Rates effective January 1, 2025

SERVICES	DENTAL PLAN A	DENTAL PLAN B	DENTAL PLAN C	DENTAL PLAN D	DENTAL PLAN E
Contract Year Deductible	N/A	N/A	N/A	$50	$50
Per Individual Family Limit				$150	$150
Waived for Type I				Yes	Yes
Reimbursement Type:					
In-Network	Negotiated PDP fee	Negotiated PDP fee	Negotiated PDP fee	Negotiated PDP fee	Negotiated PDP fee
Out-of-Network	90th percentile of R&C	90th percentile of R&C	90th percentile of R&C	90th percentile of R&C	90th percentile of R&C
Type I	100%	100%	100%	100%	100%
Preventative Services	oral exams (1 per 6 months), cleanings (1 per 6 months), bitewing x-rays (1 per 6 months for children; 1 per 12 months for all others), fluoride treatment (children under age 14)	oral exams (1 per 6 months), cleanings (1 per 6 months), bite-wing x-rays (2 per 12 months), fluoride treatment (children under age 14), space maintainers (children under age 14), sealants (children under age 14)	oral exams (1 per 6 months), cleanings (1 per 6 months), bite-wing x-rays (2 per 12 months), fluoride treatment (children under age 14), space maintainers (children under age 14), sealants (children under age 14), full mouth x-rays	oral exams (1 per 6 months), cleanings (1 per 6 months), bite-wing x-rays (2 per 12 months), fluoride treatment (children under age 19), space maintainers (children under age 14), sealants (children under age 14), full mouth x-rays, periapical x-rays	oral exams (1 per 6 months), cleanings (1 per 6 months), bite-wing x-rays (2 per 12 months), fluoride treatment (children under age 19), space maintainers (children under age 14), sealants (children under age 14), full mouth x-rays, periapical x-rays
Type II	80%	80%	80%	80%	80%
Basic Services	space maintainers (children under age 14), fillings, sealants (children under age 14), full mouth x-rays, periodontal maintenance, periapical x-rays, injection of antibiotic drugs	fillings, full mouth x-rays, periodontal maintenance, periapical x-rays, injection of antibiotic drugs, endodontics	fillings, periodontal maintenance, periapical x-rays, injection of antibiotic drugs, endodontics, anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery	fillings, periodontal maintenance, injection of antibiotic drugs, endodontics, anesthesia, simple & surgical extractions, oral surgery, consultations	fillings, periodontal maintenance, injection of antibiotic drugs, endodontics, anesthesia, simple & surgical extractions, oral surgery, consultations
Type III	50%	50%	50%	50%	50%
Major Services	endodontics, anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, consultations, implantology	anesthesia, simple & surgical extractions, oral surgery, periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, consultations, implantology	crowns, inlays, onlays, dentures, bridges, consultations, implantology	periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, implantology	periodontics, periodontal surgery, crowns, inlays, onlays, dentures, bridges, implantology
Waiting Period	12 months	12 months	12 months	12 months	12 months
Contract Year Maximum	$1,000	$1,250	$1,500	$1,500	$5,000
Type IV	N/A	50%	50%	50%	50%
Child Orthodontia (Optional)					
Lifetime Maximum		$1,000	$1,000	$1,500	$1,500
Deductible		None	None	None	None
Waiting Period		12 months	12 months	12 months	12 months
Monthly Costs					
without Ortho					
Employee	$35.87	$49.17	$52.96	$55.81	$58.63
Employee + One	$68.61	$94.02	$101.22	$106.71	$112.07
Employee + Two	$88.53	$121.31	$130.66	$137.68	$144.38
Employee + Family	$120.10	$164.50	$177.22	$186.74	$195.87
with Ortho					
Employee	N/A	$49.17	$52.96	$55.81	$58.63
Employee + One	N/A	$94.02	$101.22	$106.71	$112.07
Employee + Two	N/A	$129.23	$139.97	$151.71	$159.12
Employee + Family	N/A	$177.11	$190.93	$207.39	$217.52

Limitations & Exclusions

The following expenses are not Covered Dental Expenses for plans A-E. The Essential Health Benefits (EHB) Plan is subject to the Schedule of Benefits for North Carolina. Please contact Curi Benefits Solution for more information.

Services and Supplies:

- Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
- Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  – Scaling and polishing of teeth; or
  – Fluoride treatments.
- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
  – otherwise is a Covered Dental Expense; and
  – is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
  – is required for reconstructive surgery because of a congenital disease or
- anomaly of a dependent child which has resulted in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
- Services or supplies which are covered by any employers' liability laws.
- Services or supplies which any employer is required by law to furnish in whole or in part.
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
- Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
- Services or supplies for which a Covered Person is not required to pay.
- Services or supplies which are deemed experimental in terms of generally accepted dental standards.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
- Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.
- Charges for broken appointments.
- Charges by the Dentist for completing dental forms.
- Sterilization supplies.
- Services or supplies furnished by a family member.
- Treatment of temporomandibular joint disorders. This exclusion does not apply to residents of Minnesota.

The following expenses are not Covered Dental Expenses for any of the plans with Ortho:

- Repair or replacement of an orthodontic appliance.

The following expenses are not Covered Dental Expenses for any of the plans without Ortho:

- Orthodontia not available with Plan A.