DENTAL BENEFITS

Dental benefits are provided as shown in the **SUMMARY OF DENTAL BENEFIT FEATURES** and in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS.**

SUMMARY OF DENTAL BENEFIT FEATURES

OUTPATIENT BENEFITS

You and your eligible Dependents are entitled to the Dental Covered Services shown in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS.** These Dental Covered Services are eligible provided they are performed directly by a Primary Dentist. Dental Covered Services are subject to the provisions listed in this **SUMMARY OF DENTAL BENEFIT FEATURES**, the exclusions contained in the list of **DENTAL EXCLUSIONS** and to the cost sharing and Limitations listed in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS.**

HOW TO ACCESS DENTAL CARE

In order to access dental care for you and your eligible Dependents, you need to know the following requirements:

Selection of a Primary Dentist

Prior to the time your coverage becomes effective, you need to choose the Primary Dentist from whom you and your Dependents will receive Dental Covered Services

Changing a Primary Dentist

1. If you and your eligible Dependents wish to transfer to a different Primary Dentist, a request may be submitted in writing or by telephone to the Customer Service Department. If notification to change a Primary Dentist is received prior to the fifteenth day of the month, the change will become effective the first day of the next month. Requests received after the fifteenth will become effective the first day of the month immediately following the next month.
2. A Primary Dentist may request in writing that care for you and your eligible Dependents be transferred to another Primary Dentist. However, a Primary Dentist may not request a transfer because of the physical condition of a patient or the amount of Dental Covered Services required by a patient.
3. Transfer to another Primary Dentist may be required if the Member-Primary Dentist relationship is unsatisfactory.
4. If the Primary Dentist terminates his relationship with the HMO, you and your eligible Dependents must select another Primary Dentist. Customer Service will assist you in this selection process.

IMPORTANT DENTAL DEFINITIONS

For the purpose of understanding the benefits under your dental program, the terms below have the following meaning:

DENTAL COVERED SERVICES – professional services of Dentists and auxiliary personnel as set forth in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS** and except as excluded under the **DENTAL EXCLUSIONS** section.

DENTALLY NECESSARY – services or supplies provided by a Primary Dentist, except for Dental Emergency Care, that are:

A. Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury.

B. Provided for the diagnosis, or the direct care and treatment of the patient's condition, illness, disease or injury.

C. In accordance with accepted standards of American dental practice.

D. Not primarily for the convenience of the patient or the provider.

DENTIST – A licensed Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Medicine, or Doctor of Osteopathy.

PRIMARY DENTAL OFFICE – The dental office maintained by the Primary Dentist.

PRIMARY DENTIST – A person licensed to practice dentistry who is under contract to provide all primary Dental Covered Services.

DENTAL EXCLUSIONS

The following are excluded from coverage under your dental benefits:

Except as specifically provided in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS**, no benefits will be provided for services, supplies, or charges:

1. Which are not prescribed or performed by or under the direct supervision of the Primary Dentist;
2. Which are not Dentally Necessary as defined in the **IMPORTANT DENTAL DEFINITIONS** section;
3. Which are cosmetic in nature, including but not limited to, charges for personalization or characterization of prosthetic appliances;
4. Which do not meet accepted standards of American dental practice;
5. For labial veneers and laminates when done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered;
6. For duplicate devices, appliances, and services;
7. For temporary devices, appliances, and services that are integral to the overall procedure;
8. Related to the diagnosis and treatment of temporomandibular joint dysfunctions;
9. For implantology and related services;
10. Performed in a facility by a Primary Dentist who is compensated by facility for similar Dental Covered Services performed for patients;
11. To alter vertical dimension or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth;
12. For local anesthesia when billed separately by a Primary Dentist;
13. For gold foil restorations;
14. If you have a previous unresolved cost sharing balance that has been outstanding for sixty (60) or more days, unless special payment arrangements have been made with the Primary Dentist Office;
15. For prescription medications or nitrous oxide;
16. For general anesthesia or IV sedation;
17. In a Hospital unless Dentally Necessary;
18. Which are necessary due to a lack of patient cooperation or failure of the patient to follow a professionally prescribed Dental Plan Of Treatment;
19. For periodontal splinting and any related procedures;
20. For treatment of congenital malformations, including but not limited to, cleft palate, anodontia and mandibular prognathism;

21. For dental prosthetic devices including dentures, bridges, crowns, inlays and onlays and the fitting thereof;
22. For replacement of a lost or stolen prosthetic device (such as a denture) or the replacement or repair of orthodontic braces;
23. For treatment of orthodontic conditions;
24. For orthognathic surgery to cover non-traumatic jaw deformity;
25. Other than those specifically provided in the **DENTAL SCHEDULE OF COST SHARING & LIMITATIONS.**

DENTAL SCHEDULE OF COST SHARING & LIMITATIONS

BENEFIT	COPAYMENT/LIMITATION
DENTAL VISITS	
Dental Office Visit	$5 per visit
Missed Dental Office Visit	$15 per half hour appointment without 24 hour notice

The following services are covered subject to the $5 office visit Copayment when provided by the Primary Dentist.

DENTAL PREVENTIVE	
Oral Examination & Diagnosis	once every six (6) months
Prophylaxis (teeth cleaning)	once every six (6) months
Oral Hygiene Instruction	
Topical Fluoride Application	limited to children up to age 19, once every six (6) months