

PPO PLAN

Summary of Benefits Dental Insurance

Employer Sponsored Dental				
Class Description	AAFTE & Retirees Electing High Plan (30 Hours)		AAFTE & Retirees Electing Low Plan (30 Hours)	
	In-Network	Out-of-Network*	In-Network	Out-of-Network
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile	Negotiated Fee Schedule	Schedule Amount
Type A – Preventive	100%	100%	100%	100%
Type B – Basic	80%	80%	80%	80%
Type C – Major	50%	50%	50%	50%
Calendar Year Deductible applies to:	B & C	B & C	B & C	B & C
▪ Individual	\$50	\$50	\$50	\$50
▪ Family	\$150	\$150	\$150	\$150
	Aggregate	Aggregate	Aggregate	Aggregate
Calendar Year Maximum	\$2,000 <i>(applies to A,B,C services)</i>	\$2,000 <i>(applies to A,B,C services)</i>	\$1,500 <i>(applies to A,B,C services)</i>	\$1,500 <i>(applies to A,B,C services)</i>
Orthodontia	50%	50%	Not Covered	Not Covered
Orthodontia Lifetime Maximum	\$1,500	\$1,500	Not Covered	Not Covered

PPO HIGH PLAN

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: AAFTE & Retirees Electing High Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 12 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 12 months
▪ Sealants	▪ 1 per molar in 36 months for a child under age 16
▪ Space Maintainers	▪ 1 per lifetime for a child under age 16
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 16
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Emergency Palliative Treatment	
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Consultations	▪ 1 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 per tooth per lifetime
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Labs & Other Tests	
▪ General Anesthesia	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Prefabricated Crowns	▪ 1 per tooth in 60 months
▪ Crown Buildups / Post Core	▪ 1 per tooth in 60 months
▪ Repairs	▪ 1 in 12 months

▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 60 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 60 months
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 60 months
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months
Orthodontics	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions
AAFTE & Retirees Electing High Plan
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Caries susceptibility tests.

- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

PPO LOW PLAN

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: AAFTE & Retirees Electing Low Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 12 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 12 months
▪ Sealants	▪ 1 per molar in 36 months for a child under age 16
▪ Space Maintainers	▪ 1 per lifetime for a child under age 16
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 16
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Emergency Palliative Treatment	
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Consultations	▪ 1 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 per tooth per lifetime
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Labs & Other Tests	
▪ General Anesthesia	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	

▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Prefabricated Crowns	▪ 1 per tooth in 60 months
▪ Crown Buildups / Post Core	▪ 1 per tooth in 60 months
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 60 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 60 months
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 60 months
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months

Exclusions
AAFTE & Retirees Electing Low Plan
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.

- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.

The PPO dental plan groups services into three categories, with each category covered at a different benefit level:

- **Type A (Preventive Services)** – Includes routine exams, cleanings, and X-rays. These services are covered at **100%**, helping members maintain their oral health with little to no out-of-pocket cost.
- **Type B (Basic Services)** – Includes procedures such as fillings, simple extractions, and certain periodontal treatments. These services are covered at **80%**, meaning the member is generally responsible for the remaining 20% after any applicable deductible.
- **Type C (Major Services)** – Includes more extensive procedures such as crowns, bridges, dentures, and other major restorative services. These services are covered at **50%**, with the member responsible for the remaining 50% after any applicable deductible.

The plan also includes an annual deductible of **\$50 per individual / \$150 per family** for Basic and Major services.

For members choosing between the two PPO options:

- The **High PPO Plan** includes a **\$2,000 annual maximum** and **orthodontia coverage (50% up to a \$1,500 lifetime maximum)**.
- The **Low PPO Plan** includes a **\$1,500 annual maximum** and does **not** include orthodontia coverage.

In short, both plans provide the same coverage levels for preventive, basic, and major services. The primary advantage of the High PPO Plan is the higher annual maximum and inclusion of orthodontic benefits.