Schedule of Benefits

Dental - Base Plan

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group this may not apply. Please contact the policyholder for additional information.

Prepared for:

Field	Value
Policyholder	The Arc of Washington County, Inc.
Policyholder Number	F127AWC
Schedule of Benefits	1A
Group Policy Effective Date	January 1, 2027
Plan Name	PPO Dental Base Plan
Plan Effective Date	January 1, 2027
Dental Network	Cigna Dental PPO Shared Administration

Schedule of Benefits

This schedule of benefits lists the eligible dental services, deductibles, coinsurance, maximums, and other limits that apply to the services you get under this plan.

How to Read Your Schedule of Benefits

- "In-network coverage" means that you get care from in-network providers.
- "Out-of-network coverage" means that you can get care from out-of-network providers.
- The deductibles and coinsurance listed in the schedule of benefits below reflects the deductibles and coinsurance amounts under your plan.
- You must incur any deductibles and your part of the coinsurance.
- The coinsurance listed in the schedule of benefits reflects the plan coinsurance percentage. This is the coinsurance amount the plan pays. You are responsible for any remaining coinsurance.
- You are responsible for the full amount of any dental care services you get that are not a covered benefit or that exceed your Calendar Year maximums and lifetime maximums.
- This plan also has limits for some covered benefits, including visit limits. They may be combined limits between or separate limits for in-network providers and out-of-network providers unless we state otherwise.

Important note: All covered benefits are subject to a Calendar Year deductible and coinsurance unless otherwise noted in the schedule of benefits below.

How to Contact Us for Help

- Register and log onto our self-service website available 24/7 at https://www.LoomisCo.com/
- Call us at 1-800-246-1223

The coverage described in this schedule of benefits will be provided under The Loomis Company's group policy. This schedule of benefits replaces any schedule of benefits previously in effect under the group policy. Keep this schedule of benefits with your booklet-certificate.

General Coverage Provisions

This section explains the deductibles and maximums.

Calendar Year Deductible

Eligible dental services applied to the out-of-network deductibles will be applied to satisfy the in-network deductibles. Eligible dental services applied to the in-network deductibles will be applied to satisfy the out-of-network deductibles.

Individual Deductible

You incur for eligible dental services each Calendar Year before this plan begins to pay. This individual deductible applies separately to you and each covered dependent. After the amount paid reaches the individual deductible, this plan starts to pay for eligible dental services for the rest of the Calendar Year.

Family Deductible

You incur eligible dental services each Calendar Year before this plan begins to pay. After the amount paid for eligible dental services reaches this family deductible, this plan starts to pay for eligible dental services for the rest of the Calendar Year. To satisfy this family deductible for the rest of the Calendar Year, the combined eligible dental services that you and each of your covered dependents incur toward the individual deductible must reach this family deductible in a Calendar Year.

Calendar Year Maximum

The most the plan will pay for eligible dental services incurred by any one covered person in a Calendar Year is called the Calendar Year maximum. This Calendar Year maximum applies to in-network and out-of-network eligible dental services combined.

Dental Emergency Services Maximum

The most the plan will pay for eligible dental services incurred by any one covered person for any one dental emergency is called the dental emergency services maximum.

Your Financial Responsibility and Determination of Benefits Provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan Features

Calendar Year Deductible

You have to meet your Calendar Year deductible before this plan pays for benefits.

Deductibles	In-Network Coverage	Out-of-Network Coverage
Calendar Year Deductible*	Individual: $50 Family: $150	Individual: $50 Family: $150

**Important note: The Calendar Year deductible applies to all eligible dental services except Type A expenses.*

Coinsurance

The coinsurance listed below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

Expenses	In-Network Coverage Coinsurance	Out-of-Network Coverage Coinsurance
Type A expenses	100% of the negotiated charge	80% of the recognized charge
Type B expenses	80% of the negotiated charge	60% of the recognized charge
Type C expenses	50% of the negotiated charge	40% of the recognized charge

Calendar Year Maximum

Maximums	In-Network Coverage Amount	Out-of-Network Coverage Amount
Calendar Year Maximum	$1,500	$1,000

Dental Emergency Services Maximum

Maximum	In-Network Coverage Amount	Out-of-Network Coverage Amount
Dental Emergency Services Maximum	None	$75

Eligible Dental Services

Type A Expenses: Diagnostic & Preventive Care

Visits and Exams

- Oral evaluations (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning) (2 treatments per year)
- Topical application of fluoride if you are under age 16 (1 application per year)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)
- Sealant repair-per tooth (for permanent molars only and if you are under age 16)
- Scaling-moderate/severe inflammation, full mouth (2 treatments per year, frequency combined with prophylaxis)
- Application of hydroxyapatite regeneration medicament-per tooth (1 application every 3 years)
- Testing for cracked tooth (frequency combined with oral evaluations)
- Caries preventive medicament application – per tooth

Space Maintainers — Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

Images and Pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Type B Expenses: Basic Restorative Care

Visits and Exams

- Office visit after hours (we will pay either for the office visit charge or for the eligible dental services performed, whichever is more)
- Emergency palliative treatment, per visit

Images and Pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative

Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations (other than for molars)

- Placement of interim direct restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (primary teeth only, excludes temporary crowns)
- Recementation
- Excavation of a tooth resulting in the determination of non-restorability

Oral Surgery

- Extractions-coronal remnants-deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth — Soft tissue
- Removal of impacted tooth — Partially bony
- Removal of impacted tooth — Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Excisional biopsy of minor salivary glands
- Coronectomy

Periodontics

- Periodontal maintenance procedures following active therapy (2 per year)
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant (1 per quadrant every 3 years)
- Surgical exposure of root surface without apicoectomy or repair — anterior, pre-molar and molar
- Unscheduled dressing change (by someone other than treating dentist or their staff)
- Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
- Osseous surgery (including flap and closure), 4 or more teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Clinical Crown Lengthening – Hard Tissue
- Full mouth debridement (1 per lifetime)

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment — Anterior
- Root canal therapy and retreatment — Bicuspid
- Root canal therapy and retreatment — Molar
- Pulpal regeneration
- Hemisection
- Retrograde filling
- Root amputation
- Surgical repair of root resorption — anterior, premolar and molar

General Anesthesia and Intravenous Sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

Type C Expenses: Major Restorative Care

Restorative

Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 years. (See the Replacement rule.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs — inlay, onlay, veneer, crown
- Removal of an indirect restoration on a natural tooth
- Core Build Up including any pins

Prosthodontics

The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See the Tooth missing but not replaced rule.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See the Replacement rule.)

- Bridge abutments
- Pontics
- Complete upper and lower denture
- Partial upper and lower (including any conventional clasps, rests and teeth)
- Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance
- Accessing and retorquing loose implant screw-per screw
- Cleaning and inspection of occlusal guard-per appliance

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service — Only for impacted wisdom teeth procedure

Important note: The following apply:
• Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.
• There is an extra charge for eligible dental services that use high noble metals (ex. gold or titanium).
• General anesthesia and sedation are covered benefits when part of a covered surgical procedure.

Additional Eligible Dental Services

We will provide additional eligible dental services if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

Additional Services Covered

- Prophylaxis (cleaning) (one additional per Calendar Year)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of Benefits

We will waive the Calendar Year deductible and coinsurance for the additional eligible dental services above.

Expense	In-Network Coverage Coinsurance	Out-of-Network Coverage Coinsurance
Additional Eligible Dental Services	100%	100%