

Dental Benefits

Benefits are provided for a Covered Service incurred for the following dental services. A Covered Service is incurred on the date the Insured receives the service or supply for which the charge is made.

Deductible

- 1. Your Yearly Deductible for Covered Services is \$25.00. During each Year, You are responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts toward the Deductible so amounts over Covered Expense a Non-Contracting Dentist may charge You won't count. **The Deductible does not apply to diagnostic and preventive services when performed by a Contracting Dentist.**

Yearly Maximum Benefit

All dental benefits are limited to a maximum payment of \$500.00 for expense incurred by You during a Year.

Payment

Payment is provided as follows for Covered Expense incurred. All payments are subject to any maximum amounts, limitations and exclusions as indicated in this Plan. If a Contracting Dentist provides services, any billed amount above Covered Expense will be a savings to You. Contracting Dentists have agreed to accept the Negotiated Fee Rate as payment in full. Non-Contracting Dentists have no such policy with UniCare, therefore, they will bill You for any amounts over Covered Expense in addition to any deductible.

What The Plan Pays For

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE. NO BENEFITS WILL BE PROVIDED FOR ANYTHING ELSE.

At a Contracting Dentist benefits will be paid for Covered Expenses as follows:

- 100% of the Covered Expense You incur for diagnostic and preventive services (see Benefit Schedule below for a list of Covered Services) (Deductible is waived); and
- 80% of the Covered Expense You incur in excess of the Deductible for fillings (see Benefit Schedule below for a list of Covered Services).

At a Non-Contracting Dentist:

Benefits will be paid as indicated in the following Benefit Schedule **(after the deductible has been satisfied)**. Please note, You may have a greater share of the costs if services are performed by a Non-Contracting Dentist.

Benefit Schedule

Diagnostic and Preventive care

Procedure Code and Description	At a Non-Contracting Dentist, the Plan Pays
*D0120 Periodic Oral Exam (limited to 2 per Insured per year).....	\$15
*D0140 Limited oral exam.....	\$20
*D0150 Initial oral exam.....	\$18
*D0160 Detailed and extensive oral exam-new or established patient	\$41
*D0170 Re-evaluation exam-limited, problem focused.....	\$23
*D0180 Comprehensive periodontal exam-new or established patient.....	\$20

**D0210 Full mouth X-rays (limited to one set every 3 years).....	\$43
D0220 Single (periapical) X-rays – first film.....	\$9
D0230 Single X-rays – additional films	\$9
D0240 Intraoral – Occlusal film.....	\$12
D0250 Extraoral- First film	\$11
D0260 Extraoral- Each additional film.....	\$7
D0270 Bitewing X-rays – single film	\$11
D0272 Bitewing X-rays – two films	\$14
D0274 Bitewing X-rays – four films.....	\$20
D0277 Vertical bitewing X-rays.....	\$14
**D0290 Posterior-anterior or lateral skull and facial bone survey film.....	\$35
**D0330 Panoramic X-ray.....	\$28
**D0340 Cephalometric film.....	\$30
D1110 Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	\$33
D1120 Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	\$21
D1201 Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per year)	\$33
D1203 Topical fluoride only (child through age 18) (limited to 2 per year)	\$14
D1205 Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	\$33
*Exams are limited to two per Year	
** Full mouth X-rays or its equivalent are limited to one set every 3 Years.	

Fillings

After the Deductible has been satisfied, benefits will be paid for fillings as specified in the following Benefit Schedule. Please note, You may have a greater share of the costs if services are performed by a Non-Contracting Dentist.

Procedure Code and Brief Description	At a Non-Contracting Dentist, the Plan Pays
D2140 Amalgam filling – one surface, primary or permanent.....	\$32
D2150 Amalgam filling – two surfaces, primary or permanent	\$41
D2160 Amalgam filling – three surfaces, primary or permanent.....	\$50
D2161 Amalgam filling – four or more surfaces, primary or permanent	\$59
D2330 Resin-based composite filling-one surface, anterior	\$32
D2331 Resin-based composite filling-two surfaces, anterior.....	\$41
D2332 Resin-based composite filling-three surfaces, anterior	\$50
D2335 Resin-based composite filling-four surfaces, incisal	\$59
D2390 Resin-based composite crown, anterior	\$65
***D2391 Resin-based composite filling-one surface, posterior	\$32
***D2392 Resin-based composite filling-two surfaces, posterior.....	\$41
***D2393 Resin based composite filling-three surfaces, posterior	\$50
***D2394 Resin based composite filling-four surfaces, posterior	\$59

*** If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspid.

Conditions Of Services

- Services must be provided by a licensed Dentist and must be for treatment of dental disease, defect or injury.
- When the anticipated expense for any course of treatment exceeds \$350.00, the Insured should submit to UniCare a request for pre-treatment benefit estimation as prepared by the attending Dentist on the appropriate form before the treatment commences.

Other Insurance In This Company

Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies.

Exclusions And Limitations: What The Plan Does Not Pay For

In addition to any other exclusions and limitations described in this Plan, the Plan does not provide benefits for:

Unlisted Services: Services not specifically listed in the Benefit Schedule of this Plan.

Any amounts in excess of the maximum amounts of Covered Expenses stated in this Plan.

Experimental or Investigative Procedures: Services or supplies that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures and are considered experimental within the organized medical community. Any amounts which exceed the Covered Expense as determined by UniCare.

Expenses Before Coverage Begins: Services received before Your Effective Date.

End of Coverage: Services received after Your coverage ends.

Services For Which You Are Not Legally Obligated To Pay: Services for which no charge would be made to You in the absence of insurance coverage.

Services for someone other than the Insured: Any person other than the Insured, including but not limited to Your dependents, such as spouse, newborn, legal ward, natural and/or adopted child.

Workers' Compensation: Any condition for which benefits could be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if You do not claim those benefits.

Conditions caused by: (a) an **act of war**; (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured participating in the **military service** of any country; (d) an Insured participating in an **insurrection, rebellion, or riot**; (e) services received as a direct result of an Insured's commission of, or attempt to commit a **felony or as a direct result of the Insured being engaged in an illegal occupation**; (f) an Insured being under the influence of illegal narcotics, alcohol, or non-prescribed controlled substances unless administered under the advice of a Physician. Any services provided by a local, state, county or federal government agency, except when payment under this Plan is expressly required by federal or state law.

Services From Relatives: Professional services received from a person who lives in Your home or who is related to You by blood, marriage or adoption.

Cosmetic Dentistry: Any services performed for cosmetic purposes are not covered under this Plan, unless they are for the correction of functional disorders or as a result of an Accidental Injury occurring while You were covered under this Plan.

Charges for treatment by other than a licensed Dentist, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a Dentist.

Orthodontic services, braces, appliances and all related services.

Diagnosis or Treatment of the Joint of the Jaw and/or Occlusion (the way upper and lower teeth meet) services, supplies or appliances provided in connection with:

1. Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or
2. Any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (Occlusion); or
3. Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.

Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:

1. Changing the vertical dimension;
2. Replacing or stabilizing lost tooth structure by attrition, abrasion, or erosion;
3. Realignment of teeth;
4. Gnathological recording;
5. Occlusal equilibration;
6. Periodontal splinting.

Oral examinations exceeding two visits per Year.

Prophylaxis treatments, exceeding two treatments per Year.

Fluoride applications if You are **over eighteen (18) years of age**. Fluoride applications exceeding two visits per year.

More than one set of full-mouth X-rays or its equivalent in a three year period.

Periapical and bitewing x-rays submitted singly will be combined and paid up to the amount of a full mouth series and are subject to the full-mouth x-ray limitation. No more than 2 bite wing x-ray series for standard in a Year will be covered. No more than 8 films for vertical bite wings in a 36 month period will be covered.

Correction of congenital or development malformation including but not limited to supernumerary and/or over retained deciduous teeth, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth). This exclusion does not apply to otherwise eligible charges incurred for the treatment of a congenital defect or defects in an Insured. who is eligible to be covered under this Policy and who has been so covered continuously from the date of her or his birth until the date the expense is incurred.

Fillings exceeding one per Year per surface per tooth if You are under the age of 19 and one every 3 (three) Years per surface per tooth if You are over the age of 19.

If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

Replacement of existing fillings for any purpose other than restoring active decay.

Transfer of care: If an Insured transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, UniCare shall be liable only for the amount it would have been liable for had one Dentist rendered the services.

Prescribed drugs, pre-medication or analgesia including nitrous oxide.

Oral hygiene instruction.

Malignancies and Neoplasms: Services for treatment of malignancies and neoplasms are not Covered Services.

All hospital costs and any additional fees charged by the Dentist for hospital treatment.

Implants: (Materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under this Plan.

Services or supplies that are not Medically Necessary.

Services for oral surgery, for example, tooth extractions.

Services for endodontics, for example, root canals. Endodontics means the branch of dentistry dealing with diseases of the tooth pulp.

Services for periodontics, for example, scaling and root planning. Periodontics is the dental specialty of treating periodontal disease.

Services for prosthodontics, for example, crowns. Prosthodontics is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures.

Space maintainers. Space maintainers are appliances that are designed to prevent tooth movement.

Sealants.