

# UniCare Life & Health Insurance Company

## Dental Insurance 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 per Year. During each Year, You are responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts towards the Deductible so amounts over Covered Expense a Non-Participating Dentist may charge You won't count. The Deductible does not apply to diagnostic and preventive services when performed by a Participating Provider or Non-Participating Provider.

### YEARLY MAXIMUM BENEFIT

All dental benefits are limited to a maximum payment of \$500 for expense incurred by You during a Year.

### PAYMENT

If a Participating Dentist provides services or supplies, any billed amount above Covered Expense will be a savings to You, the Insured. Participating Dentists have agreed to accept the Negotiated Rate as payment in full. Non-Participating Dentists have no such policy with Us, therefore, they will bill You for any amounts over Covered Expense in addition to any deductible.

### PAYMENT TO PARTICIPATING AND NON-PARTICIPATING DENTISTS

- 1) 100% of Covered Expense each Insured incurs for preventive services; (deductible is waived)
- 2) 100% of Covered Expense each Insured incurs for diagnostic services; (deductible is waived)
- 3) 80% of the Covered Expense each Insured incurs in excess of the Deductible for filling of cavities.

### BENEFITS WILL BE PROVIDED ONLY FOR THE FOLLOWING PROCEDURES:

Diagnostic and Preventive Care

*D0120	Periodic Oral Exam
*D0140	Limited Oral Evaluation-Problem Focused
*D0150	Comprehensive/Initial Oral Exam
*D0160	Detailed and extensive oral evaluation-new or established patient
*D0170	Re-evaluation-limited, problem focused
*D0180	Comprehensive Periodontal Evaluation-new or established patient
**D0210	Intraoral-Complete Series Including Bitewings
D0220	Intraoral-Periapical-First Film
D0230	Intraoral-Periapical-Each Additional Film
D0240	Intraoral-Occlusal Film
D0250	Extraoral-First film
D0260	Extraoral-Each Additional Film
D0270	Bitewing-One Film
D0272	Bitewings-Two Films
D0274	Bitewings-Four Films
D0277	Vertical Bitewings
**D0290	Posterior-Anterior or Lateral skull and Facial Bone Survey Film
**D0330	Panoramic Film
**D0340	Cephalometric film
D1110	Prophylaxis-Adult

D1120	Prophylaxis-Child
D1201	Topical Appl. Of Fluoride Incl. Prophy-Child to age 19
D1203	Topical Appl. Of Fluoride Excl. Prophy-Child to age 19
D1205	Topical Appl. Of Fluoride Incl. Prophy-Adult

**\*Exams are limited to two per Year**

**\*\* Full mouth X-rays or its equivalent are limited to one set every 3 Years.**

### **Fillings**

D2140	Amalgam-One Surface Permanent or Primary
D2150	Amalgam-Two Surfaces Permanent or Primary
D2160	Amalgam-Three Surfaces Permanent or Primary
D2161	Amalgam-Four or more surfaces, Permanent or Primary
D2330	Resin-One Surface, Anterior
D2331	Resin-Two Surfaces, Anterior
D2332	Resin-Three Surfaces, Anterior
D2335	Resin - Four (4) Surfaces, incisal
D2390	Resin-based composite crown, anterior
***D2391	Resin-based composite-one surface posterior
***D2392	Resin-based composite-two surfaces posterior
***D2393	Resin-based composite-three surfaces posterior
***D2394	Resin-based composite-four surfaces posterior

**\*\*\* 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.**

### **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.

### **EXCLUSIONS AND LIMITATIONS: WHAT THE PLAN DOES NOT PAY FOR**

We will not furnish benefits for:

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

**Excess Amounts:** Any amounts in excess of the maximum amount stated in section IV How The Plan Works.

**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.

**Government Services:** Any services provided by a local, state, county or federal government agency including any foreign government.

**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 Policy.

**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 Insured 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 per Insured 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 bitewing x-ray series for standard in a Year will be covered. No more than 8 films for vertical bitewings 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).

**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 bicuspid.

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

**Transfer of care:** If a Policyholder 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.**

**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 Certificate.

**Sealants**

**Services or supplies that are not Medically Necessary**

**Services for oral surgery, for example, tooth extractions.**

**Services for endodontics,** for example, root canals. Endodontic 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.

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