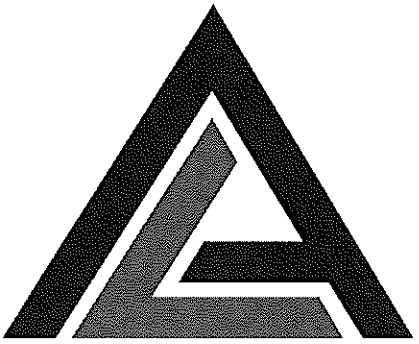

Athens-Limestone Hospital

Dental Benefits

Schedule of Dental Benefits for Covered Employees and Dependents

Annual Benefit	$1,250
Calendar Year Deductible:	
Individual	$50.
Family Maximum	$150.
Benefit Co-Insurance	
Type I – Preventive and Diagnostic Treatment	100%
Type II – Basic Treatment (after deductible)	80%
Type III – Major Treatment (after deductible)	80%

Predetermination of Benefit

The purpose of this benefit is to assure you and your dentist that a proposed dental treatment (in excess of $500) is covered by your dental plan. If a Covered person expects to incur such charges, a Request for Predetermination of Benefits should be filled by your dentist on a dental claim form. The treatment plan along with pre-operative X-Rays should be submitted including the findings of the oral exam and other information to identify the services to be rendered. You and the dentist will be notified in advance of treatment.

Late Entrant Requirement

If you apply for coverage more than 30 days after the eligibility period, Types II and III dental expenses will not be covered until 12 months following the effective date of coverage.

DENTAL PLAN PROVISIONS

The Plan will pay the benefit percentage in excess of the Deductible amount for dental services and supplies received during any Calendar Year, if the services and supplies are:

a. Received while the Covered Person's coverage is in force under the Plan; and
b. Listed in the paragraphs entitled "Dental Benefits".

A. THE DEDUCTIBLE

The Deductible for any Covered Person for any Calendar year will be the amount stated in the Schedule of Benefits.

Any Eligible Expenses a Covered Person has during October, November or December of a year which count toward that person's Deductible for that year will also count towards that person's Deductible for the next year. This section applies only if the person meets all or part of the Individual Calendar Year Cash Deductible during the last 3 months of that year. In addition, a Deductible will not be applied to any expenses incurred by a family unit during the remainder of any Calendar Year after the date on which the maximum per family Deductible for that Calendar Year as stated in the Schedule of Benefits has been satisfied.

B. MAXIMUM BENEFIT

The total annual benefit for any Covered Person is the amount stated in the Schedule of Benefits.

C. DENTAL BENEFITS

Eligible Expenses (as defined herein) under the Dental Benefits portion of the Plan will be covered only to the extent the fee is reasonable and does not exceed the customary fee for comparable services. Eligible expenses are restricted to the following items:

1. Type I – Preventive & Diagnostic Treatment

Services listed below are payable at 100% of the Reasonable and Customary Charges with no deductible required.

- Dental examinations, including preparation of treatment plan if necessary; limited to two exams per calendar year.
- Dental x-ray examinations:
  - Full mouth x-rays, limited to one set during any of 36 consecutive months period;
  - Supplementary bitewing x-ray examinations, limited to two per calendar year; and
  - Other necessary dental x-ray examinations, rendered in connection with the diagnosis of a specific condition requiring treatment.
- Routine prophylaxis including cleaning of teeth, limited to two per calendar year.
- Topical fluoride application for children under age 19, limited to two per calendar year.
- Space maintainers (not made of precious metal) that replace prematurely lost teeth for dependent children under age 19.
- Sealants for dependent children under age 19.

2. Type II – Basic Treatment

Services listed below are payable at 80% of Reasonable and Customary Charges and are subject to the deductible.

- Fillings made of silver amalgam and synthetic tooth color materials.

- Simple tooth extractions.
- Endodontic treatment, including direct pulp capping, removal of pulp, and root canal treatment.
- Denture repairs
- Emergency palliative treatment

3. Type III – Major Treatment

Services listed below are payable at 80% of the Reasonable and Customary Charges and are subject to the deductible.

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, or crown restorations to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate to restore services.
- Oral surgery, consisting of treatment of fractures and dislocations of the jaw, to diagnose and treat cysts and abscesses of the mouth and for tooth extractions and impacted teeth.
- General anesthesia when medically necessary and rendered in connection with oral or dental surgery.
  Anesthesia is "general" when anesthetic drugs or agents are administered by injection or inhalation and when it is given for relaxing muscles, loss of sensation, or loss of consciousness. (It does not include analgesics, drugs given by local infiltration, or oxide.)
- Treatment of the root tip of the tooth including apicoectomies.
- Surgical periodontic examination.
- Gingivectomy and gingivoplasty (removal of diseased gum tissue and reconstructing gums).
- Osseous surgery including flap entry and closure (removal of diseased bone).
- Mucogingivoplasty surgery (reconstruction of gums and mucous membranes by surgery).
- Management of acute infection and oral lesions (full program for periodontal disease).

DENTAL BENEFITS EXTENSION

Benefits will be extended for a Covered Person for the purpose of the completion of any dental services for which a treatment plan has been approved by the Plan Supervisor which actually began prior to the date of termination of the Covered Person's coverage provided the services are completed within thirty (30) days from the date of termination of coverage.

D. DENTAL PLAN LIMITATIONS AND EXCLUSIONS

1. Limitations – Type III Services

- Partial Dentures – If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of the procedure will be made toward a more elaborate or precision appliance that the Covered person and his dentist may choose to use, however, the balance of the cost remains the responsibility of the Covered Person.
- Precision Attachments – Benefits will not be provided for precision attachments.
- Dentures – If, in the provision of denture services, the Covered Person and his dentist decide on personalized or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward the treatment and the balance of the cost remains the Covered Person's responsibility.
- Replacement of Existing Dentures, Fixed Bridgework or Crowns – Replacement of an existing denture, fixed bridgework or crown will be covered only if the existing denture, bridgework or crown is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services, which are necessary to render the

appliances serviceable. Replacement of prosthodontic appliances will be covered only if at least five years have elapsed since the date of the initial installation of that appliance.
- Any replacement made necessary by reason of loss or theft is not covered.

2. Limitations – All Services

- Benefits for examination and diagnosis will be provided not more than twice during any calendar year.
- Benefits for full-mouth x-rays will be provided once each 36 months. Special needs may result in more frequent full mouth x-rays. Benefits for supplementary bitewings will be provided upon request but not more than twice during any calendar year.
- Benefits for routine prophylaxis cleaning will be provided not more than twice during any calendar year.
- Benefits for fluoride treatment will be provided to all eligible dependent children under the age of 19 not more than twice during any calendar year.
- In the event a Covered Person transfers from the care of one dentist to that of another during the course of treatment, or if more than one dentist renders services for one procedure, the plan shall be liable for not more than the amount it would have been liable for had but one dentist rendered the services.
- In all cases in which there are optional techniques of treatment carrying different charges, the plan will pay the charge allowed for the lesser procedure. The dentist may charge the patient the difference for any amount over that for which the dental plan is liable.
- Appliances or restorations necessary to alter existing vertical dimension in restoring occlusion are considered optional and their cost remains the Covered Person's responsibility.
- Prosthetic – Gold, baked porcelain restorations, crowns and jackets – If a tooth can be restored with a materials such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration which the Covered Person and his dentist may select. However, the member is responsible for the balance of the treatment charge.
- Prosthetic – Based on the applicable percentage, payment will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth.

3. Exclusions

No benefits shall be provided under the dental plan for:

- Charges for dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.
- Charges for dental services for which the Covered Person incurs no charge.
- Charges for dental services for which coverage is available to the Covered Person, in whole or in part, under any worker's compensation law or similar legislation whether or not the Covered Person claims compensation or receives benefits thereafter.
- Charges for dental services with respect to congenital malformations or primarily for cosmetic or esthetic purposes.
- Charges for dental services furnished or available to a Covered Person in whole or in part under the laws of the United States (except as provided by federal law), or any state, or political subdivision thereof, or for which the Covered Person would have no legal obligation to pay in the absence of this or any similar coverage.
- Charges for dental care or treatment by a person other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.
- Charges for gold foil restorations.
- Charges for failure of the Covered person to keep scheduled visit with the dentist.

- Charges for services or expenses of any kind, if not required by a dentist, or if not medically necessary.
- Charges for sealants and for oral hygiene and dietary information.
- Charges for plaque control program.
- Charges for implantology.
- Charges for anesthetic services performed by and billed for by a dentist other than the attending dentist or his assistant.
- Charges for dental services rendered or furnished to the Covered Person prior to such person's effective date of coverage, or subsequent to the effective date of termination.
- Charges for dental care or treatment not specifically identified as a covered dental expense.
- Charges for appliances or restoration for the sole purpose of changing vertical dimensions from its present state or restoring the occlusion.
- Charges for the use of any facility (including, but not limited to, a hospital) in which dental services are rendered, whether or not the use of such a facility was medically necessary.
- Charges for services of a dentist rendered to a Covered Person who is related to the dentist by blood or marriage or who regularly resides in the dentist's household.
- Charges for services or expenses of any kind either (a) for which a claim submitted for a Covered Person in the form prescribed by the Plan Supervisor has not been received by the Plan Supervisor, or (b) for which a claim is received by the Plan Supervisor later than 24 months after the date services were performed.
- Charges for any dental treatment or procedure drugs, drugs usage, equipment, or supplies which are investigational.
- Charges for services or expenses for which a claim is not properly submitted.