Types of Covered Services and Supplies

Type I : Preventative Dental Services

Coverage is provided for the following preventive dental services:

- Initial or periodic oral exams, limited to 1 per six month period.
- Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film, limited to 1 per 60 month period.
- Bitewing x-rays *(two or four films)*, limited to 1 per 12 month period.
- Intraoral periapical x-rays.
- Intraoral occlusal x-rays, limited to 1 film per arch per 6 month period.
- Extraoral x-rays, limited to 1 film per 6 month period.
- Other x-rays *(except film related to orthodontic procedures or temporomandibular joint dysfunction).*
- Dental prophylaxis *(cleaning and scaling)*, limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period. *(During the 6 month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both).*
- Topical fluoride treatment is limited to 1 per 6 month period for Dependent children under age of 14.

Type II : Basic Dental Services (Non-Restorative)

Coverage is provided for the following non-restorative dental services:

- Emergency oral exams, considered for payment as a separate benefit only if no other treatment *(except x-rays)* is rendered during the visit.
- Space maintainers, including all adjustments made within 6 months of installation, limited to Dependent children under age 14.
- Sealants are limited to 1 application to an unrestored permanent molar tooth per 36-month period for Dependent children under age 14.
- Stainless steel crowns, limited to 1 per 36 month period for teeth not restorable by an amalgam or composite filling for Dependent children to age 19.
- Pulpotomy.
- Root canal therapy, including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth per 24 month period.
- Apicoectomy/periadicular surgery *(anterior, bicuspid, molar, each additional root),* including all pre-operative and post-operative x-rays, bacterio logic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling – *per root.*
- Root amputation – *per root.*
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.
- Periodontal scaling and root planing *(per quadrant),* limited to Periodontal Case Type II *(minimum of 5mm pocket formation)* on a minimum of three teeth per quadrant 1 time per quadrant per 24 month period. Root planing is generally not

a benefit in the same quadrant for at least 24 months following the completion of active therapy. Active therapy generally must be completed within three months of beginning treatment. Root planning is generally not a benefit until 36 months after surgery in the same area.

- Periodontal maintenance procedure *(following active treatment),* limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period. *(During the 6 month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both).*

Periodontal related services as listed below, limited to one *(1)* time per quadrant of the mouth in any 36 month period with charges combined for gingivectomy, gingival curettage, mucogingival or osseous surgery performed in the same quadrant within the same 36 month period.

- Osseous grafts, including tissue regeneration and bone grafts.
- Pedicle grafts.
- Tissue grafts.

Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:

- Simple extraction.
- Surgical extractions *(including extraction of symptomatic wisdom teeth).*
- Alveoloplasty.
- Vestibuloplasty.
- Removal of exostosis – *maxilla or mandible.*
- Frenulectomy *(frenectomy or frenotomy).*
- Excision of hyperplastic tissue – *per arch.*

- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/ore alveolus.

- Palliative *(emergency)* treatment of dental pain, considered for payment as a separate benefits only if no other treatment *(except x-rays)* is rendered during the visit.

- Root removal – *exposed roots.*

- Biopsy.

- Incision and drainage.

General anesthesia and intravenous sedation, limited as follows:

- Considered for payment as a separate benefit only when medically necessary *(as determined by Us)* and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.

- Nitrous oxide limited to Dependent Children through age 6.

Consultation, including specialist consultations, limited as follows:

- Considered for payment only if billed by a Dentist who is not providing operative treatment.

- Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan

Types of Covered Services and Supplies

Type II : Basic Dental Services
(Restorative)

Coverage is provided for the following restorative basic dental services for restoration of tooth structure loss from caries:

Amalgam restorations, limited as follows:

- Multiple restorations on one surface will be considered a single filling.
- Multiple restorations on different surfaces of the same tooth will be considered connected.
- Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:
  - 12 months have passed since the existing amalgam restoration was placed
  - If the Covered Person is under age 19
  - 36 months have passed since the existing amalgam restoration was placed if the Covered Person is age 19 or older.

Composite restorations, limited as follows:

- Multiple restorations on one surface will be considered a single filling.
- Multiple restorations on different surfaces of the same tooth will be considered connected.
- Mesial-lingual, distal-lingual, mesial-facial and distal-facial restorations on anterior teeth will be considered single surface restorations.
- Acid etch is not covered as a separate procedure.
- Benefits for the replacement of an existing composite restoration will only be considered for payment if at least:
  - 12 months have passed since the existing amalgam restoration was placed
  - If the Covered Person is under age 19
  - 36 months have passed since the existing amalgam restoration was placed if the Covered Person is age 19 or older.
- Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.
- Pins, in conjunction with a final amalgam restoration.

Type III : Major Dental Services

Inlays and onlays (metallic):

- Covered only when the tooth cannot be restored by an amalgam or composite filling.
- Covered only if more than 5 years have elapsed since last placement.
- Limited to persons age 16 and above.
- Porcelain restorations on anterior teeth.

Crowns:

- Covered only when the tooth cannot be restored by an amalgam or composite filling.
- Covered only if more than 5 years have elapsed since last placement.
- Limited to persons age 16 and above.
- Recementing inlays, crowns and bridges, limited to three per tooth.
- Post and core, covered only for endodontically treated teeth requiring crowns.

Endodontic endosseous implant and endosseous implant, limited as follows:

- Benefits for the replacement of an existing implant are payable only if the existing implant is more than 5 years old and cannot be made serviceable.

Full dentures, limited as follows:

- Limited to 1 time per arch unless 5 years have elapsed since last replacement and the denture cannot be made serviceable.
- We will not pay additional benefits for personalized dentures or overdentures or associated treatment.
- We will not pay for any denture until it is accepted by the Covered Person.

Partial dentures, including any clasps and rests and all teeth, limited as follows:

- Limited to 1 partial denture per arch unless 5 years have elapsed since last replacement *(please refer to the Denture or Bridge Replacement/ Addition provision for exceptions)* and the partial denture cannot be made serviceable.
- There are no benefits for precision or semi-precision attachments.

Denture adjustments, limited to:

- 1 time in any 12 month period; and
- Adjustments made more than 12 months after the insertion of the denture.
- Repairs to full or partial dentures, bridges, and crowns, limited to repairs or adjustments performed more than 12 months after the initial insertion.

Relining or rebasing dentures, limited to:

- 1 time per 12 month period.

- Tissue conditioning, limited to repairs or adjustment performed once in a 12-month period.

Fixed bridged *(including Maryland bridges)* **limited as follows:**

- Limited to persons age 16 and above.
- Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 5 years old *(see the Denture of Bridge Replacement/Addition provision for exceptions)* and cannot be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth is not covered.
- The date the bridge is cemented in the mouth will be used in determining the amount that will be applied to the Maximum Benefit Limited shown in the Schedule of Benefits.

- Recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion.

Exclusions and Limitations

Missing Teeth Limitation

We will not pay benefits for replacement of teeth missing on Your or Your Dependents effective date of coverage for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for coverage as follows:

- Benefits will be covered for the replacement of a tooth which was missing on the Covered Person's coverage immediately prior to coverage under the Policy. The tooth must have been extracted within 12 months of the effective date of coverage under the Policy.

- Replacement of the extracted tooth will not be considered a Covered Charge if it was an abutment of an existing Prosthesis.

Denture or Bridge Replacement/Addition
Replacement of a full denture, partial denture, or fixed bridge is not covered under benefits unless:

- 5 years have elapsed since last replacement of the denture or bridge; and

- The denture of bridge cannot be made serviceable; or
- The denture or bridge was damaged while in the Covered Person's mouth when an injury was suffered while insured under this Policy, and it cannot be made serviceable.

However, the following exceptions will apply:

- Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional functioning Natural Tooth.

- Benefits for the replacement of an existing fixed bridge that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth, and the extracted tooth was not an abutment to an existing bridge.

General Exclusions

Covered Services and Supplies do not include:

1) Treatment which: a) is not included in the list of Covered Services and Supplies; b) in not Dentally Necessary; c) is experimental in nature; or d) does not have uniform professional endorsement.

2) Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.

3) Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.

4) Replacement of a lost or stolen Appliance or Prosthesis.

5) Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.

6) Completion of claim forms.

7) Missed dental appointments.

8) Personal supplies or equipment, including but no limited to water piks, toothbrushes or floss holders.

9) Treatment for a jaw fracture.

10) Services or supplies provided by a Dentist, Dental Hygienist, Denturist or Doctor who is:

A) A Close Relative or a person who ordinarily resides with You or a Dependent;
B) An Employee;
C) The Employer.

11) Hospital or facility charges for room, supplies or emergency room expenses; or routine chest x-rays and medical exams prior to oral surgery.

12) Services and supplies obtained while outside the United States, except for Emergency Dental Care.

13) Services or supplies resulting from or in the course of Your of Your Dependent's regular occupation for pay or profit for which You or You Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.

14) Any Charges which are:

A) Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.

B) Not imposed against the person or for which the person is not liable.

C) Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program *(including part B)* but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.

15) Services and supplies provided primarily for cosmetic purposes.

16) Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least three years, as determined by Us.

17) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.

18) Orthodontic services and supplies, unless an Orthodontic rider was included in the Policy.

19) Asymptomatic third molar extraction or removal.

20) Crown build-up is not covered as a separate service.

21) Therapeutic drug injection.

22) Replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.

23) Temporary tooth stabilization, other than covered space maintainers, is not covered.

24) Oral sedation and nitrous oxide analgesia are not covered, except for Dependent Children through age 6.

BACK COVER
(Not completed)