Dental Benefits

Savings, flexibility and service. For healthier smiles.

MetLife

Overview of Benefits for: EASTERSEALS SOUTH CAROLINA **Date Prepared: 09-28-2016**

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type	In-Network: % of Negotiated Fee	Out-of-Network: % of R&C Fee[1]
Type A	100%	100%
Type B	80%	80%
Type C	50%	50%
Orthodontia	50%	50%
Deductible: Individual/Family*	$50 (Type B & C)	$50 (Type B & C)
Annual Maximum Benefit: Per Individual	$1000	$1000
Orthodontia Lifetime Maximum: Per Individual	$1000	$1000
	Ortho applies to Child Only (up to age 19)	

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice —in or out of the network.

- Plan benefits for in-network services are based on the percentage of the negotiated fee – the fee that participating dentists have agreed to accept as payment in full for covered services
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits** and follow the easy registration instructions.

Certain plan benefits are based on a percentage of the negotiated fee. This is the amount that participating dentists have agreed to accept as payment in full. If your plan benefits are based on a percentage of the Reasonable and Customary (R&C) charges, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

* If you are enrolled for dependent coverage, a maximum family deductible may apply.

Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

Selected Covered Services and Frequency Limitations*

Type A	
• Oral Examinations	1 in 6 months.
• Cleanings	1 in 6 months.
• Fluoride	Children to age 14 / 1 in 12 months.
• Bitewing X-rays	Adult - 1 in 12 months / Children - 1 in 12 months.
• Full Mouth X-rays	1 in 60 months.
Type B	
• Periodontal Maintenance	4 in 1 year less the number of teeth cleanings.
• Space Maintainers	
• Emergency Palliative Treatment	
• Periodontal Root Planing & Scaling	1 per quadrant in any 24 months period.
• Periodontal Surgery	1 in 36 months.
• Sealants (1st & 2nd permanent molars)	1 per tooth in 60 months of a dependent child up to 14th birthday.
• Amalgam & Composite Fillings	1 per surface in 24 months.
• Root Canal	1 in 24 months.
Type C	
• Crowns	1 in 60 months.
• Dentures	1 in 10 years.
• Bridges	1 in 10 years.
• Simple Extractions	
• Surgical Extractions	
• Deep Sedation/General Anesthesia	each 15 minutes
• Repairs (Crowns)	1 in 12 months.
• Implants	1 in 60 months.
Orthodontia	
• Dependent children are covered up to their 19th birthday.	
• All procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.	

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

1. The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90th percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.
2. Services for which You would not be required to pay in the absence of Dental Insurance.
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person.
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
20. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
21. Caries susceptibility tests.
22. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
23. Other fixed Denture prosthetic services not described elsewhere in this certificate.
24. Precision attachments.
25. Adjustment of a Denture
26 Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
27 Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota. [1]
28. Repair or replacement of an orthodontic device.[1]
29. Duplicate prosthetic devices or appliances.
30. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
31. Intra and extraoral photographic images.

[1] Some of these exclusions may not apply. Please see your plan design and certificate for details.

COMMON QUESTIONS… IMPORTANT ANSWERS

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

Does the Preferred Dentist Program offer any discounts on non-covered services?
Negotiated fees may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If permitted, you may only be responsible for the negotiated fee.

* Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket expenses may be higher.
He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for PDP participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application*. The website and phone number are designed for use by dental professionals only.

* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

How are claims processed?
Dentists may submit your claims for you, which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits if you are registered on MetLife's MyBenefits. You can also request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics). To receive a benefit estimate, simply have your dentist submit a request for a pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate online or by fax for most procedures while you are still in the office so you can discuss treatment and payment options and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Do I need an ID card?
No, you do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, eligible employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage elected after the 31-day application period is subject to the following waiting periods:*

- No waiting period for Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

*If the policy holder participates in a section 125 plan and has an annual open enrollment period, the dental coverage will not be subject to any waiting periods. Please consult your Benefits Administrator or your certificate for this plan information.

Am I eligible for all benefits the first day of coverage?
Your plan may include benefit waiting periods. Please refer to the certificate of insurance or your Benefits Administrator for details about the services that are subject to the waiting periods and the length of time they apply.

How can I learn about what dentists in my area charge for different procedures?
If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where you can learn more about fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you approximate the in-network and out-of-network fees[1] dental services in your area.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through MetLife's International Dental Travel Assistance program[2] you can obtain a referral to a local dentist by calling 1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network[3] benefits. Please remember to hold on to all receipts to submit a dental claim.

1 Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, pre-treatment estimates through your dentist will provide the most accurate fee and payment information.
2 International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services provided are separate and apart from the benefits provided by MetLife.
3 Refer to your dental benefits plan summary your out-of-network dental coverage.

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Por favor, indique a quién y a dónde debe enviarse el documento traducido.
NOMBRE_____

DIRECCIÓN_____

☐ **免費語言服務。**您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。
爲收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____

地址_____

Անվճար թարգմանչական ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus lv-saws-las ntawm 1-800-927-4357.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضہ مترجم دی خدمات مل سکدی اے۔ تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گر ہوتو، دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔

CA LAP STANDALONE NOTICE **September 2008**

SCHEDULE OF BENEFITS

MetLife

SOUTH CAROLINA HEALTH BENEFITS (EHB) PLAN

This schedule shows the benefits that are available under the Group Policy. Your Dependents will only be insured for the benefits:

- for which Your Dependents become and remain eligible, and
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For Your Dependents

This certificate only applies to a Child until the end of the Year in which the Child reaches age 19. This certificate describes the benefit available under the Pediatric Dental Essential Health Benefit. However if Your Dependent Child receives a covered service, and is also covered for that covered service under another certificate under the same policy between the Group Policyholder and MetLife, We will pay the higher of the two benefits for that covered service.

Covered Percentage for:	**In-Network based on the Maximum Allowed Charge**	**Out-of-Network based on the Maximum Allowed Charge**
Type A Services	90%	80%
Type B Services	50%	40%
Type C Services	50%	40%
Type D Services (medically necessary Orthodontics)	50%	50%
Deductibles for:	**In-Network**	**Out-of-Network**
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type A, Type B & Type C	$100 for the following Covered Services Combined: Type A, Type B & Type C

Maximum Benefit:	**In-Network**	**Out-of-Network**
Yearly (Annual)* Individual Maximum	None	None
Lifetime Individual Maximum for Type D Covered Services (medically necessary Orthodontics)	None	None

*For a Child under age 19, there is no lifetime maximum for pediatric essential health benefits provided by an In-Network or an Out-of-Network Dentist.

Out-of-Pocket Annual (Yearly) Maximum:	**In-Network**	**Out-of-Network**
Individual Out-of-Pocket Annual Maximum (for 1 Child)	$350 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None
Family Out-of-Pocket Annual Maximum (for 2 or more Children)	$700 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams, oral evaluation for a patient under 3 years of age and counseling with a primary caregiver and limited oral evaluation – problem focused, with a combined frequency limitation of once every 6 months also combined with detailed and extensive oral evaluation – problem focused, by report.

2. Full mouth x-rays, but not more than once every 60 months.

3. Bitewing x-rays, but not more than 1 set every 6 months. Periapical films on an emergency or episodic basis are a Covered Service.

4. Dental x-rays except as mentioned elsewhere in this certificate.

5. Cleaning of teeth (oral prophylaxis), but not more than once every 6 months including periodontal cleanings.

6. Topical fluoride treatment, but not more than twice in 12 months.

7. Sealants which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 36 months.

8. Space maintainers.

9. Emergency palliative treatment of dental pain.

10. Preventive resin restoration in a moderate to high caries risk patient – applied to non-restored, non-decayed first and second permanent molar.

Type B Covered Services

1. Fillings: Amalgam and resin composite. Restorations are limited as follows:

   - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a Covered Service.
   - Composite resin or acrylic restorations on molar teeth will be benefited as an alternative benefit.
   - Micro filled resin restorations which are non-cosmetic.
   - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

2. Sedative fillings.

3. Prefabricated crowns, but no more than one replacement for the same tooth surface within 60 months for a Covered Person under 15 years of age.

4. Simple extractions.

5. Surgical extractions. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.
6. Oral surgery except as mentioned elsewhere in this certificate.

7. Pulp capping.

8. Pulp therapy.

9. Therapeutic pulpotomy. (If a root canal is completed within 45 days of the pulpotomy, We will only pay benefits for the root canal therapy.)

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (Continued)

10. Recementations.

11. Adjustment of a Denture made 6 or more months after installation by the same Dentist who installed it.

12. Relinings and rebasings of existing removable Dentures made 6 or more months after installation by the same Dentist who installed them, but not more than once in any 36 month period.

13. Tissue conditioning.

14. Consultations.

15. Adjunctive general services.

16. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty, and osseous surgery) has been performed. Periodontal maintenance is limited four times per 12 months less the number of teeth cleanings received during such 12 months.

17. Periodontal, non-surgical treatment.

18. Scaling and root planing, but not more than once per quadrant in any 24 month period.

19. Adding teeth to Dentures.

20. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when such anesthesia is determined to be medically necessary or Dentally Necessary.

21. Injections of therapeutic drugs.

Type C Covered Services

1. Periodontal surgery, but not more than one surgical procedure per quadrant in any 36 month period**.**

2. Periodontal soft and connective tissue grafts, but no more than one per unique site per 36 months.

3. Detailed and extensive oral evaluation – problem focused, by report, but not more than once every 6 months combined with oral examinations.

4. Initial installation of Cast Restorations.

5. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 60 months of a prior replacement.

6. Crown buildups/post and core, but no more than once per tooth in a period of 60 months.

7. Simple repairs of Cast Restorations.

8. Repair of Dentures.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (Continued)

9. Root canal treatment (initial treatment), but no more than once per tooth per lifetime.

10. Apexification/recalcification.

11. Full mouth debridements, but no more than once per lifetime.

12. Initial installation of full or removable Dentures, but no more than once every 60 months. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers are only available if they are Dentally Necessary.

13. Fixed partial dentures, but no more than once every 60 months, and only if they are Dentally Necessary and a partial cannot satisfactorily restore the case. (If fixed partial dentures are used when a partial could satisfactorily restore the case, the benefit determination will be based upon the partial which is the less costly service.)

14. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and only if such replacement is done within 12 months of the installation of the immediate, temporary full Denture.

15. Replacement of a non-serviceable removable Denture, but only if such Denture was installed more than 60 months prior to replacement.

16. Replacement of a non-serviceable fixed Denture, but only if such Denture was installed more than 60 months prior to replacement.

17. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation) but no more than once for the same tooth position in a 60 month period.

18. Repair of implants, but not more than once in a 60 month period.

19. Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period.

20. Occlusal guards, but no more than one every 12 months and only for a Covered Person age 13 and older.

21. Local chemotherapeutic agents.

Type D Covered Services

Orthodontia, must be medically necessary and must begin while this insurance is in force. If the insurance ends during the course of the treatment, the monthly payments will end. Dental procedures performed in connection with Orthodontia treatment are considered under the Orthodontia benefit.

The Lifetime Individual Maximum Benefit Amount and Out-of-Pocket Annual Maximum for orthodontia is shown in the SCHEDULE OF BENEFITS.

DENTAL INSURANCE: EXCLUSIONS

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.

2. Services for which a Dependent would not be required to pay in the absence of Dental Insurance.

3. Services or supplies received by Your Dependent before the Dental Insurance starts for that person.

4. Services not performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:

    - scaling and polishing of teeth; or
    - fluoride treatments.

5. Services which are primarily cosmetic, unless.

    - required for the treatment or correction of a congenital defect of a newborn Child; or
    - required for the treatment of a congenital cleft in the lip or palate, or both.

6. Replacement of an orthodontic appliance.

7. Services or appliances which restore or alter occlusion or vertical dimension.

8. Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.

9. Restorations or appliances used for the purpose of periodontal splinting.

10. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.

11. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.

12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.

13. Charges for missed appointments.

14. Services:

    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.

15. Services covered under other coverage provided by the Employer.

16. Temporary or provisional restorations.

17. Temporary or provisional appliances.

18. Prescription drugs.

19. The following when charged by the Dentist on a separate basis:

    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.

20. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.

21. Intra and extraoral photographic images.

22. Services for which the submitted documentation indicates a poor prognosis.

23. Caries susceptibility tests, pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents..

25. Labial veneers.

26. Modification of removable prosthodontic and other removable prosthetic services.

27. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.

28. Application of desensitizing agents and occlusal adjustments.

29. Fixed and removable appliances for correction of harmful habits, unless part of overall treatment plan for medically necessary Orthodontia.

31. Precision attachments associated with fixed and removable prostheses..

32. Biopsies of hard or soft oral tissue.

33. Duplicate prosthetic devices or appliances.

34. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.

35. Composite resin or acrylic restorations for posterior molars.

36. The prophylactic removal of third molars is not a Covered Service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.

37. Any procedures not specifically listed as a Covered Service.

38. The following services are not Covered Services:

    - a connector bar;
    - a stress breaker; or
    - coping.