Superior Dental Care®
A Medical Mutual® Company

SUPERIOR DENTAL CARE

Schedule of Benefits – Plan #1375	In Network	Out of Network
Preventive	**100%**	**100%**
Basic	**50%**	**50%**
Major	**N/A**	**N/A**
Contract Maximum	**$1,000.00**	**$1,000.00**
Deductible *(applies to Basic and Major services)*	**$50/$150**	**$50/$150**
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. Covered Expenses incurred in, and applied toward the Deductible in the last three months of the Contract Period will be applied towards the Deductible in the next Contract Period.
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;* **TOPICAL APPLICATION OF FLUORIDE** *2 treatments per contract period for children under 18;* **BITEWING X-RAYS** *up to 4 Bitewings per contract period;* **FULL MOUTH X-RAYS OR PANORAMIC SURVEY** *1x 3 years;* **INTRAORAL PERIAPICAL X-RAYS** *5 per contract period*

BASIC SERVICES

SPECIALIST EXAMINATIONS *endodontics, periodontics, or oral surgery;* **SPACE MAINTAINERS** *1x lifetime per area for children under 19;* **ORAL SURGERY** (includes local anesthesia/routine postop care); Extractions of non-impacted teeth (pre-orthodontic extractions are not covered); Removal of Periapical and Follicular Cysts; Intraoral Incision and Drainage; Biopsy; Exposure of Tooth to Aid Eruption; Frenectomy; General Anesthesia or IV Sedation - in connection with oral surgery (excluding simple extractions); **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 2 years per surface;* Sedative Filling *1x 2 years per tooth;* Pins *1x 2 years per tooth;* Prefabricated Crowns *(replaceable after 2 years in place);* Recementation (onlays, crowns, bridges and space maintainers)*;* **REPAIRS** (includes repairs to crowns, bridges, and complete or partial dentures)*;* **SEALANTS** (posterior permanent molars only) *1x 5 years per tooth for children under 15;* **PERIODONTICS/SURGICAL PERIODONTICS** (includes local anesthesia and postop care); Periodontal Scaling and Root Planing *1x 12 months each quadrant;* Periodontal Maintenance (root planing followed by osseous surgery - a single course of treatment) *2x contract period following a course of full mouth periodontal treatment;* Complete Occlusal Adjustment *1x 2 years following periodontal surgery;* Gingivectomy; Guided Tissue Regeneration; Gingival Grafts*;* Osseous Surgery*;* **MINOR EMERGENCY TREATMENT** *for the temporary relief of pain, bleeding or swelling;* **LIMITED ORAL EVALUATIONS**

EXCLUSIONS

The following are services specifically excluded from coverage under the Plan. The Member is financially obligated for payment to the dentist of the full charge for any service that is excluded/not covered under the Plan. **1.** Any services not specifically listed as a Covered Dental Service. **2.** Services performed for cosmetic reasons, including personalization or characterization of dentures **3.** Services or supplies which are considered experimental according to standard dental practice. **4.** Services or procedures started prior to the effective date of coverage. Prosthetic devices and crowns will not be covered if impressions are taken before the effective date of coverage **5.** Services or procedures completed after the date of termination, unless stated elsewhere in this Evidence of Coverage **6.** Missed appointment charge. **7.** Completion of claim forms. **8.** Replacement of lost, stolen, or broken prosthetic devices unless it is after the limitation date. **9.** Analgesics, nitrous oxide, non-intravenous conscious sedation and other drugs and prescriptions. **10.** Localized delivery of antimicrobial or chemotherapeutic agents. **11.** Hospital related charges. **12.** Appliances, restorations, and procedures other than full dentures, for the primary purpose of increasing vertical dimension, restoring the occlusion or treatment of Bruxism. **13.** Veneers **14.** Services for educational purposes. **15.** Splinting **16.** Services covered under Workers Compensation, or by Federal or State agencies. **17.** Implants & related services unless detailed as a covered service on the Schedule of Benefits. **18.** Services performed by other than by a licensed dentist, except for legally delegated services to a licensed hygienist or licensed expanded functions auxiliary. **19.** Surgery, treatment and x-rays for Craniomandibular disorders (TMJ) **20.** Orthognathic surgery. **21.** Services or supplies rendered, or furnished in connection with, any duplicate appliance. **22.** Services or supplies which are not necessary according to accepted standards of dental practice. **23.** Expenses incurred for a temporary full denture. **24.** Services which are determined to be eligible expenses under any medical plan in which the Member is enrolled. **25.** House calls. **26.** Dental services or supplies for a condition resulting from civil disobedience active participation in a riot or in the commission of a felony, self-inflicted injury, nonaccidental injury, or an act of war. **27.** Services performed for which no payment would normally be required **28.** Acid etches. **29.** Expenses for the completion of periodontal charting. **30.** Asepsis. **31.** Charges for services received after a Member has reached the Annual or Lifetime Maximum Benefits payable under the Plan.

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.