SCHEDULE OF DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Deductibles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>Payable at 100%, deductible waived</td>
</tr>
<tr>
<td>Basic</td>
<td>Payable at 80% after deductible</td>
</tr>
<tr>
<td>Major</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Orthodontic*</td>
<td>Payable at 50% after deductible</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Dental Benefits Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Dental Calendar Year Maximum</td>
</tr>
<tr>
<td>Individual Orthodontic Lifetime Maximum*</td>
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</tbody>
</table>

*Dental Benefits for orthodontic treatment and appliances apply only to dependent children under the age of nineteen.

PREVENTIVE CARE
The following services are covered as Preventive Care.
1. Oral examination (periodic) two times per calendar year.
2. Prophylaxis (surface cleaning of the teeth), two times per calendar year.
3. Topical application of fluoride for dependent children up to 19 years of age and under, not more than one (1) application per person per calendar year.
4. Dental X-rays:
   a. full mouth set of X-rays including panograph (one set of panograph in each period of three consecutive calendar years).
   b. bite-wings X-rays, two sets per calendar year (one set equals two X-rays if large, four X-rays if small).
5. Space maintainers for dependent children up to the 18th birthday.
6. One (1) sealant per permanent 1st & 2nd non-restored non-decayed molar in 60 months of a dependent child up to 16th birthday.

BASIC CARE
The following services are covered as Basic Care.
1. Extractions (non-surgical and non-orthodontic), including surgical extractions for the removal of fully impacted teeth.
2. General and local anesthetic when administered with oral surgery including extractions and restorative-type fillings.
4. Restorative-type fillings.
5. Injection of antibiotic drugs.
6. Root canal treatment limited to one (1) in twenty-four months.
7. Periodontal maintenance: four (4) periodontal treatments in one (1) calendar year.
8. Periodontal scaling and root planning: one (1) per quadrant in any twenty-four (24) month period.
9. Periodontal surgery: one (1) per quadrant in any thirty-six (36) month period.
10. Prefabricated Stainless Steel & Resin Crowns: one (1) replacement in sixty (60) months.
11. Re-cementing of crowns, inlays and bridgework.
MAJOR RESTORATIVE CARE
The following services are covered as Major Restorative Care.
1. Implants: Services one (1) per tooth in position in sixty (60) months. Repairs one (1) per twelve (12) months.
2. Inlays, onlays, and crown restorations: one (1) replacement every five (5) years.
3. Initial installation of fixed bridgework.
4. Installation of full or partial dentures.
5. Rebasing and relining of dentures once every five (5) years.
6. Oral pathology/laboratory.

ORTHODONTIC CARE
The following services are covered as Orthodontic Care*.
1. Orthodontic extractions.
2. Services or supplies for orthodontic treatment, including necessary orthodontic appliances.
   *Dental Benefits for orthodontic treatment and appliances apply to dependent children under the age of nineteen (19).

DENTAL ELIGIBILITY PROVISIONS
New employees will be eligible for Preventive on the first day that all Eligibility Requirements for employee coverage have been met. Please see the ELIGIBILITY section. There will be a twelve (12) month waiting period for Late Enrollees from the enrollment date for all Basic and Major Restorative benefits.

COVERED DENTAL EXPENSES
The eligible covered dental charges referred to in the Schedule of Dental Benefits are those charges made for services, supplies and treatment performed by a legally qualified dentist for oral examinations and treatment of accidentally injured or diseased teeth or supporting bone or tissue, provided such services are reasonably necessary and the charges therefore are reasonably priced, as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned. The covered individual may be requested to provide supporting proofs of loss, clinical reports, charts and X-rays.

PREDETERMINATION OF BENEFITS
The Pre-Determination of Dental Benefits provision of this Plan is a voluntary program to assist you and your dentist when planning extensive dental treatment. It assures you in advance that the recommended service is dentally necessary, is an allowable expense under the Plan, and is within reasonable costs.

When you expect to incur dental charges greater than $300, ask your dentist to submit a “Request for Pre-Determination of Benefits”.

Request that your dentist send to Primary PhysicianCare a description of the expected treatment plan to include:

- copies of appropriate preoperative X-rays,
- findings of the oral examination,
- specific proposal for course of treatment,
- specific diagnostic and treatment codes and fees for each component of the treatment proposal, and
- any other appropriate information to support the necessity of the treatment plan.

Upon review of this information, Primary PhysicianCare will forward to you and to your dentist verification of the availability of dental benefits to cover, in whole or in part, the anticipated dental treatment.

Pre-determination of benefits does not guarantee payment. Exact benefits are determined based on the eligibility of the Plan participant at the time services are rendered. Also, benefits are determined based on the seat date of the appliance (the date the appliance is placed) rather than the date of initial preparation.
SPECIAL DENTAL CONDITIONS

Major Restorative covered charges include:

A. The initial installation (including adjustments during the six (6) months period following installation) of full or partial removable dentures, temporary dentures or fixed bridgework, provided that such installation is required as a result of the extraction on or after the effective date of the eligible individual's insurance under this provision, of one or more natural teeth (excluding third molars) accidentally injured or diseased, and that such denture or bridgework includes the replacement of teeth so extracted.

B. The replacement, or alteration, of full or partial dentures, or fixed bridgework which is necessary because of:
   1. Oral surgery resulting from an accident;
   2. Oral surgery for repositioning muscle attachments or for removal of a malignancy, cyst, torus or redundant tissue, but only if this occurs after the eligible individual has become insured under this provision, and the replacement or alteration is completed within twelve (12) months after such surgery.

C. The replacement of a full denture which is necessary because of:
   1. Structural change within the mouth, but only if more than eight (8) years has elapsed since the prior placement; or
   2. The initial placement of an opposing full denture, but only after the eligible individual has been covered under this provision for at least two (2) years or;
   3. The prior installation of an immediate or temporary denture, but only within twelve (12) months of the installation of such denture.

D. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if:
   1. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while insured under this provision and after the existing denture or bridgework was installed; or
   2. The existing denture or bridgework was installed at least eight (8) years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

E. The adjustment of full or partial dentures, limited to two (2) procedures in any five (5) years.

F. The replacement of a crown, inlay or onlay restoration provided the original was installed more than eight (8) years prior to the replacement.

G. Inlays, gold fillings, crowns, including precision attachments for dentures.
DENTAL EXPENSE EXCLUSIONS

No benefits will be paid for the following charges:

1. Charges not specifically shown as covered charges in the SCHEDULE OF DENTAL BENEFITS.
2. Charges for any treatment, including material and supplies, not begun and completed while the individual is insured for dental benefits under the Plan, except as specifically provided under Major Restorative Benefit.
3. Charges for treatment, material or supplies furnished by other than a legally qualified dentist, EXCEPT charges for scaling or cleaning of teeth and topical application of fluoride, by a licensed dental hygienist under the direction of a legally qualified dentist.
4. Charges for treatment, materials or supplies for cosmetic purposes, including but not limited to, personalization or characterization of dentures.
5. Charges for replacement of lost, missing or stolen prosthetic.
6. Charges for dentures, crowns, inlays, onlays, bridgework or other treatment, material or supplies provided to alter vertical dimension or alter occlusion (arrangement of teeth and their supporting structure).
7. Charges which in the absence of this insurance, an individual is not legally obligated to pay.
8. Charges for treatment, material or supplies for which benefits are provided or paid under any law of a government.
9. Charges for prosthetic appliances (including but not limited to bridges and crowns) and the fitting of them, which were ordered while the individual was not insured by this Plan.
10. Charges incurred after termination of insurance except for prosthetic devices (including bridges and crowns) delivered within 90 days of termination date.
11. Charges for failure to keep a scheduled appointment with the dentist.
12. Charges for periodontal splinting.
13. Charges for materials or supplies which are experimental in nature.
14. Myofunctional therapy, or correction of harmful habits.
15. Charges for the diagnosis and treatment of temporomandibular joint (TMJ) syndrome.
16. Charges for services or supplies which are not necessary, according to accepted standards of dental practice, and/or for charges that exceed reasonable and customary charges.
17. Rebasing or relining of a denture less than six (6) months after the initial placement and not more than one rebasing or relining in any five (5) year period.
18. Charges for local anesthesia and analgesia and their administration, except as provided for oral surgery;
19. Charges for oral hygiene and dietary instruction.