COVENTRY Dental

Coventry Health and Life Insurance Company
6705 Rockledge Drive, Suite 900 Bethesda, MD 20817

DENTAL SCHEDULE OF BENEFITS

This Policy gives You access to services of a dentist who is either a Participating Provider or a Non-Participating Provider. If a Participating Provider is used, You will generally incur less out-of-pocket cost. A Participating Provider may be located in your area. Participating Providers agree to accept Our Maximum Allowable Charge. Please Note: If You choose an Out-of-Network Provider, You may be responsible for Deductible and/or Coinsurance amounts, in addition to Out-of-Network Covered Services. You are also responsible for paying the billed charges that exceed the amount We would have paid a Participating Provider. This excess amount may be substantial. Please read Section 4 in the Individual Member Policy to learn more about how Your In-Network and Out-of-Network benefits work, and call our Customer Service Department at 1-866-690-4908 if You have any questions.

Plan Summary:

	In-Network	Out-of-Network
Deductible	$25 (Applies to Type I & II)	$25 (Applies to Type I & II)
Reimbursement Level	Maximum Allowable Charge	Maximum Allowable Charge
Annual Maximum Benefit	Unlimited up to Maximum Allowable Charge	Unlimited up to Maximum Allowable Charge

Schedule of Covered Procedures:

Type	Codes	Description	Member Pays Co-Insurance In- Network	Member Pays Co-Insurance Out –of- Network	Limitations
I	D0120 D0140 D0145 D0150 D0160 D0170 D0180	Periodic oral evaluation – established patient Limited oral evaluation – problem focused Oral evaluation for a patient under three years of age and counseling with primary caregiver Comprehensive oral evaluation – new or established patient Detailed and extensive oral evaluation – problem focused, by report Re-evaluation – limited, problem focused (established patient; not post-operative visit) Comprehensive periodontal evaluation – new or established patient	0%	0%	Limited to a total of two visits per Policy Year Deductible must be met before coinsurance applies.
I	D0210 D0220 D0230 D0240 D0250 D0260 D0270 D0272 D0273 D0274	Intraoral *radiographs* – complete series (including bitewings) – *limited to 1 series every 24 months* Intraoral – periapical first film Intraoral – periapical each additional film Intraoral – occlusal film Extraoral – first film Extraoral – each additional film Bitewing *radiograph* – single film Bitewings *radiographs* - two films Bitewings *radiographs* – three films Bitewings *radiographs* – four films – *limited to 1 series every 6 months*	0%	0%	Limited to a total of one time per Policy Year Deductible must be met before coinsurance applies.

I	D1110 D1120 D1203 D1206 D4910	Prophylaxis *cleaning* – adult – *1 per 6 month period* Prophylaxis *cleaning* – child – *1 per 6 month period* Topical application of fluoride (prophylaxis not included) – child – *to age 19; 1 per 6 month period* Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – *child to age 19; 1 per 6 month period* Periodontal maintenance – *limited to 1 treatment each 6 month period*	0%	0%	Limited to two times per Policy Year; D1204 is Not Covered. Deductible must be met before coinsurance applies.
II	D2140 D2150 D2160 D2161	Amalgam-one surface, primary or permanent Amalgam-two surfaces, primary or permanent Amalgam-three surfaces, primary or permanent Amalgam-four or more surfaces, primary or permanent	40%	40%	Limited to a total of four per Policy Year; D2160, D2161 will be paid up to the D2150 amount. Deductible must be met before coinsurance applies.
II	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	40%	40%	Limited to a total of two per Policy Year Deductible must be met before coinsurance applies.

Codes not listed on this Schedule of Benefits are non-covered services.

We will pay a Non-Preferred Provider Dentist the same amount as a Preferred Provider Dentist, however, the Non-Preferred Provider Dentist may balance bill You for charges over the amount We have contracted with the Preferred Provider Dentist.

For non-covered services provided by an In-Network dentist, members may receive the discounts Coventry Dental has negotiated with the provider network. For assistance in finding a network provider; please visit us at www.cvtydental.com or call our Customer Service Department at 1-866-690-4908.

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LIMITATIONS AND EXCLUSIONS

All Covered Dental Services are subject to the following exclusions, limitations and frequency limits:

1. Coverage is limited to those services set forth in **Dental Schedule of Benefits**. If a service is not listed, it is not included and is not covered.
2. Services furnished solely for cosmetic reasons are not covered.
3. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the Insured by any municipality, county, or other political subdivision is not covered. This exclusion does not apply to any treatment covered by Medicaid or Medicare.
5. Treatment as a result of, civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime is not covered.
6. Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth is not covered.
7. Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction is not covered.
8. Treatment of jaw fractures or orthognathic surgery is not covered
9. Consultations and/or evaluation for non-Covered Dental Services are not covered
10. Analgesia, anxiolysis, inhalation of nitrous oxide or non-intravenous sedation is not covered.
11. Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be Experimental or Investigational in nature is not covered.
12. Any outpatient facility, surgical center facility, or inpatient hospital facility and associated facility charges, services and supplies is not covered
13. House, extended care facility calls, hospital calls, office visits for observation (during regularly scheduled hours) when no other services are provided, office visits after regularly scheduled hours or case presentations are not covered.
14. Drugs obtainable with or without a prescription are not covered.
15. Fees for equipment sterilization, OSHA or other regulatory agency requirements or mandates, infection control, and medical waste disposal are not covered
16. Treatment that is not described by the most recent (current edition) of the American Dental Association (ADA) Current Dental Terminology (CDT) book is not covered.
17. Not experimental or investigational as determined by Us.
18. A child born to or adopted by a Dependent child shall not be eligible to be covered under this Policy.
19. A claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

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RENEWABILITY:

This Contract is renewable and may only be non-renewed (terminated) as set forth in Section 3 of the Contract. You are subject to all terms, conditions, limitations, and exclusions in this Contract and to all the rules and regulations of the Dental Plan. By paying premiums or having premiums paid on Your behalf, You accept the provisions of this Contract.

PREMIUM RATE INCREASES:

Notice of any premium increase will be mailed or delivered to You not less than 60 days prior to the effective date of such increase.