SCHEDULE OF BENEFITS

Employer Contract Number: 70-53995-00 through 06 and 09 through 89
Employer: National Wild Turkey Federation
Dental Plan
Plan of Benefits Effective Date: January 1, 2018

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the Plan of Benefits. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following date of employment.
In addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of twenty-six (26).
Actively at Work:	
Minimum hours per week:	At least thirty (30) hours per week.
Minimum weeks per year:	At least forty-eight (48) weeks per year.

Benefit Year Deductibles	$50 per Member, limited to 3 per family for Participating Providers. $50 per Member, limited to 3 per family for Non-Participating Providers.
Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 01/01.	

	Participating Provider	Non-Participating Provider
Diagnostic and preventive Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Corporation pays 100% of the Allowable Charges	The Corporation pays 100% of the Allowable Charges The Member must pay the balance of the Provider's charge
Basic dental Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Corporation pays 80% of the Allowable Charges after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charges after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Major dental Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Corporation pays 50% of the Allowable Charges after the Benefit Year Deductible The Member pays the remaining 50% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charges after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthodontic Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	Non-Covered	Non-Covered
Limitations:	1. Oral examinations are limited to two (2) per Benefit Year; 2. Bitewing X-rays are limited to one (1) per Benefit Year for Participating and Non-Participating Providers; 3. Prophylaxis is limited to two (2) per Benefit Year; 4. Full mouth X-rays or panoramic films are limited to once every three (3) years; 5. Topical fluoride applications are limited to two (2) applications per Benefit Year for Members under age nineteen (19) for Participating and Non-Participating Providers; 6. Space maintainers are limited to permanent teeth for Members under age nineteen (19); 7. Sealants are limited to Members from the ages of six (6) through fifteen (15); 8. Prosthodontics may be replaced once every five (5) years;	

	9. Relining of removable dentures is covered six (6) months after initial placement then once every five (5) years for Participating and Non-Participating Providers; 10. Diagnostic and preventive Benefits, basic dental Benefits and major dental Benefits are subject to a combined maximum of $2,000 per Member per Benefit Year.	
Services related to previously missing teeth	Non-Covered	Non-Covered
Cleft lip and palate	Covered	Covered
Temporomandibular joint (TMJ) disorder	Non-Covered	Non-Covered
Orthognathic surgery	Non-Covered	Non-Covered
Impacted teeth	Covered	Covered