The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage, the Certificate/Plan Administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

**General Limitations**

**PERIODIC ORAL EVALUATION** Limited to 2 times every year.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to one time per 3 years. Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, cysts or neoplasms.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.

**EXTRAORAL RADIOGRAPHS** Limited to 1 films per calendar year.

**DENTAL PROPHYLAXIS** Limited to 2 prophylaxis and/or periodontal maintenance per calendar year.

**FLUORIDE TREATMENTS** Limited to Covered Persons under the age of 18 years, and limited to 1 time per calendar year.

**SEALANTS** Limited to Covered Persons under the age of 18 years and once per first or second permanent molar every 3 years.

**SPACE MAINTAINERS** Limited to Covered Persons under the age of 12 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation.

**RESTORATIONS** Multiple restorations on 1 surface will be treated as a single filling. Limited to 1 per 6 months.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.

**INLAYS AND ONLAYS** Limited to 1 time per tooth per every 5 years. Covered only when a filling cannot restore the tooth.

**CROWNS** Limited to 1 time per tooth per every 5 years. Covered only when a filling cannot restore the tooth.

**POST AND CORES** Covered only for teeth that have had root canal therapy.

**SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

**SCALING AND ROOT PLANNING** Limited to 1 time per quadrant per consecutive 12 months.

**ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.

**PERIODONTAL MAINTENANCE** Limited to 2 prophylaxis and/or periodontal maintenance every year, following active or adjunctive periodontal therapy; exclusive of gross debridement.

**FULL DENTURES** Limited to 1 time every 5 years. No additional allowances for precision or semi-precision attachments.

**PARTIAL DENTURES** Once per tooth every 5 years.

**RELINING AND REBASED DENTURES** Limited to relining/rebased performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

**REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

**PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than x-ray and radiographs, were performed on the same tooth during the visit.

**OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

**FULL MOUTH DEBRIDMENT** Limited to 1 time every consecutive 36 months.

**GENERAL ANESTHESIA** Covered only when clinically necessary.

**OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.

**PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per 2 years per surgical area.

**REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 every 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

**General Exclusions**

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacochemical regimes not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal identity or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Foreign services are not covered unless required as an Medical Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, replacement is necessary because of tissue, including excision.
14. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crowns or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMD).
24. Acupuncture; acupuncture and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours’ notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.