Summary of benefits.

DentaTrust
Underwritten by DCP, Inc.

GOOD FOR EFFECTIVE DATES OF JANUARY 1 - DECEMBER 31, 2018.

KENTUCKY

	Pediatric Only Coverage Plans		Family Coverage Plans	
	Pediatric High Option	**Pediatric Low Option**	**Family High Option**	**Family Low Option**
One Child	$29.38	$25.34		
Two or More Children	$48.48	$41.81		
Individual			$26.01	$22.38
Individual + Spouse			$52.02	$44.76
Individual + Child(ren)			$67.15	$57.86
Family			$100.51	$86.57
	Pediatric High Option	**Pediatric Low Option**	**Family High Option**	**Family Low Option**
Copay*	N/A	$10	N/A	$10
Deductible*	$50 per covered individual $150 maximum per policy	$50 per covered individual $150 maximum per policy	$50 per covered individual $150 maximum per policy	$50 per covered individual $150 maximum per policy
Preventive Services*	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services*	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Major Services*	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Medically Necessary Orthodontia*	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Maximum Out-of-Pocket	$350 one child $700 two or more children	$350 one child $700 two or more children	$350 one child $700 two or more children	$350 one child $700 two or more children
Annual Benefit Max (21 and over)	N/A	N/A	$1,000	$1,000

Contact Information

- Questions related to enrollment, billing or payment should be directed to DentaTrust Billing and Enrollment at **(855) 890-3243**.
- Questions related to member services (claims) should be directed to DentaQuest at **(844) 254-9465**.
- Search for participating providers by using our Find a Dentist tool at: **hixfadky.dentalcareplus.com**.

Underwritten by Dental Care Plus, Inc., 100 Crowne Point Place, Cincinnati, Ohio 45241. NAIC number 96265.
*Note: Out-of-network providers are permitted to charge for the difference between the allowed amount and out-of-network provider's billed charges. You may be required to pay more for services obtained from an out-of-network provider than for the same services provided by an in-network provider.
This is a dental PPO policy, form number DQ KY 300 HIX IND FAMILY and DQ KY 300 HIX IND CHILD. Coverage is subject to policy terms, limitations and exclusions. Plan benefits provided and premium amounts will vary depending on the level of coverage selected. For costs and complete details of coverage, call (855) 890-3243. For age 21 and under there are no waiting periods for Restorative/Other Basic Services, Complex Dental Services or Orthodontic Services.

Covered services.

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KENTUCKY

Please see the Summary of Benefits for more information on plan coverage.

Diagnostic and Preventive Services

No waiting period

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most covered individuals receive during a routine preventive dental visit. Examples of these services include:

- Bitewing x-rays (x-rays of the crowns of the teeth); limited to 4 films per 12 months.
- Intra/Extraoral X-rays; limited to 2 films per 12 months.
- Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full set of X-rays); limited to 1 time per 12 months.
- Periodic Oral Evaluation (Check Up Exam); limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.
- Dental Prophylaxis (Cleanings); limited to 2 times per 12 months.
- Fluoride Treatments; limited to covered persons under the age of 21; limited to 2 times per 12 months; treatment should be done in conjunction with prophylaxis.
- Sealants (Protective Coating); limited to covered persons under the age of 21; limited to once per first or second permanent molar every 36 months.
- Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.
- Sealants on unrestored permanent molars, once per tooth every 36 months.

Restorative and Other Basic Services

6 month waiting period for adults over age 21

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or recement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. Examples of these services include:

- Space maintainers (Spacers); limited to Covered persons under the age of 21; limited to 2 per 12 months. Benefit includes all adjustments within 6 months of installation.
- Amalgam Restorations (Silver Fillings); multiple restorations on one surface will be treated as a single filing.
- Composite Resin Restorations (Tooth Colored Fillings); for anterior (front) teeth only; multiple restorations on one surface will be treated as a single filing.
- Endodontics (Root Canal Therapy); limited to 1 time per tooth per lifetime.
- Periodontic Surgery (Gum Surgery); limited to 1 time per quadrant per 12 months.
- Scaling and Root Planing (Deep Cleanings); limited to 1 time per quadrant per 12 months.
- Periodontal Maintenance (Gum Maintenance); limited to 2 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.
- Simple Extractions (Simple tooth removal); limited to 1 time per tooth per lifetime.
- Oral Surgery, including Surgical Extraction.
- General Services (including Emergency Treatment); covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.
- Occlusal guard limited to 1 guard every 12 months.

Major (Complex) Dental Services

12 month waiting period for adults over age 21

Benefits are available for the following dental services and supplies to treat oral disease including: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth and restore severely decayed or fractured teeth. Examples of these services include:

- Inlays/Onlays/Crowns (Partial to Full Crowns); limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
- Fixed Prosthetics (Bridges); limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
- Removable Prosthetics (Full or partial dentures); limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.
- Relining and Rebasing Dentures; limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.
- Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns; limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months

Medically Necessary Orthodontics

No waiting period

Covered orthodontic services are limited to medically necessary orthodontic treatment for individuals under age 21. Medical necessity will be determined by the Plan after review of the orthodontic case records, which must be submitted for approval prior to the commencement of treatment.

Exclusions and Limitations

- A dental service or procedure that is not described as a benefit in this Policy.
- Dental services that are not necessary.
- Hospitalization or other facility charges.
- Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any Dental Procedure not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

(Continued on next page)

- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to treatment of temporomandibular joint syndrome or craniomandibular joint disorders for which Benefits are provided as described under Temporomandibular and Craniomandibular Joint Services in Section 1: Covered Health Services.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hour notice.
- Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Certificate.
- Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
- Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- Foreign Services are not covered unless required as an Emergency.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. This does not apply to pediatric patients under the age of 21.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. This exclusion does not apply to space maintainers for which Benefits are provided under Space Maintainers or lost or broken retainers for which Benefits are provided under General Services in the Pediatric Dental Services Schedule of Benefits or to the treatment of temporomandibular joint syndrome or craniomandibular joint disorders.
- Services that are covered by a health insurance policy or similar coverage in which you are enrolled.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Policy.
- An illness, injury, or dental condition to the extent for which benefits are provided in one form or another through a government program other than Medicaid or Medicare.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a dentist or a hygienist who is employed by a dentist.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to any covered orthodontic services.
- Tooth desensitization.
- Occlusal adjustment.
- Injury incurred as a result of participating in a riot or insurrection or the commission of a felony.

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