Superior Dental Care®
A Medical Mutual® Company

SUPERIOR DENTAL CARE

Schedule of Benefits – Plan #949	In Network	Out of Network
Preventive	**100%**	**100%**
Basic	**80%**	**80%**
Major	**50%**	**50%**
Contract Maximum	**$3,000.00**	**$3,000.00**
Deductible *(applies to Basic and Major services)*	**None**	**None**
Orthodontia	**100%**	**100%**
Lifetime Ortho Max	**$3,000.00**	**$3,000.00**
Copay *(applies to eligible oral evaluations)*	**None**	**None**

Contract Period – The defined time during which your benefits will apply. This is typically a 12 month period of time; however please check with your employer to be sure.
Contract Maximum – The amount of dental expenses allotted to each member per Contract Period. Typically includes all benefits paid under the Preventive, Basic, Major categories.
Deductible – The amount of dental expense, which you are responsible for before SDC begins calculations of benefits. Deductibles follow the contract period and have individual and family maximums.
Lifetime Ortho Maximum – The amount of orthodontia benefit, per member per lifetime, while enrolled with SDC. Any orthodontia payments made by SDC are applied toward the Lifetime Maximum. The orthodontia Lifetime Maximum is separate from the Contract Maximum and does not refresh. Timely submission of ortho claims is necessary for prompt consideration of benefit.
Copay - This amount is applied to eligible oral evaluations in the Preventive Category only and is to be paid per Covered Person per occurrence, at the time of the visit.

PREVENTIVE SERVICES

ORAL EVALUATIONS *2x contract period;* **PROPHYLAXIS** (cleaning) *2x contract period less benefited Periodontal Maintenance (additional cleaning considered when documented medical condition warrants);* **TOPICAL APPLICATION OF FLUORIDE** *1 treatment per contract period for children under 19;* **BITEWING X-RAYS** *2x contract period;* **FULL MOUTH X-RAYS OR PANORAMIC SURVEY** *1x 3 years;* **INTRAORAL PERIAPICAL X-RAYS** *3 per contract period;* **MINOR EMERGENCY TREATMENT** *for the temporary relief of pain, bleeding or swelling;* **SEALANTS** (posterior permanent teeth only) *1x 2 years for children under 14;* **SPACE MAINTAINERS** *1x lifetime per area for children under 16*

BASIC SERVICES

SPECIALIST EXAMINATIONS *1x per contract period for endodontics, periodontics, or oral surgery;* **ORAL SURGERY** (includes local anesthesia/routine postop care); Extractions; Removal of Periapical and Follicular Cysts; Intraoral Incision and Drainage; Exposure of Tooth to Aid Eruption; Frenectomy; General Anesthesia or IV Sedation, Nitrous Oxide/Analgesia - in connection with oral surgery (excluding simple extractions); Alveoplasty, Vestibuloplasty *1x 5 years;* Removal of Exostosis or Tori; **ENDODONTICS** (includes local anesthesia, x-rays and routine postop care); Root Canal Treatment *1x 3 years per tooth;* Surgical Endodontics *1x lifetime per tooth;* **RESTORATIVE** (includes local anesthesia); Restorations (amalgam and composite) - to restore teeth damaged by decay or traumatic injury *1x 3 years per surface;* Sedative Filling *1x 3 years per tooth;* Pins *1x 3 years per tooth;* Prefabricated Crowns *(replaceable after 3 years in place);* Recementation (onlays, inlays, crowns and bridges) *1x 2 years;* **REPAIRS** (includes repairs to crowns, bridges, and complete or partial dentures) *1x 2 years;* Rebasing *1x 3 years;* Relining *1x 3 years;* Denture Adjustments; **PERIODONTICS/SURGICAL PERIODONTICS** (includes local anesthesia and postop care); Full Mouth Debridement 1x 3 years; Periodontal Scaling and Root Planing *1x 2 years each quadrant;* Periodontal Maintenance (root planing followed by osseous surgery - a single course of treatment) *2x contract period less benefited Prophylaxis;* Complete Occlusal Adjustment *1x 3 years following periodontal surgery;* Gingivectomy *each quadrant/area 1x 3 years;* Gingival Grafts *1x 3 years each quadrant/area;* Osseous Surgery *1x 3 years each quadrant/area;* Crown Lengthening *1x 5 years per tooth;* Bone Grafts and Guided Tissue Regeneration *1x area/tooth per lifetime;* **THERAPEUTIC INJECTABLE MEDICATION**; **OCCLUSAL GUARDS** *1x lifetime;* **CROWNS ONLAYS AND INLAYS** *(replaceable after 5 years in place);* (treatment for decay or traumatic injury and when teeth cannot be restored with a filling material or when the tooth is an abutment. Applies interchangeably to onlays, inlays, crowns, abutments, and pontics for the same tooth); Crowns, Onlays, Inlays, Post and Core;

MAJOR SERVICES

PROSTHODONTICS *(replaceable after 5 years in place)* Bridge Abutments (See Crowns Onlays and Inlays); Pontics (See Crowns Onlays and Inlays); Removable Partial Dentures; Complete Dentures; **IMPLANTS,** *1x lifetime per tooth;* Surgical placement of implant, Implant supported prosthetics, Repair of an implant, Removal of an implant; **HARMFUL HABIT APPLIANCES** *for children under 14*

ORTHODONTIC SERVICES

Coverage includes orthodontic procedures under a "Treatment Plan" that has been evaluated through a pre-determination of benefits. Treating dentists providing this service must supply SDC with films and study models upon request. The one-time Record/Diagnosis fee consists of initial exam, diagnosis and consultation, x-rays, and study models. This fee can be submitted for payment separately and will apply to the member's lifetime maximum. Ortho payments for members will be made monthly beginning after the first month of treatment, and continue for the estimated duration of the treatment plan, as long as the patient is in active treatment. Retention is covered. For treatment in progress at the time of eligibility, SDC will review the initial treatment months and total cost to determine benefit eligibility. All calculations are based on the appropriate plan percentage, up to the plan's allowable orthodontic lifetime maximum, and for the remaining months of estimated treatment. Benefits will automatically terminate when the patient ceases to be eligible.

EXCLUSIONS

1. Any service or supply which is not specifically listed in this plan's List of Covered Dental Services. **2.** Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan. **3.** Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction. **4.** Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments. **5.** Overdentures and related services, including root canal therapy on teeth supporting an overdenture. Any restoration, procedure, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (c) treat a condition necessitated by attrition or abrasion; or (d) splint or stabilize teeth for periodontal reasons. **6.** The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this plan. **7.** The use of local anesthetic. **8.** Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment. **9.** Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis. **10.** Prescription medication. **11.** Desensitizing medicaments and desensitizing resins for cervical and/or root surface. **12.** Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges. **13.** Pulp vitality tests or caries susceptibility tests. **14.** Bite registration or bite analysis.**15.** Gingival curettage. **16.** The localized delivery of chemotherapeutic agents. **17.** Tooth transplants. **18.** Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation. **19.** Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan. **20.** Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (a) characterization and personalization of a dental prosthesis; (b) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (c) bleaching of discolored teeth; and (d) odontoplasty. **21.** Replacing an existing appliance or dental prosthesis with a like or un-like appliance or dental prosthesis; unless (a) it is at least 5 years old and is no longer usable; or (b) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable. **22.** A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth. **23.** The replacement of extracted or missing third molars/wisdom teeth. **24.** Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth. **25.** Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis. **26.** Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature. **27.** Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ). **28.** Treatment needed due to: (a) an on-the-job or job-related injury; or (b) a condition for which benefits are payable by Worker's Compensation or similar laws. **29.** Treatment for which no charge is made. This usually means treatment furnished by: (a) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (b) a facility owned or run by any governmental body; and (c) any public program, except Medicaid, paid for or sponsored by any governmental body. **30.** Evaluations and consultations for non-covered services; detailed and extensive oral evaluations. **31.** The repair of an orthodontic appliance. **32.** The replacement of a lost or broken orthodontic retainer. **33.** Labial veneers.

NATIONAL NETWORK

While SDC is licensed to sell to groups domiciled in Ohio, Kentucky and Indiana, our network of participating dentists and specialists offers coverage across the country with **over half a million access points nationwide**. SDC members are encouraged to seek service from a Participating Dentist or Specialist. **You may access our directory of Participating Dentists on our website superiordental.com. Participating dentists are prohibited from collecting any amount beyond the assigned member responsibility and SDC's reimbursement.** Unless otherwise contracted, SDC's payments for out of network services will be directed to the Enrollee. Members receiving SDC payment for services performed by a non-participating dentist will be responsible for the full payment to that dentist. Any out of network service may be subject to a "balance bill" for any amount that the dentist's charge exceeds SDC's then current allowable amount for an eligible service.

PLAN SPECIFICS

Pre-determination of Benefits

Pre-determination of Benefits is necessary for services $400.00 or more and for periodontal services. Alternate benefits may be received when there is more than one acceptable course of treatment.

Coordination of Benefits

SDC coordinates benefits with other carriers and with other SDC plans. SDC follows the rules established by state law for Coordination of Benefits to decide which plan pays first. The birthday rule applies for covered dependents – the parent's birthday first in the calendar year is considered the primary carrier. If a divorce has occurred, the plan follows the divorce decree.

Evidence of Coverage

Your Evidence of Coverage is on file with your employer or you may call our office to request a copy. Additional access is provided on our website at: superiordental.com. Important information addressed in the Evidence of Coverage includes: claims appeal procedures, exclusions, coordination of benefit rules, contact information for SDC's Member Services Team, for State Departments of Insurance, for State Dental Associations and more.

Claim Submission

All claims must be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status.

VALUE-ADDED BENEFITS

SMILE*RIDER*®

Dentists who participate in our Smilerider program offer a 15% discount for elective services such as teeth whitening, veneers, bonding and porcelain facings. This discount comes with the SDC dental plan at no additional charge.

EyeMed Vision Care® Discount Plan

SDC offers a vision discount plan through EyeMed Vision Care at eyemed.com. This program offers significant savings and there are no limitations on the frequency of use. Please contact your employer to confirm this benefit is available to you. After confirming this benefit, be sure to mention to your eyecare provider that you are a member of Superior Dental Care. This plan is not vision insurance.

Free Second Opinion

SDC will provide a Free Second Opinion by a participating dentist for extensive treatment plans. This is provided at no cost and without utilizing any portion of the individual's Contract Maximum. This benefit is required to be coordinated, in advance, through SDC's Dentist and Member Services team.

General SDC Information

Warning: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.