FARMERS HOME FURNITURE

2023-2024 SCHEDULE OF DENTAL AND ORTHODONTIC BENEFITS

MAXIMUM DENTAL BENEFITS	**Benefit**
Calendar Year Maximum Dental Benefit (Preventive, Basic and Major Services)	
Per Covered Person (age 19 and older)	$1,300
Per Covered Person (under age 19)	No Dental
Maximum*	
*Dental expenses for Covered Persons under age 19 are notsubject to the Calendar Year Maximum Dental Benefit. Dental Expenses for Covered Persons under age19 apply to the Annual Out-of-Pocket Maximum.	
Lifetime Maximum Orthodontic Benefit	
Per Covered Person	$1,500
DENTAL CALENDAR YEAR DEDUCTIBLE	
Per Covered Person	$50
BENEFIT PERCENTAGE	
Preventive Dental Services waived	100%; Deductible
Basic Dental Services Deductible	80% after
Major Dental Services Deductible	50% after
Orthodontic Services* Deductible	50% after
BENEFIT WAITING PERIOD	

*Benefits for Orthodontic Services begin the first day following **twelve (12) months** of continuous coverageunder the Plan.

CALENDAR YEAR DEDUCTIBLE REQUIREMENT

The Covered Person is responsible for the Deductible amount. The Dental Calendar Year Deductible maybe satisfied by either Covered Basic Dental Services, Major Dental Services or Orthodontic Services. Payment of Basic, Major and Orthodontic Dental benefits will begin each Calendar Year after the Deductibleamount has been satisfied by Covered Charges. The Plan will not reimburse any charges applied to the Deductible.

There is no Deductible carryover for Covered Dental Expenses incurred and applied to the Deductible during the last three (3) months of a Calendar Year.

ALTERNATIVE TREATMENT

This Dental Plan has an "alternative treatment" clause that governs the amount of benefits the Dental Plan will pay for treatments covered under the Dental Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost- effective level.

For example, if a regular Amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary Charge for an Amalgam filling. The patient will be responsible for the difference in cost.

NOTE: A temporary Dental Service will be considered an integral part of the final dental service rather than a separate service.

PREVENTIVE DENTAL SERVICES

PREVENTIVE

1. Dental Prophylaxis (cleaning and Scaling of teeth) – Not more than two (2) cleanings per CoveredPerson each Calendar Year

2. Fluoride Treatment (covered to age 19) – limited to one (1) such treatment or series of treatments perCovered Person each Calendar Year

3. Sealants (covered to age 16)

4. Space Maintainers (covered to age 20):

    a. Fixed - unilateral and bilateral types
    b. Removable - unilateral and bilateral types
    c. Recementation of space maintainer

DIAGNOSTIC

Routine Oral Examination – Not more than two (2) examinations per Covered Person each Calendar Year

X-RAYS

1. Bitewings - Not more than one (1) series of films each Calendar Year
2. Intraoral periapical - films
3. Intraoral - occlusal films
4. Extraoral - films
5. Posterior/anterior or lateral skull and facial bone survey film
6. Complete Series (full mouth) –Not more than once every thirty-six (36) consecutive months
7. Panoramic - Not more than once every thirty-six (36) consecutive months

TESTS AND LABORATORY EXAMINATIONS

1. Caries susceptibility tests
2. Pulp vitality tests
3. Bacteriological studies
4. Screening for oral cancer – limited to once per Calendar Year

EMERGENCY PALLIATIVE TREATMENT

Palliative treatment of dental pain, minor procedures

BASIC DENTAL SERVICES

RESTORATIONS

1. Amalgam fillings (including polishing) - Pin Retention is exclusive of Amalgam

2. Silicate Cement per filling

3. Acrylic or Composite fillings:

    a. Acrylic
    b. Composite resin
    c. Pin retention - exclusive of Composite resin
    d. Composite resin (involving incisal angle)

REPAIRS AND OTHER RESTORATIVE SERVICES

1. Recement Inlays/Onlays
2. Recement Bridges and Crowns

ENDODONTICS

1. Root Canal Therapy (includes Treatment Plan, clinical procedures, and follow-up care; excluding finalRestoration)
2. Pulp Capping (excluding final Restoration)
3. Vital Pulpotomy (excluding final Restoration)
4. Apicoectomy - performed as separate Surgical Procedure (per root)

PERIODONTICS

1. Periodontal Evaluations

2. Periodontal Prophylaxis

3. Surgical Services (including usual postoperative services):

    a. Gingivectomy or gingivoplasty - per quadrant
    b. Gingival curettage
    c. Gingival flap procedure - per quadrant
    d. Osseous Surgery (including flap entry and closure) - per quadrant
    e. Osseous graft - single site and multiple sites (including flap entry, closure, and donor site)
    f. Free soft tissue grafts (including donor site)

4. Adjunctive Periodontal Services:

    a. Periodontal Scaling and root planing
    b. Full mouth debridement

MISCELLANEOUS SERVICES/APPLIANCE(S)

1. Problem Focused Exam
2. Dental Consultations (required by the attending Dentist)
3. Nitrous oxide
4. Antibiotic injections by the attending Dentist
5. X-rays and pathology to include panoramic survey (not in relationship to Preventive and Diagnostic)

ORAL SURGERY

1. Extractions - includes local Anesthesia and routine postoperative care

2. Surgical Extractions (except those performed for Orthodontic purposes) - includes local Anesthesia and routine postoperative care:

    a. Extraction of tooth
    b. Root recovery (surgical removal of residual root)

3. Other Surgical Procedures:

    a. Surgical exposure of impacted or unerupted tooth to aid eruption
    b. Biopsy of oral tissue (hard or soft)
    c. Incision and drainage

4. Alveoloplasty (surgical preparation of ridge for Dentures):

    a. Per quadrant - in conjunction with extractions
    b. Per quadrant - not in conjunction with extractions

5. Anesthesia

    a. Local anesthetic
    b. General anesthesia (only when Medically Necessary and when administered in conjunction withoral or Dental Surgery)
    c. IV sedation

MAJOR DENTAL SERVICES

RESTORATIONS

1. Gold Inlay Restorations:

    a. Inlay - gold, two (2) or three (3) surfaces
    b. Onlay - per tooth (in addition to above)

2. Inlay - Porcelain

3. Crowns:

    a. Plastic
    b. Porcelain
    c. Gold (full cast or 3/4 cast)
    d. Semi-precious metal (full cast)
    e. Non-precious metal (full cast)
    f. Crown buildups - pin retained
    g. Cast post and core in addition to Crown
    h. Dowel pin-metal per tooth (in addition to Abutment Crown)
    i. Crown lengthening
    j. Stainless steel

PROSTHODONTICS – REMOVABLE – FIXED

1. Complete Dentures - including six (6) months post-delivery care:

    a. Complete upper and/or lower
    b. Immediate upper and/or lower

2. Partial Dentures - including six (6) months post-delivery care:

    a. Upper or lower - without clasps, Acrylic base
    b. Upper or lower - with two (2) gold clasps with rests, Acrylic base
    c. Upper or lower - with gold palatal bar or gold lingual bar and two (2) clasps, Acrylic base
    d. Upper or lower - with gold palatal bar or gold lingual bar and two (2) clasps, cast base
    e. Removable unilateral Partial Denture one (1) piece gold casting, clasp attachments, per unit including Pontics
    f. Full cast partial - with two (2) gold clasps (upper and lower)

3. Additional Units for Partial Dentures:

    a. Each additional clasp with rest

b. Each tooth (applies only to full cast partial)

4. Fixed Bridges (each Abutment and each Pontic constitute a unit in a Bridge)

5. Bridge Pontics:

   a. Casts
   b. Slotted facing or Pontic
   c. Porcelain fused to gold or non-precious metal
   d. Plastic processed to gold or non-precious metal

6. Retainers:
   a. Gold Inlay – two (2), three (3) or more surfaces
   b. Gold Inlay (onlaying cusps)

PROSTHODONTICS, REMOVABLE-ADJUSTMENTS, REPAIRS, REBASING AND RELINING

1. Adjustments to Dentures:

   a. Complete Denture
   a. Partial Denture – upper and/or lower

2. Repairs to Dentures (Complete and partials)

3. Denture Rebasing/Relining:

   a. Rebasing/Relining upper or lower complete or Partial Denture (office Reline)
   b. Relining upper or lower complete or Partial Denture (laboratory)

4. Tissue Conditioning

PROSTHODONTICS, FIXED – REPAIRS AND OTHER SERVICES

1. Repairs to Bridges
2. Recement Dentures

ORTHODONTIC SERVICES

ORTHODONTIC TREATMENT

"Orthodontic treatment" means the movement of teeth through bone by means of active Appliances whenrequired to correct a Malocclusion for either:

1. Overbite or overjet (vertical or horizontal overlap of upper teeth over lower teeth);
2. Maxillary and mandibular arches in either protrusive or retrusive relation;
3. Crossbite; or
4. Arch length discrepancy.

COVERED ORTHODONTIC SERVICES

1. Cephalometric x-rays - limited to one (1) time in any two (2) year period

2. Orthodontic Treatment - limited to Malocclusions including:

    a. Necessary services related to an active course of Orthodontic treatment
    b. Surgical exposure of impacted or unerupted teeth for Orthodontic reasons including wire attachment when indicated and extractions performed for Orthodontic purposes
    c. The initial and subsequent, if any, installation of Orthodontic Appliances for an active course of Orthodontic treatment, including retainers and cervical traction Appliances
    d. Adjustment of active Orthodontic Appliances

3. Study Models/Diagnostic casts - limited to one (1) Study Model per Covered Person

4. Diagnostic photos