Plan Benefit Summary

Choice of Dentist
You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a Fidelio participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles, or amounts exceeding the program maximum. Participating dentists will also complete and send claims directly to Fidelio.

If you go to a dentist who is not a Fidelio participating dentist, you may have to pay the dentist at the time of service. In addition to any coinsurance or deductible, you will also have to pay the difference between the dentist's charge and the amount that the Plan allows.

To find a participating dentist, visit Find a Dentist on Fidelio's Subscriber Login at www.fideliodental.com or telephone at (215) 885-2443.

When you visit the dental office, let your dentist know that you are covered under a Fidelio program. If your dentist has questions about your eligibility or benefits, instruct the office to call Fidelio.

Pre-Determination Estimates
When uncertain about your coverage for a specific dental procedure, especially if the anticipated costs surpass $300, Fidelio Dental suggests obtaining a pre-treatment estimate. You should request your dentist to forward the claim form prior to initiating the proposed treatment. Pre-treatment estimate requests are particularly beneficial for intricate procedures such as crowns, extractions of wisdom teeth, bridges, dentures, or periodontal surgeries. This way, you gain clarity about your part of the expenses and what Fidelio Dental is likely to cover before the treatment commences. It is important to note that this estimate is not binding. Factors like changes in eligibility, reaching the maximum benefit limit, or frequency limitations related to specific procedures could alter the actual benefits you receive from the time the estimate was provided. Some procedures, such as Orthodontia, may be denied without a Pre-Determination.

Procedures listed are subject to plan limitations and exclusions.

Fidelio DPPO Summary Schedule

DPPO - Fidelio Schedule		
Network	**IN-NETWORK***	**OUT-OF-NETWORK****
Deductible (Individual / Family) *Waived for Preventive and Diagnostic*	$50/$150 per benefit year	$50/$150 per benefit year
Annual Max	$1,000	$500
Waiting Periods	None	None
Class I – Preventive and Diagnostic - Oral Exams - Cleanings - X-rays - Sealants - Space Maintainers	90%	90%
Class II - Basic - Fillings - Simple Extractions - Crown repairs - Oral Surgery - Periodontal Maintenance - Endodontics (root canal therapy)	70%	70%
Class III - Major - Inlays - Onlays - Crowns - Periodontal Surgery - Full & partial dentures - Bridgework	50%	50%
Class IV - Orthodontics - Dependent children up to age 19 - Lifetime orthodontic maximum of $1,000	50%	50%

* In-Network benefits are payable based on the contracted fee between Fidelio and the participating provider.

** Out-Of-Network benefits are payable based on the MAC determined by Fidelio.

Frequency and/or limitations may apply to services.

DPPO Limitations and Exclusions

Subject to the exclusions, conditions and limitations, hereinafter set forth, each Covered Person hereunder shall be entitled to the following benefits:

Class I Services:

1. Clinical Oral Examination: Limited to two per person each calendar year.
2. Palliative Treatment for Dental Pain: Covers minor procedures for emergency dental pain relief, provided no other definitive dental services are performed. Any X-rays taken in connection with this treatment are considered separate services.
3. X-rays: A complete series or panoramic (Panorex) X-rays are covered once per person in any 36 consecutive months, including panoramic films.
4. Bitewing X-rays: Limited to two charges per person each calendar year.
5. Prophylaxis (Cleaning): Includes periodontal maintenance procedures following active therapy, limited to two per person per calendar year.
6. Topical Fluoride Application (Excluding Prophylaxis): Available for individuals under 19 years old, limited to one application per person each calendar year.
7. Topical Application of Sealant: Applicable per tooth on a posterior tooth for individuals under 14 years old. The limit is one treatment per tooth every three calendar years.
8. Space Maintainers, Fixed Unilateral: Covered for non-orthodontic treatment only.

Class II Services:

1. Amalgam and Composite/Resin Fillings: Standard filling procedures.
2. Root Canal Therapy: Includes all X-rays, tests, lab exams, and follow-up care. These are considered part of the root canal therapy and not billed separately.
3. Periodontal Scaling and Root Planing: Covers the entire mouth.
4. Adjustments to Complete Denture: Adjustments or repairs to dentures within six months of installation are included in the initial service.
5. Recement Bridge: Standard procedure for reattaching a bridge.
6. Routine Extractions: Standard tooth extractions.
7. Surgical Removal of Erupted Tooth: Covers cases requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth.
8. Removal of Impacted Tooth: Covers soft tissue, partially bony, and completely bony cases. Local anesthetic, analgesic, and routine postoperative care are included in the global surgical fee.
9. General Anesthesia: Covered when medically or dentally necessary for complex oral surgical procedures.

10. I.V. Sedation: Paid as a separate benefit when medically or dentally necessary for complex oral surgical procedures.

Class III Services:

1. Osseous Surgery: Procedure includes flap entry and closure as part of overall treatment, not as separate services.
2. Crowns: Eligible when a tooth cannot be restored with regular fillings due to extensive caries or fractures. Examples:
    a. Porcelain Fused to High Noble Metal
    b. Full Cast, High Noble Metal
    c. Three-Fourths Cast, Metallic
3. Removable Appliances:
    a. Complete (Full) Dentures, Upper or Lower
4. Partial Dentures:
    a. Lower, Cast Metal Base with Resin Saddles
    b. Upper, Cast Metal Base with Resin Saddles
5. Fixed Appliances:
6. Bridge Pontics:
    a. Cast High Noble Metal
    b. Porcelain Fused to High Noble Metal
    c. Resin with High Noble Metal
7. Retainer Crowns:
    a. Resin with High Noble Metal
    b. Porcelain Fused to High Noble Metal
    c. Full Cast High Noble Metal
8. Prosthesis Over Implant: Covered when a prosthetic device is supported by an implant or abutment. Replacement of a prosthesis supported by an implant is covered only if the existing prosthesis is at least 60 consecutive months old, not serviceable, and cannot be repaired.

Class IV Services: Orthodontics

1. Covered Expenses Include:
    a. Orthodontic Work-Up: Includes X-rays, diagnostic casts, treatment planning, and the first month of active treatment, including retention appliances.

b. Continued Active Treatment: Coverage extends beyond the first month of treatment.

c. Fixed or Removable Appliances: Coverage includes one appliance per person, used for tooth guidance or controlling harmful habits.

d. Periodic Observation: Monitoring patient dentition up to four times per calendar year.

2. Lifetime Coverage Limit: The total payable for all orthodontic expenses during a dependent child's lifetime is capped at the maximum of $1,000.

3. Payment Structure for Comprehensive Full-Banded Orthodontic Treatment:

   a. Payments are made in installments.

   b. The first payment is due when the appliance is installed, and remaining charges are prorated over the treatment period. Payments are only made for services provided while the child is insured.

Expenses Not Covered (Exclusions)

4. Cosmetic Dentistry or Dental Surgery: No coverage for procedures solely aimed at improving appearance.

5. Replacement of Lost or Stolen Appliances: No coverage for replacing lost or stolen dental appliances.

6. Specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth. These are payable under a medical insurance contract or a medical or hospital service contract by which the Member is covered shall be determined first, under this Agreement. When there is no medical or hospital coverage, Fidelio's obligation for oral surgery Services shall be limited to the Usual Customary and Reasonable Fee for those Services provided under the Contract less the applicable deductible and patient co-insurance.

7. Replacement of Bridge, Crown, or Denture within 5 Years: No coverage for replacements within seven years of the original installation unless:

   a. Necessary due to the placement of an original opposing full denture or required extraction of natural teeth.

   b. The item is damaged beyond repair while in the mouth due to an injury incurred while insured.

8. Usable Bridge, Crown, or Denture Replacement: No coverage for replacing items that can be made usable according to common dental standards.

9. Procedures for Specific Purposes: No coverage for procedures, appliances, or restorations (except full dentures) whose main purpose is to change vertical dimension, diagnose or

treat temporomandibular joint (TMJ) conditions, stabilize periodontally involved teeth, or restore occlusion.

10. Porcelain or Acrylic Veneers on Certain Teeth: No coverage for porcelain or acrylic veneers of crowns or pontics on, or replacing, the upper and lower first, second, and third molars.
11. Bite Registrations and Attachments: No coverage for bite registrations, precision or semi-precision attachments, or splinting.
12. Instruction for Plaque Control, Oral Hygiene, and Diet: No coverage for instructional services.
13. Non-Standard Dental Services: No coverage for dental services that do not meet common dental standards.
14. Services Deemed Medical: No coverage for services that are considered medical rather than dental.
15. Hospital Services and Supplies: No coverage for services and supplies received from a hospital.
16. Surgical Implant Procedures: No coverage for the surgical placement of implants, related surgical procedures, treatment or repair of existing implants, and removal of implants.
17. Localized Delivery of Antimicrobial Agents
18. General Limitations Clause: No coverage for services explicitly excluded in the "General Limitations" section.
19. Personal Injury Protection (PIP) or Out-of-State Automobile Insurance (OSAIC):
    a. When expenses result from an automobile-related injury, this policy determines whether coverage is primary or secondary to PIP or OSAIC.
    b. This certificate provides secondary coverage to PIP unless health coverage is elected as primary by or for the person covered. This affects family members not named insureds under another automobile certificate.
    c. Coverage may vary between individuals based on their selections regarding the primacy of health coverage in their separate automobile insurance policies.
20. Experimental procedures.
21. Appliances, restorations, and procedures to alter vertical dimension, including, but not limited to, occlusal guards and periodontal splinting.
22. Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance.
23. Restorations that are not of any dental health benefit, but purely cosmetic in nature.
24. Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including posterior composites or the use of fixed bridgework, where a

removable partial denture would restore the arch. Payment of the applicable scheduled benefit amount for the alternate service will be made toward such treatment and the balance of the cost remains the responsibility of the patient.

25. General anesthesia, except for the reasons outlined in the benefit summary.
26. Duplicate charges.
27. Services incurred prior to the effective date of coverage.
28. Services incurred after cancellation of coverage, whether or not services commenced while covered.
29. More than two oral examinations in any calendar year.
30. Services incurred in excess of the benefit year maximum.
31. Services or supplies that are not necessary according to accepted standards of dental practice or are incomplete.
32. Orthodontic services which did not commence prior to an eligible dependent child's eighteenth birthday, or which are provided after the loss of eligibility.
33. Services such as trauma, bony impaction removal, or jaw treatment for which coverage is provided under the Dental portion of the medical Plan.
34. The use or purchase of PPE equipment.
35. Completion of reporting forms.
36. Chares made by the attending Dentist or Provider for the patient's failure to appear as scheduled for an appointment.
37. Scaling and root planing procedures, when performed as standalone treatments and not followed by necessary comprehensive periodontal therapy. In the absence of continuing periodontal therapy, scaling and root planning will be considered a prophylaxis and subject to the limitation of that procedure.