RF Micro Devices, Inc.

SCHEDULE OF DENTAL PROCEDURES

Type A Expenses-Preventive Procedures

Dental Procedure

Examinations

Oral examinations (evaluation)
Period examination (evaluation)

Only two of the listed examinations will be covered in any benefit year.

Radiographs

Full mouth survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 36 consecutive months.

Bitewing

Two per benefit year.

Occlusal
Periapical

Extraoral x-rays

Sialography
TMJ
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey
Other extraoral

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Type A Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth)

Covered twice in any benefit year.

Topical application of fluoride

Applicable only to Dependent children under the age of 16. Two applications will be covered in any benefit year.

Space maintainers
Applicable only to Dependent children under age 16. Repairs to space maintainers are not covered.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent children under age 16. Covered once each tooth in any 36 consecutive months.

Other Services

Harmful habit appliance

Limited to one time per person under the age of 16.

Type B Expenses-Basic Procedures

Dental Procedure

Restorations

Fillings (amalgam, silicate, plastic or composite)

Stainless steel crown

Oral Surgery

Extraction of teeth

Alveoloplasty

Removal of dental cysts and tumors

Surgical incision and drainage of dental abscess

Other Surgical Procedures

Surgical exposure to aid eruption

Excision of hyperplastic tissue

Periodontic Services

Scaling and root planing (each quadrant)

Covered twice each quadrant in any benefit year.

Periodontal appliance

One appliance is covered in any 36 consecutive months

Periodontal prophylaxis (includes probing, charting, exam, polishing, scaling, root planing, and similar maintenance procedures).

Covered once every three months, not to exceed 4 per benefit year.

Endodontic Services

Vital pulpotomy
Covered for deciduous teeth only

Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care

Apexification
Apicoectomy
Retrograde filling
Root Resection
Hemisection

**Anesthesia**

General anesthesia
IV sedation
Nitrous oxide

Covered as a separate procedure only when required for complex oral surgical procedures covered under this plan (and only when performed in a dental office).

**Other Services**

Emergency exam

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Consultation with a specialist

Antibiotic drug injection
Biopsy of oral tissue
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Bacteriologic culture
Histopathologic examination

**Type C Expenses-Major Procedures**

**Dental Procedure**

**Periodontal Surgical Procedures**

Gingival flap procedure
Gingivectomy
Gingival curettage
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft

**Other Services**

Recementing

Inlay
Onlay
Crown Bridgework

Repairs to complete or partial denture, bridge, or crown

Relining or rebasing complete or partial dentures

Tissue conditioning

Denture adjustment

Restorations

Gold inlays and onlays

Gold inlay and onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Labial veneer

Veneer restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Crowns (single restorations only)

<table>
<thead>
<tr>
<th>Material Type</th>
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<tbody>
<tr>
<td>Resin (laboratory)</td>
</tr>
<tr>
<td>Resin, prefabricated</td>
</tr>
<tr>
<td>Resin with nonprecious metal</td>
</tr>
<tr>
<td>Resin with semiprecious metal</td>
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<tr>
<td>Resin with gold</td>
</tr>
<tr>
<td>Porcelain</td>
</tr>
<tr>
<td>Porcelain with nonprecious metal</td>
</tr>
<tr>
<td>Porcelain with semiprecious metal</td>
</tr>
<tr>
<td>Porcelain with gold</td>
</tr>
<tr>
<td>Gold (3/4 cast)</td>
</tr>
<tr>
<td>Gold (full cast)</td>
</tr>
<tr>
<td>Nonprecious metal (full cast)</td>
</tr>
<tr>
<td>Semiprecious metal (full cast)</td>
</tr>
</tbody>
</table>

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least five years (60 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered.

Cast post and core

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

Prosthodontics, Fixed
Fixed bridges – initial placement or replacement

Benefits for the replacement of an existing bridge are payable only if the existing fixed bridge is more than five years (60 consecutive months) old, is not serviceable, and cannot be repaired unless there is a necessary extraction of a functioning natural tooth (which was not an abutment to an existing partial denture or fixed bridge that is less than five years old).

Prosthodontics, Removable

Complete or partial dentures – initial placement or replacement

Replacement of complete or partial dentures is covered only if the existing denture cannot be made serviceable and five years (60 consecutive months) have elapsed since the placement. Covered Charges for complete or partial dentures do not include any additional charges for overdentures or for precision or semi-precious attachments.

**Type D Expenses-Orthodontia (For Dependent Children Only)**

Orthodontic Services

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.