

**First Commonwealth Insurance Company
Limited Benefit Health Coverage – Dental
Outline of Coverage**

(1) **Read Your Policy Carefully** — This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The policy provides Limited Benefit Health Coverage for Dental coverage only—policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) **The services covered by the policy are named in the list of Covered Dental Services and Patient Charges. If a service, treatment or procedure is not on that list, it is not a covered service. All services must be provided by the assigned Primary Care Dentist (PCD).**

The Member must pay the listed Patient Charge. The benefits First Commonwealth provides are subject to all of the terms of the policy, including the Limitations and Conditions on Covered Dental Services and Exclusions.

There is a limit on the total amount of Patient Charges a Member who is under age 19 must pay each calendar year for pediatric essential health benefits as determined by Illinois. The limit is \$350.00 for each such Member. Once this limit is reached the policy waives Patient Charges for such benefits for the rest of the calendar year for such Member. But if two or more such Members meet the limit of \$700.00 in a calendar year, the policy waives the Patient Charges for such benefits for all other such Members for the rest of the calendar year.

The Patient Charges listed in the Covered Dental Services and Patient Charges section are only valid for covered services that are: (1) started and completed under the policy, and (2) rendered by Participating Dentists in the State of Illinois.

(4) **Non-Renewal of Policy:** Should either of the parties decide not to renew the policy, such party will provide the other party with written notice of non-renewal. Such notice will be provided to the other party at least 60 days prior to the end of the Initial Policy Term or any Renewal Policy Term. Failure to submit timely notice of non-renewal will result in the policy renewing for a successive one-year Policy Term.

Premium Rate Adjustments. First Commonwealth shall adjust Premium rate(s) by providing the Policyowner written notice of the change at least 60 days prior to the last day of the period for which the Premium rate(s) are guaranteed.

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Limitations:

(5)

1. Routine cleaning (prophylaxis) (D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
2. Fluoride treatment (D1203, D1204, D1206, D1208) – four (4) in any twelve (12) month period.
3. Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
4. Full mouth x-rays – one (1) set in any three (3) year period.
5. Bitewing x-rays – two (2) sets in any twelve (12) month period.
6. Panoramic x-rays – one (1) in any three (3) year period.
7. Sealants – limited to permanent teeth, up to the 19th birthday – one (1) per tooth in any three (3) year period.
8. Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (3) year period.
9. Periodontal soft tissue graft procedures (D4270, D4271, D4277, D4278) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
10. Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
11. Emergency dental services when more than fifty (50) miles from the Primary Care Dentist's office – limited to a \$50.00 reimbursement per incident.
12. Emergency dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by First Commonwealth – limited to the benefit for palliative treatment (D9110) only.
13. Reline of a complete or partial denture – one (1) per denture (upper and lower) in any twelve (12) month period.
14. Rebase of a complete or partial denture – one (1) per denture (upper and lower) in any twelve (12) month period.
15. Second Opinion Consultation – when approved by First Commonwealth, a second opinion consultation will be reimbursed up to fifty dollars (\$50.00) per treatment plan.

Exclusions:

The policy does not pay benefits for the following:

1. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
2. Dental services performed in a hospital, surgical center, or related hospital fees.
3. Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a)

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- congenitally missing or (b) supernumerary teeth.
4. Any histopathological examination or other laboratory charges.
 5. Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
 6. Any oral surgery requiring the setting of a fracture or dislocation.
 7. Placement of osseous (bone) grafts.
 8. Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
 9. Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the Participating Dentist is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes.
 10. Precision attachments, stress breakers, magnetic retention or overdenture attachments.
 11. The use of: (a) intramuscular sedation or (b) oral sedation.
 12. Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.
 13. Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
 14. Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
 15. Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without a referral from the PCD and approval from us.
 16. Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
 17. Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons (d) realign teeth.
 18. Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
 19. Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's assigned PCD, unless First Commonwealth had provided written authorization.
 20. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
 21. Treatment which requires the services of a Prosthodontist.
 22. Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 19th birthday.
 23. Consultations for non-covered services.
 24. Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
 25. Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
 26. Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under the policy, except as described under Treatment in Progress - Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be: (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be: (a) started when the impressions are taken, and (b) completed when the denture is delivered to the

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- Member).
27. Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under the policy, except as described under Treatment in Progress - Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed).
 28. Orthodontic treatment started prior to the Member's eligibility to receive benefits under the policy, except as described under Treatment in Progress - Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded).
 29. Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which are covered under the policy as Emergency Dental Services.
 30. Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which are covered under the policy as Emergency Dental Services.
 31. Orthodontic treatment started by a non-participating dentist while the Member is covered under the policy. (Orthodontic treatment is considered to be started when the teeth are banded).
 32. Extractions performed solely to facilitate orthodontic treatment.
 33. Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
 34. Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
 35. Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
 36. Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
 37. Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
 38. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
 39. Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
 40. Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

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- (6) This Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the Policyowner and First Commonwealth Insurance Company.