### Covered Services

**Covered Services Include:**
- Preventive Services
- Diagnostic Services
- Basic Dental Services
- Major Dental Services
- Orthodontic Services

**Benefit Guidelines:**
- Limited to 1 time per tooth per lifetime.
- 80% limited to 1 time per tooth per consecutive 60 months.
- 60% limited to 1 time per tooth per consecutive 24 months.

**Non-Network Benefits:**
- The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

**Network Benefits:**
- The network percentage of benefits is based on the discounted fee negotiated with the provider.

### Orthodontics

**Limited to 1 time per tooth per lifetime.**

- Root Canal Therapy

### Preventive Services

- **Dental Prophylaxis (Cleanings):** Limited to 2 times per consecutive 12 months.
- **Fluoride Treatments:** Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
- **Sealants:** Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
- **Space Maintainers:** For covered persons under the age of 16 years, limit 1 per consecutive 60 months.

### Basic Dental Services

- **Restorations:** Amalgam or Anterior Composite
- **General Services:** (including Emergency Treatment)

### Major Dental Services

- **Inlays/Onlays/Crowns:** Limited to 1 time per tooth per consecutive 60 months.
- **Dentures and other Removable Prosthetics:** Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- **Fixed Partial Dentures (Bridges):** Limited to 1 time per tooth per consecutive 60 months.

### Orthodontics

- **Diagnose or correct misalignment of the teeth or bite:** 50% and 50%.

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*Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agree on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.**

**The network percentage of benefits is based on the discounted fee negotiated with the provider.**

**The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.**

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.
**GENERAL LIMITATIONS**

- **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
- **COMPLETE SERIES OR PANOREX RADIOGRAPHY** Limited to 1 time per consecutive 36 months.
- **BITEWING RADIOGRAPHY** Limited to 1 series of films per calendar year.
- **EXTRAORAL RADIOGRAPHY** Limited to 2 films per calendar year.
- **DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.
- **FLUORIDATION TREATMENT** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

**SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

**SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

**RESTORATIONS** Multiple restorations on one surface will be treated as a single filling.

**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 consecutive 60 months. Covered only when a filling cannot restore the tooth.

**CROWNS** Limited to 1 time per tooth per consecutive 60 months. 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 24 months.

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

**PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

**COMPLETE DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

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

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

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

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

**FULL MOUTH DEBRIDEMENT** 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 quadrant or site per consecutive 36 months 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 time per consecutive 60 months 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 dental procedure not performed in a dental setting.**
7. **Procedures that are considered to be Experimental, Investigational or Unproven.** This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmaceutical 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 residence as a covered person 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 Emergency.**
13. **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.
14. **Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction.**
15. **Attachments to conventional removable prostheses or fixed bridgework.** This includes semi-precision or precision attachments associated with partial dentures, crown 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.
16. **Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).**
17. **Placement of dental implants, implant-supported abutments and prostheses.**
18. **Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.**
19. **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.
20. **Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.**
21. **Services related to the temporomandibular joint (TMJ), either bilateral or unilateral.** Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. **Acupuncture; acupuncture and other forms of alternative treatment, whether or not used as anesthesia.**
23. **Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.**
24. **Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.**
25. **Occlusal guards used as safety items or to affect performance primarily in sports-related activities.**
26. **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.**
27. **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.**