per ***benefit year.***

2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per ***benefit year.***

3. Dental x-rays as follows:

   a: Supplementary bite-wing x-rays, limited to twice per ***benefit year.***
   b: Panorex or full mouth series limited to one of each every thirty-six (36) months.
   c: Other **dental** x-rays necessary for the diagnosis of a specific condition requiring treatment.

4. Topical application of fluoride for ***dependent*** children through the age of fifteen (15), limited to one treatment per ***benefit year.***

5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six(6) months of installation, limited to_***dependent*** children through the age of fifteen (15). This does not include space maintainers used in orthodontics to create a space between teeth.

6. Topical application of sealant to permanent posterior teeth, for ***dependent*** children through the age of fifteen (15), limited to one treatment per tooth every thirty-six (36 months).

7. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Basic Dental Services

1. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

2. Restorations, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or ***injury.***

3. Pin retention when part of the restoration instead of gold or crown retention.

4. Periodontics as follows:

   a: Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure, or mucogingival surgery.
   b: Scaling and root planning limited to twice per quadrant in any ***benefit year.***
   c: Pedicle and free soft tissue grafts, and vestibuloplasty.
   d: Occlusal adjustment, excluding charges for TMJ.
   e: Excision of pericoronal gingiva.
   f: Periodontal prophylaxis limited to twice per ***benefit year*** with proof of previous periodontal treatment.
   g: Osseous surgery.

5. Endodontics as follows:

a: Pulp Capping.
b: Pulpotomy.
c: Root canal therapy on permanent teeth only.
d: Apicoectomy.
e: Hemisection.
f: Retrograde fillings.

6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:

a: Simple extraction of one or more teeth.
b: Surgical extraction of erupted teeth and of soft tissue ,partially bony, and completely bony impacted teeth.
c: Extraction of tooth root.
d: Incision and drainage of a tumor or cyst.
e: Alveolectomy, alveoloplasty, and frenectomy.
f: Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
g: Re-implantation or transplantation of a natural tooth.
h: General anesthesia, only when provided in conjunction with a surgical procedure.

7. Bacteriologic cultures in connection with a covered dental service.

8. Therapeutic injections administered by a ***dentist.***

9. Repairs and adjustments to full or partial dentures.

10. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

11. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.

12. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture.

13. Repair or recementing of crowns, inlays, onlays or bridgework.

14. Specialists consultations and specialty examinations provided the ***covered person*** has been referred by a general dentist. These consultations and examinations are not restricted to the limitations for routine oral exams.

Major Dental Expense

1. Post and core on permanent teeth only.

2. Plastic or stainless steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.

3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.

4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.

5. Crowns: Covered only when the tooth cannot be restored by a basic restoration, and then only if at least five (5) consecutive years have elapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.

6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth extracted.

7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth extracted.

8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.

9. Complete dentures for teeth extracted.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Orthodontic Services

For ***dependent*** children ONLY, through age 26

Subject to the limitations specified on the *Schedule of Benefits,* ***covered expense*** shall include:

1. Any dental expense furnished in connection with the orthodontic treatment.

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances, diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Orthodontia benefits will begin upon submission of proof that the orthodontia services have been received. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The ***maximum benefit*** for orthodontia services is specified on the *Schedule of Benefits.* This maximum applies to the entire period(s) a person is covered under the **Plan.**

Dental Exclusions

In addition to the *Plan Exclusions*, no benefit will be provided in this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Charges for any device ordered while the individual was covered under this ***Plan*** and not delivered or installed within thirty (30) days after termination of coverage.

2. Replacement of duplicate, lost, missing or stolen appliances or prosthetic devices.

3. Charges for all services, supplies, and treatment related to dental implants.

4. Any procedure not listed under *Covered Dental Expense.*

5. Any procedure which began before the date the ***covered person's*** dental coverage started to include a service which is:

   a: An appliance, or modification of an appliance, for which an impression was made before such person became covered or
   b: A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered or
   c: Root canal therapy, for which the pup chamber was opened before such person became covered.

   X-ray and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspids are considered optional, and as such, are not ***covered expenses.***

7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services.*

9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.

10. A service not furnished by a ***dentist***, except:

    a: That performed by a licensed dental hygienist under a ***dentist's*** supervision.
    b: X-rays ordered by a ***dentist***; and
    c: Denturist.

11. Charges for over-dentures, including related root canal therapy and supportive restorations.

12. Replacement of a prosthetic which in the dentists opinion, can be repaired or does not need replacement.

13. Fixed prosthetics and/or partials for children through the age of fifteen (15). An allowance will be made for a temporary acrylic partial.

14. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.

15. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

16. Charges resulting from changing from one dentist to another while receiving treatment, or from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.

17. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children through the age of fifteen (15).

18. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienic, or nutritional counseling.

19. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.