

Phoenix Healthcare Dental Schedule of Benefits

Schedule of Benefits:

Effective for those meeting the eligibility and waiting period requirements identified below.

Annual Maximum Benefits Paid

Annual Maximum Reimbursement for Dental Expenses per Calendar Year is \$1,500 per participant.

Copayment Levels for Covered Expenses

Amount of Dental Expense	Employer Share	Employee Share	Paid Benefit
First \$200	100%	0%	\$200
Next \$500	80%	20%	\$400
Next \$800	50%	50%	\$400

Dental Expense Benefits

After the Employee or licensed Dentist submits a paid receipt, itemized statement or a completed dental claim form, as proof that a Covered Person has incurred Covered Expenses for care or treatment by a Dentist, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Claims must be submitted within ninety (90) days of the date on which charges were incurred. Amount payable is subject to coordination of benefits is applicable.

Exceptions – The Plan does not cover:

1. Expenses covered by Worker's compensation or employer liability laws.
2. Expenses covered by any governmental agency or under any governmental program or law, except as to charges, which the person is legally obligated to pay.
3. Expenses incurred prior to the date the person became covered under this Plan, or after the date the person ceases to be covered.
4. Cosmetic procedures.
5. Purchases of toothbrushes, toothpaste, floss, or other personal care items, including nonprescription drugs.
6. Procedures covered under the Employer's medical plan, whether or not the Covered Person is enrolled in the medical plan.
7. Any other expenses, which are determined by the Administrator and communicated to Eligible Employees by notice or other reasonable means.
8. Experimental procedures.
9. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
10. Services performed by any person other than a dentist (Doctor of Dentistry) or auxiliary personnel legally authorized to perform services under the supervision of a dentist.

Limited Benefit Vision Plan: AMENDMENT NUMBER 1
This amendment forms a part of the Phoenix Healthcare LLC
Dental Benefits Plan established on July 1st, 2007.

The entire policy is supplemented by this amendment.

The effective date of these changes is October 1, 2007. The changes only apply to benefits which start or are received on or after the effective date.

The policy's terms and provisions will apply other than as stated in this amendment.

Dated at Roanoke, Alabama on September 1st, 2007.

By: Signature on File

Title: _____

**Exclusions and Limitations of the Phoenix Healthcare
Dental Benefits Plan**

1. Labial veneers and laminates done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered.
2. Alteration of vertical dimension and the restoration or maintenance of occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration for mal-alignment of the teeth.
3. Orthodontic services (treatment of poor alignment of teeth and or jaws)
4. Services with respect to any disturbance of the temporomandibular joint (jaw joint)
5. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
6. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
7. Experimental procedures
8. Prescribed drugs, medications or analgesia
9. Any single procedure started prior to the date the person became covered for such services under this program.
10. Services for injuries or conditions which are compensable under workers compensation or employers liability laws; services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision except as such exclusion may be prohibited by law.
11. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis of the teeth and anodontia, except those services provided to newborn children for congenital defect or birth abnormalities.

12. The plan will not pay to replace any crown, jacket or cast restoration which the patient received in the previous five (5) year.

13. Crowns, jackets and cast restorations are limited to enrollees who have been enrolled in the plan for 12 consecutive months. This provision will be waived for employees and their dependent enrolling on the Effective date.

14. This plan will not pay to replace any bridge or denture that the patient received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

15. This plan will not pay for a new set of dentures either upper or lower until the enrollee has been enrolled in the plan for 12 consecutive months.

16. Prosthodontic Benefits are limited to Enrollees who have been enrolled in this plan for 12 consecutive months. This provision will be waived for employees and their dependents enrolling on the Effective Date.

17. Gold foil restorations

18. Charges for implants

Limitations on Diagnostic and Preventive Benefits:

- a) Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than twice (2) in any twelve (12) month period while the patient is an Enrollee under this plan.
- b) Full mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but no more once each 5 years will be paid by the Employer.
- c) Bitewing x-rays are limited to twice in any 12 month period when provided to Enrollees under age 18 and once each 12 months for Enrollees age 18 and over.
- d) The Employer will not pay for topical application of fluoride for anyone nineteen (19) years or older.

Eligible Dependents: (1) Legal spouse of an Eligible Employee. (2) Unmarried children of an Eligible Employee to age 19 provided such children are dependent upon the employee for support and maintenance. College age children shall be covered provided they are full-time students. (3) Children of an Eligible Employee who have attained the age specified in item 2 above who are incapable of self-sustained employment due to a handicap or disability and are still dependent on the Eligible Employee

The limited benefit vision plan schedule of benefits.

The plan pays 100% of the first \$100 in vision care expenses
then
50% of the next \$300 in vision care expenses.

Maximum calendar year benefit is \$250 per participant

To be eligible to receive the benefit, the employee and dependants must be active enrollees in the Phoenix Healthcare LLC Dental Benefits Plan.