PREMIER ACCESS

California Family Dental PPO

This summary of benefits, along with the exclusions and limitations describe the benefits of the California Family Dental PPO Plan. Please review closely to understand all benefits, exclusions and limitations. Member Cost Share amounts describe the Enrollee's out of pocket costs.

Child-ONLY* Essential Health Benefit	Member Cost Share In-Network	Covered Percentage In Network	Member Cost Share Out-of-Network**	Covered Percentage Out-of-Network** Network
Class I/Preventive - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain, and Radiographs-Bitewings	0%	100%	0%	100%
Class II/Basic - Radiographs (Full Mouth X-ray, Panoramic Film) Restorations (Amalgams and Anterior Resins), Simple Extractions and Anesthesia (General Anesthesia and Intravenous Sedation)	20%	80%	20%	80%
Class III/Major - Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics, Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures, and Denture Repair.	50%	50%	50%	50%
Class IV/Orthodontia *(Only for pre-authorized Medically Necessary Orthodontia)*	50%	50%	50%	50%
Deductible (waived for Class I)(per person)	$65	N/A	$65	N/A
Family Deductible (waived for Class I)(2+ children)	$130	N/A	$130	N/A
Out of Pocket Maximum (OOP) (per person)	$350	N/A	N/A	N/A
Family Out of Pocket Maximum*** (OOP) (2+ children)	$700	N/A	N/A	N/A
Annual Maximum	N/A			
Ortho Lifetime Maximum	N/A			
Waiting Period	N/A			

** This plan is available for individuals up to age 19.*
***Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.*
****2 family members must each meet the out of pocket maximum in a plan year. Once fulfilled the family maximum has been met and will not be applied to additional family members*

California Essential Health Benefit – PPO Family with EHB (for Children)

Adult-ONLY* PPO Plan	Member Cost Share In-Network	Covered Percentage In Network	Member Cost Share Out-of-Network**	Covered Percentage Out-of-Network** Network
Class I/Preventive - Cleanings, Exams, Emergency ain, Radiographs-Bitewings, Radiographs (Full Mout X-ray, Panoramic Film)	0%	100%	0%	100%
Class II/Basic - Restorations (Amalgams &Anterior Resin), Simple Extractions, Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics, and Anesthesia	20%	80%	20%	80%
Class III/Major - Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures, and Denture Repair.	50%	50%	50%	50%
Class IV/Orthodontia	N/A			
Deductible (waived for Class I)	$50			
Family Deductible (waived for Class I)(2+ children)	N/A			
Out of Pocket Maximum (OOP) (per person)	N/A			
Out of Pocket Maximum (OOP) (per family - 2+ children)	N/A			
Annual Maximum	$1,500			
Ortho Lifetime Maximum	N/A			
Waiting Period	6 months for Major Services (Waived with proof of prior coverage)			

** This plan is available for individuals ages 19 and over.*
***Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.*

CLASSES OF COVERED SERVICES AND SUPPLIES
(Individuals up to Age 19)

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

Class I: Preventive Dental Services

Diagnostic and Preventive Benefits
Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Radiographs (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Limitations
X-Rays are limited as follows:

- Exams are limited to two in a 12 month period
- Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months
- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
- Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period
- Fluoride treatments are limited to two in a 12 month period
- Dental sealant treatments are limited to permanent first and second molars only

Class II: Basic Dental Services

Restorative Dentistry
Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations
Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional
- Composite resin or acrylic restorations in posterior teeth are optional

- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary

Class III: Major Dental Services

Oral Surgery

Oral Surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists

Endodontics

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit

Periodontics

Periodontic benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months

Crown and Fixed Bridge

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitations

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every sixty (60) consecutive months, except when the crown is no longer functional as determined by the dental plan
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case.
    - If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic
- Fixed bridges are optional when provided in connection with a partial denture on the same arch
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair
- The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment

Removable Prosthetics

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space Maintainer
- Stayplate

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within sixty (60) consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
  2. The denture is unsatisfactory and cannot be made satisfactory
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional
- Full upper and/or lower dentures are not to be replaced within sixty (60) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges
- Office or laboratory relines or rebases are limited to one (1) per arch in any twelve
- (12) consecutive months
- Tissue conditioning is limited to two (2) per denture
- Implants are considered an optional benefit
- Stayplates are a benefit only when used as anterior space maintainers for children

Class IV: Medically Necessary Orthodontia

Orthodontics

Medically necessary orthodontia is treatment to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions..

Other Benefits

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

General Exclusions

Covered Services and Supplies do not include:

1. Treatment which is:
   a. not included in the list of Covered Services and Supplies except Medically Necessary Orthodontia;
   b. not Dentally Necessary; or
   c. Experimental in nature.
2. Any Charges which are:
   a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a

governmental agency of the United States. However, the Plan will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.

b. Not imposed against the person or for which the person is not liable.

c. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.

3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
   a. a Close Relative or a person who ordinarily resides with You or a Dependent;
   b. an Employee of the Employer;
   c. the Employer.
5. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
6. Services and supplies provided primarily for cosmetic purposes.
7. Services and supplies obtained while outside of the United States, except for Emergency Dental Care.
8. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
9. Diagnostic casts.
10. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
11. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
12. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
13. Veneers
14. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
15. Replacement of a lost or stolen Appliance or Prosthesis.
16. Replacement of stayplates.
17. Extraction of pathology-free teeth, including supernumerary teeth (unless for medically necessary orthodontia)
18. Socket preservation bone graphs
19. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
20. Treatment for a jaw fracture.
21. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
22. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
23. Oral sedation and nitrous oxide analgesia are not covered.
24. Therapeutic drug injection.

25. Charges for completion of claim forms.
26. Missed dental appointments.
27. The difference in cost between a covered service and an optional service. For instance, when an amalgam is an appropriate restorative treatment and a crown is opted instead. The amount of the benefit payment will be for the amalgam only.

CLASSES OF COVERED SERVICES AND SUPPLIES
(Individuals age 19 and over)

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

Class I: Preventive Dental Services

- Comprehensive exams, periodic exams, evaluations, re-evaluations, limited oral exams, or periodontal evaluations. Limited to 1 per 6 month period
- Dental prophylaxis (cleaning and scaling). Benefit limited to either 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period, but not both.
- Topical fluoride treatment.
  - Limited to one per 6 month period.
- Palliative (emergency) treatment of dental pain
  - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the same visit.
- Sealant applications are limited to one per 36 month period, on un-restored pit and fissures of a 1st and 2nd permanent molar.
- X-rays:
  - Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film. Limited to one per 60 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x- rays in a calendar year.
  - Bitewing x-rays (two or four films). Limited to one per 12 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x- rays in a calendar year.
- Other X-rays:
  - Intraoral periapical x-rays.
  - Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.
  - Intraoral occlusal x-rays, limited to one film per arch per 6 month period.
  - Extraoral x-rays, limited to one film per 6 month period.
  - Other x-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).

Class II: Basic Dental Services

- Amalgam and composite restorations, limited as follows:
  - Multiple restorations on one surface will be considered a single filling.
  - Multiple restorations on different surfaces of the same tooth will be considered connected.
  - Benefits for replacement of an existing restoration will only be considered for payment if at least 36 months have passed since the existing restoration was placed (except in extraordinary circumstances involving external, violent and accidental means

or due to radiation therapy).
  - Additional fillings on the same surface of a tooth in less than 36 months, by the same office or same Dentist are not covered, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy.
  - Sedative bases and liners are considered part of the restorative service and are not paid as separate procedures.
  - Composite restorations are also limited as follows:
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations on anterior teeth will be considered single surface restorations
    - Acid etch is not covered as a separate procedure
    - Benefits limited to anterior teeth only.
    - Benefits for composite resin restorations on posterior teeth are limited to the benefit for the corresponding amalgam restoration.
- Pins, in conjunction with a final amalgam restoration
- Space maintainers, including all adjustments made within 6 months of installation.
- Stainless steel crowns, limited to one per 36 month period for teeth not restorable by an amalgam or composite filling.
- Pulpotomy (primary teeth only).
- Root canal therapy:
  - Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care
  - Limited to one time on the same tooth per 24 month period by the same provider.
  - Limited to permanent teeth only.
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all preoperative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling - per root.
- Root amputation - per root.
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care does not include a benefit for root canal therapy.
- Periodontal scaling and root planing, limited as follows:
  - 4 or more teeth per quadrant, limited to a minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per quadrant per 24 month period.
  - 1 to 3 teeth per quadrant, limited to minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per area per 24 month period.
  - Under unusual circumstances, additional documentation can be submitted to the Plan for review.
  - Following osseous surgery root planing is a benefit after 36 months in the same area.
- Periodontal maintenance procedure (following active treatment). Benefit limited to either 1 periodontal maintenance procedure or 1 dental prophylaxis per 6 month period, but not both
- Periodontal maintenance procedures may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than 3 months thereafter. The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.
- Periodontal related services as listed below, limited to one time per quadrant of the mouth in any 36 month period with charges combined

for procedures as listed below:
  - Gingival flap procedures.
  - Gingivectomy procedures.
  - Osseous surgery.
  - Pedicle tissue grafts.
  - Soft tissue grafts.
  - Subepithelial tissue grafts.
  - Bone replacement grafts.
  - Guided tissue regeneration.
  - Crown lengthening procedures - hard tissue.
  - The most inclusive procedure will be considered for payment when 2 or more surgical procedures are performed.

- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
  - Simple extractions
  - Surgical extractions, including extraction of third molars with pathology (wisdom teeth)
  - Alveoplasty
  - Vestibuloplasty
  - Removal of exostoses (including tori) – maxilla or mandible
  - Frenulectomy (frenectomy or frenotomy)
  - Excision of hyperplasic tissue – per arch
- Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus, limited to permanent teeth only.
- Root removal – exposed roots.
- Biopsy
- Incision and drainage
- The most inclusive procedure will be considered for payment when two or more surgical procedures are performed.
- General anesthesia and intravenous sedation, limited as follows:
  - Considered for payment as a separate benefit only when medically necessary (as determined by the Plan) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.
  - Not a benefit for the management of fear and anxiety;
  - Oral sedation is not a covered benefit.
- Consultation, including specialist consultations, limited as follows:
  - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date.
  - Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.

Class III: Major Dental Services

- Inlays and onlays (metallic), limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Build-up procedure is considered covered and is inclusive in the fee.
  - Benefits are based on the date of cementation.
- Porcelain restorations on anterior teeth, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to permanent teeth. Porcelain restorations on over-retained primary teeth are not covered.

  - Build-up procedure is considered covered and is inclusive in the fee.
  - Benefits are based on the date of cementation.
- Cast crowns, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to permanent teeth. Cast crowns on over-retained primary teeth are not covered.
  - Crowns on third molars are covered when adjacent first or second molars are missing and the tooth is in function with an opposing natural tooth.
  - Build-up procedure is considered covered and inclusive in the fee.
  - Benefits are based on the date of cementation.
- Crown lengthening is limited to a single site when contiguous teeth are involved.
- Re-cementing inlays, crowns and bridgesis limited to three per tooth, 12 months after last cementation.
- Post and core:
  - Covered only for endodontically- treated teeth, which require crowns.
  - 1 post and core is covered per tooth.
- Full dentures, limited as follows:
  - Limited to 1 full denture per arch.
  - Replacement covered only if 5 years have elapsed since last replacement AND the full denture cannot be made serviceable (please refer to the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions).
  - Services include any adjustments or relines which are performed within 12 month of initial insertion.
  - We will not pay additional benefits for personalized dentures or overdentures or associated treatment.
  - Benefits for dentures are based on the date of delivery.
- Partial dentures, including any clasps and rests and all teeth, limited as follows:
  - Limited to one partial denture per arch.
  - Replacement covered only if 5 years have elapsed since last placement AND the partial denture cannot be made serviceable (please refer to the denture or bridge replacement/addition provision under exclusions and limitations for exceptions).
  - Services include any adjustments or relines which are performed within 12 months of initial insertion.
  - There are no benefits for precision or semi-precision attachments.
  - Benefits for partial dentures are based on the date of delivery.
- Denture adjustments are limited to:
  - One time in any 12 month period; and
  - Adjustments made more than 12 months after the insertion of the denture.
- Repairs to full or partial dentures, bridges, and crowns are limited to repairs or adjustments performed up to 3 times after the initial insertion.
- Rebasing dentures are limited to one time per 12 month period.
- Relining dentures is a covered benefit 12 months after initial insertion of the denture.
  - Limited to one time per 12 month period
- Tissue conditioning is limited to one time in a 12 month period.
- Fixed bridges (including Maryland bridges) are limited as follows:
  - Benefits for the replacement of an existing fixed bridge are

payable only if the existing bridge:
    - Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions); and
    - Cannot be made serviceable.
  - A fixed bridge replacing the extracted portion of a hemisected tooth is not covered.
  - Placement and replacement of a cantilever bridge on posterior teeth will not be covered.
  - Benefits for bridges are based on the date of cementation.
- Re-cementing bridges is limited to repairs or adjustment performed more than 12 months after the initial insertion.

EXCLUSIONS AND LIMITATIONS

Treatment Outside of the Covered Service Area

Treatment outside of your covered state and/or United States is not covered, unless the treatment is for emergency care. Coverage for emergency services is limited to a reimbursement amount of $100.00. Please refer to your Certificate of Insurance for additional information regarding emergency care.

Missing Teeth Limitation

Initial placement of a full denture, partial denture or fixed bridge will not be covered by the Plan to replace teeth that were missing prior to the effective date of coverage for You or Your Dependents. However, expenses for the replacement of teeth that were missing prior to the effective date will only be considered for coverage, if the tooth was extracted within 12 months of the effective date of the Policy and while You or Your Dependent were covered under a Prior Plan.

Denture or Bridge Replacement/Addition

- Replacement of a full denture, partial denture, or fixed bridge is covered when:
  - 5 years have elapsed since last replacement of the denture or bridge; OR
  - The denture or bridge was damaged while in the Covered Person's mouth when an injury was suffered involving external, violent and accidental means. The injury must have occurred while insured under this Policy, and the appliance cannot be made serviceable.

  However, the following exceptions will apply:

  - Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth that cannot be added to the existing partial denture.
  - Benefits for the replacement of an existing fixed bridge that is less than 5 years old will be payable if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth, and the extracted tooth was not an abutment to an existing bridge.
- Replacement of a lost bridge is not a Covered Benefit.
- A bridge to replace extracted roots when the majority of the natural crown is missing is not a Covered Benefit.
- Replacement of an extracted tooth will not be considered a Covered Benefit if the tooth was an abutment of an existing Prosthesis that is less than 5 years old.
- Replacement of an existing partial denture, full denture, crown or bridge with more costly units/different type of units is limited to the

corresponding benefit for the existing unit being replaced.

Implants

Implants, and procedures and appliances associated with them, are not covered.

General Exclusions

Covered Services and Supplies do not include:

1. Treatment which is:
    a. not included in the list of Covered Services and Supplies;
    b. not Dentally Necessary; or
    c. Experimental in nature.
2. Any Charges which are:
    d. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Plan will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
    e. Not imposed against the person or for which the person is not liable.
    f. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
    a. a Close Relative or a person who ordinarily resides with You or a Dependent;
    b. an Employee of the Employer;
    c. the Employer.
5. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least 3 years, as determined by the Plan.
6. All services for which a claim is received more than 6 months after the date of service.
7. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
8. Services and supplies provided primarily for cosmetic purposes.
9. Services and supplies obtained while outside of the United States, except for Emergency Dental Care.
10. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
11. Diagnostic casts.
12. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
13. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
14. Restorative procedures, root canals and appliances, which are provided

because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.

15. Veneers
16. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
17. Replacement of a lost or stolen Appliance or Prosthesis.
18. Replacement of stayplates.
19. Extraction of pathology-free teeth, including supernumerary teeth.
20. Socket preservation bone graphs
21. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
22. Treatment for a jaw fracture.
23. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
24. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
25. Oral sedation and nitrous oxide analgesia are not covered.
26. Therapeutic drug injection.
27. Charges for the completion of claim forms.
28. Missed dental appointments.
29. Replacement of missing teeth prior to coverage effective date