

DENTAL BENEFITS

Effective January 1, 2007

Provider Alternatives

The covered person can obtain dental services from any provider of his or her choice. The amount the covered person has to pay as his share of expenses incurred for covered dental services depends, in part, on the participation status of the provider from who the covered person receives services and supplies. The following describes the arrangement used to make payment under the Plan.

Participating Dentist

Participating dentists are dentists who have signed an agreement currently in effect to participate in our Plan's dental network and/or a signed agreement with a third party to participate in their network. Participating dentists have agreed to accept the lesser of the actual charge or the Plan's allowance for covered services. The covered person is not responsible for charges in excess of the allowance. The covered person is responsible for the deductible, percentage not payable by the Plan, and payment of charges for non-covered services, as well as charges for non-covered services, as well as charges in excess of any maximum benefit limitations. Participating dentists will file the claim for services they provide on the covered person's behalf and payment will be made directly to the participating dentist. A list of participating dentists will be made available to you. This list is subject to change without prior notice to, or approval of, the Plan Sponsor or any covered person.

Non-Participating Dentist

These are dentists who do NOT have a signed agreement currently in effect with the Plan to participate as a preferred dental provider. Non-participating dentists have not agreed to accept our allowance for covered dental services. The covered person is responsible for the difference between the allowance and the non-participating dentist's charge, if any. The covered person is also responsible for the deductible, percentage not paid by the Plan, and the payment of charges for non-covered services as well as charges in excess of any maximum benefit limitations.

Selection of a Dentist

The covered person is solely responsible for selecting his or her own dentist. All decisions that require or pertain to independent professional dental/clinical judgment or training, or the need for dental or medical services, are solely the covered person's responsibility and that of his or her treating providers. The covered person and his or her dentist are responsible for deciding what care should be rendered or received and when that care should be provided. The Plan is only responsible for whether expenses incurred for dental care are covered under this Plan. In making coverage decisions, the Plan will not participate in or override a covered person's decisions concerning his or her health or the dental decisions of his or her medical and dental providers.

BENEFITS

The maximum benefit payable per person is shown in the Schedule of Benefits. The following describes covered dental benefits.

Preventative

1. Two (2) routine oral examinations per plan year;
2. Prophylaxis (cleaning, scaling and polishing of teeth), two (2) times per plan year;
3. Topical application of fluoride in conjunction with prophylaxis for covered dependent children under eighteen (18) years of age, two (2) times per plan year;
4. Bitewing x-rays, once per plan year; and
5. Periodontal maintenance procedures (following active therapy).

Basic

1. Palliative (emergency) treatment of an acute condition requiring immediate care;
2. Application of desensitizing medicaments;
3. Sealants for covered dependent children through age sixteen (16);
4. Periapical (root area) x-rays as required;
5. Complete mouth x-rays or panoramic x-rays (once in any thirty-six (36) consecutive month period.) Panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit;
6. Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;

7. Repair of broken partial or complete dentures;
8. Space maintainers (not made of precious metals) that replace prematurely lost teeth for covered dependent children under fourteen (14) years of age. No payment will be made for duplicate space maintainers;
9. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
10. Routine extractions;
11. Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment. No payment will be made for root canal therapy until treatment is completed. Treatment is considered to be complete on the date the canals are sealed;
12. General anesthesia given in a dentist's office for services that are; (a) performed by a person qualified to administer general anesthesia; (b) billed by such dentist; and (c) in connection with covered dental services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. The allowance for the administration of a local infiltration or block anesthetic in connection with other covered dental services is included in the allowance for these covered dental services;
13. Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year;
14. Adjustments to the maxillary and mandibular dentures, two (2) times per plan year beginning six (6) months after the initial placement date;
15. Recementation of space maintainers once per plan year and must be six (6) months after the initial placement date;
16. Replacement of core buildup, if satisfactory proof is provided that at least five (5) years have passed since the date of service when the procedure was performed;
17. Relining and rebasing of immediate dentures if more than six (6) months after the insertion of an initial or replacement denture with not more than one relining or rebasing in any thirty-six (36) consecutive month period;
18. Repair of broken crowns, inlays, onlays or bridges;
19. Surgical removal of teeth;
20. Surgical removal of maxillary or mandibular intrabony cysts;
21. Procedures performed for the preparation of the mouth for dentures;
22. Apicoectomy (dental root surgery);
23. Gingival curettage, payable once per quadrant every thirty-six (36) months;
24. Gingivectomy and gingivoplasty;

25. Periodontal scaling, payable once per quadrant every twenty-four (24) months;
26. Root amputation – per root;
27. Hemisection – (including any root removal), not including root canal therapy;
28. Alveoloplasty – per quadrant;
29. Gingival flap procedure – once per quadrant every thirty-six (36) months;
30. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis – payable every thirty-six (36) months; and
31. Cephalometric x-rays, but only in connection with orthodontic diagnosis, and only once in any thirty-six (36) consecutive month period.

Major

1. Clinical crown lengthening of hard tissue only, subject to dental consultant review for coverage approval and pricing; office notes are required for review;
2. Replacement of cast post and core along with prefabricated post and core procedures, if satisfactory proof is given that at least five (5) years have passed since the date of service when the procedure was performed;
3. Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays);
4. Initial insertion of partial or complete dentures (including any adjustments during the six (6) month period following insertion);
5. Replacement of an existing partial or complete denture or bridge by a new denture or by a new bridge, if satisfactory proof is given that:
 - (a) the existing denture or bridge was inserted at least five (5) years before it is replaced; and
 - (b) the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable;
6. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months;
7. Free soft tissue graft procedure, including donor site;
8. Frenulectomy;
9. Mucogingival surgery – once per quadrant every thirty-six (36) months;

10. Bone replacement graft – once per site every thirty-six (36) months;
11. Pedicle soft tissue graft – once per site every thirty-six (36) months;
12. Guided tissue regeneration – once per site every thirty-six (36) months; and
13. Subepithelial connective tissue graft – once per site every thirty-six (36) months.

Orthodontic Services

The following is a list of covered services for orthodontic services for the correction of an existing malocclusion and its attendant sequelae through the correction of malposed teeth:

1. Diagnosis, including radiographs and study models;
2. Active treatment, including necessary appliances; and
3. Retention treatment following active treatment.

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatments of root canals are payable one (1) year after completion date of root canal therapy.
2. Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
4. Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of covered dependent children.
5. General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
6. Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.
7. Periodontal services are limited to covered persons age eighteen (18) and older.

8. Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
9. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
10. Orthodontia services will be limited to the Lifetime Orthodontia Maximum shown on the Schedule of Benefits.
11. Benefits for covered orthodontia services will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect, not to exceed thirty-six (36) months.
12. If the treatment plan for covered orthodontia services is completed in less time than specified in the approved treatment plan, we will make payment in the amount of the remainder of the liability after we receive notice from the dentist.
13. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.
14. Benefit payment for orthodontic services will be limited to thirty-six (36) consecutive months' active treatment or eighteen (18) consecutive months' retention treatment. These limits will include the number of months of such treatment received prior to commencement of this coverage.

Exclusions

The following are excluded under this benefit booklet:

1. Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to a covered person's effective date of coverage, until the covered person has been covered under the Plan for twelve (12) consecutive months, unless otherwise specified in this benefit booklet.
2. Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
3. Charges for services or supplies when billed by other than a dentist.

4. Benefits for services rendered by a member of your family (your spouse and the children, brothers, sisters and parents of either you or your spouse).
5. Services rendered primarily for cosmetic purposes, except for orthodontic services rendered for correction of defects incurred through traumatic injuries which occurred while this coverage is in force.
6. Charges incurred for failure to keep a dental appointment.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
8. Medical services related to the treatment of temporomandibular joint (TMJ – temporal bone/lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
9. Experimental or investigational treatment.
10. Dental services received or rendered:
 - (a) through or in a veteran's hospital or government facility due to a service connected disability;
 - (b) which are covered and paid under Worker's Compensation or similar law; or
 - (c) which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total reasonable expenses that are actually incurred.
11. Services for which the covered person incurs no charge.
12. Procedures, appliances or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
13. Local anesthesia when billed separately by a dentist.

14. Any services paid or payable under the covered person's health or medical insurance plan, policy or contract.
15. Services not listed in the Benefits section of this benefit booklet.
16. Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this benefit booklet will be based on the allowance for the least costly service, procedure, or course of treatment.
17. Any additional treatment required due to the covered person's failure to follow instructions, or lack of cooperation with the dentist.
18. Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
19. Services rendered before the effective date of coverage or after termination of coverage.
20. Services rendered after termination of the Plan, except as provided under "Extension of Benefits upon Plan Termination."
21. Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
22. Any denture or bridge replacement made necessary by reason of loss, or alteration by a covered person, or a result of theft.
23. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the covered person's coverage under this benefit booklet.
24. Duplicate or temporary denture, crown, or bridge.

25. Labial Veneer restorations.
26. General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
27. Charges for nitrous oxide.
28. Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), if paid or payable under a covered person's health or medical insurance plan, policy, or contract.
29. Prescribed drugs, premedication or analgesia.
30. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues).
31. Charges for oral hygiene, plaque control, or diet instruction.
32. Charges for the replacement and/or repair of any orthodontic appliance furnished under the treatment plan or for any duplicate orthodontic device or appliance.