DESCRIPTION OF COVERED SERVICES

Preventive and Diagnostic Services

1. Oral exams and problem-focused exams, but no more than twice in a calendar year.

2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a calendar year.

3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a calendar year.

1. Bitewing x-rays:
   - 1 set every 6 months for a Child; and
   - 1 set every calendar year for everyone else.

2. Cleaning of teeth (oral prophylaxis) twice in a calendar year.

3. Topical fluoride treatment for a Child under age 14 once in a calendar year.

Basic Restorative Services (Covered after a Waiting Period of 6 months)

1. Intraoral-periapical and extraoral x-rays.

2. Full mouth or panoramic x-rays once every 60 months.

3. X-rays, except as mentioned elsewhere.

4. Pulp vitality and bacteriological studies for determination of bacteriologic agents.

5. Genetic test for susceptibility to oral diseases.


7. Initial placement of amalgam or resin fillings.

8. Replacement of an existing amalgam or resin fillings, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.

9. Protective (Sedative) Fillings.

10. 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 to four times in any calendar year less the number of teeth cleanings received during such 12 month period.

11. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.

12. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
V. DESCRIPTION OF COVERED SERVICES (continued)

Basic Restorative Services (Covered after a Waiting Period of 6 months) (continued)

13. Space maintainers for a Child under age 14 once per lifetime per tooth area.

14. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.

15. Preventive resin restorations which are applied to non-restored first and second permanent molars, once per tooth every 60 months.

16. Pulp therapy.

17. Simple extractions.

Major Restorative Services (Covered after a Waiting Period of 12 months)

1. Apexification/recalcification.

2. Diagnostic casts.

3. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.

4. Local chemotherapeutic agents.

5. Injections of therapeutic drugs.

6. Initial installation of full or partial Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth that are lost while the person receiving such benefits was insured under this policy.

7. Addition of teeth to a partial removable Denture to replace natural teeth removed while insurance under this policy was in effect for the person receiving such services.

8. Replacement of a non-serviceable Denture if such Denture was installed more than 10 years prior to replacement.

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

10. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.

11. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
V. DESCRIPTION OF COVERED SERVICES (continued)

Major Restorative Services (Covered after a Waiting Period of 12 months) (continued)

12. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.

13. Initial installation of Cast Restorations (except implant supported Cast Restorations).

14. Replacement of any Cast Restoration (except implant supported Cast Restorations) with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth within 10 years of the initial installation or a prior replacement.

15. Prefabricated crown, but no more than one replacement for the same tooth within 10 years.

16. Core buildup, but no more than once per tooth in a period of 10 years.

17. Posts and cores, but no more than once per tooth in a period of 10 years.

18. Oral Surgery, except as mentioned elsewhere in this SCHEDULE OF BENEFITS.

19. Consultations or interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.

20. Other consultations, but not more than once in a 12 month period.

21. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.

22. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.

23. Periodontal surgery, including gingivectomy, gingivoplasty, and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.

24. Surgical extractions.

25. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth that are lost while the person receiving such benefits was insured under this policy.

   but no more than once for the same tooth position in a 10 year period.

26. Repair of implants, but not more than once in a 12 month period.
V. DESCRIPTION OF COVERED SERVICES (continued)

Major Restorative Services (Covered after a Waiting Period of 12 months) (continued)

27. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 year period.

28. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 year period.

29. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 year period.

30. Tissue conditioning, but not more than once in a 36 month period.

31. Simple repair of Cast Restorations or Dentures, but not more than once in a 12 month period.

32. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

33. Full mouth debridements, but not more than once per lifetime.

34. Occlusal adjustments, but not more than once in a 12 month period.

35. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, but not more than once in a 24 month period.

36. Cleaning and inspection of a removable appliance once every 6 months.

Orthodontic Covered Services (Covered after a Waiting Period of 12 months)

Orthodontia for a Child up to age 19.
EXCLUSIONS

We will not pay benefits under this policy 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 a Covered Person before insurance under this policy starts for that person;
4. 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;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child or for the treatment of a congenital cleft in the lip or palate or both;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
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. initial installation of a Denture or implant to replace one or more teeth which were missing before such person was insured under this policy, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. 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 Covered Person receiving such services is required to pay; or
   - received at a facility maintained by an employer, labor union, mutual benefit association, or VA hospital;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
EXCLUSIONS (continued)

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. fixed and removable appliances for correction of harmful habits;
23. biopsies of hard or soft oral tissue;
24. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
25. modification of removable prosthodontic and other removable prosthetic services;
26. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
27. duplicate prosthetic devices or appliances;
28. replacement of a lost or stolen appliance, Cast Restoration or Denture;
29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging cone beam imaging associated with the treatment of temporomandibular joint disorders;
30. intra and extraoral photographic images;
31. replacement of an orthodontic device;
32. any services for which a Waiting Period applies where the Covered Person has not satisfied the Waiting Period requirement on the date of the service;
33. services delivered outside the United States, except for Emergency Dental Conditions up to a maximum benefit of $100 per calendar year.