DENTAL BENEFITS

DEDUCTIBLE
Deductible is the amount of charges you will pay before we begin to pay for certain Covered Services.

- Your Yearly Deductible for Covered Services is **$25**. During each Year, you are responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts toward the Deductible. Amounts over Covered Expense a Non-Participating Dentist may charge do not count toward the Deductible. **The Deductible does not apply to diagnostic and preventive services when performed by a Participating Dentist.**

YEARLY MAXIMUM BENEFIT
All dental benefits are limited to a maximum payment of **$500** for expenses 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 Policy. If a Participating Dentist provides services, any billed amount above Covered Expense will be a savings to you. Participating Dentists have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Dentists have no such agreement with BCBSGA, therefore, they will bill You for any amounts over Covered Expense in addition to any Deductible.

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE. NO BENEFITS WILL BE PROVIDED FOR ANY OTHER SERVICES.

At a Participating Dentist, benefits will be paid for Covered Expenses as follows:
- 100% of the Covered Expense you incur for diagnostic and preventive services, the Deductible is waived, (see Benefits Schedule for a list of Covered Services); and
- 80% of the Covered Expense you incur in excess of the Deductible for fillings (see Benefits Schedule for a list of Covered Services).

Payment to Non-Participating Dentists
If You choose a Non-Participating Dentist, we will pay the amounts listed in the Benefits Schedule for Covered Services **after the Deductible has been satisfied.** In addition to the Deductible, you will be responsible for the amount that exceeds the Benefit Schedule amount. Therefore, Your share of the costs for Your care provided by a Non-Participating Dentist may be greater than if you choose a Participating dentist.

BENEFIT SCHEDULE
BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE.

DIAGNOSTIC AND PREVENTIVE CARE

Benefits will be paid for preventive and diagnostic care as specified in the following schedule. Please note, You may have a greater share of the costs for Your care if You choose a Non-Participating Dentist.

Procedure Code	Description	Maximum Claim Payment
*D0120	Periodic oral Exam	$23
*D0140	Limited oral exam-problem focused	$37
*D0150	Initial oral exam	$41
*D0160	Detailed and extensive oral exam-new or established patient	$64
*D0170	Re-evaluation exam – limited problem focused	$26
*D0180	Comprehensive periodontal exam – new or established patient	$37
**D0210	Full mouth X-rays	$79
D0220	Single (periapical) X-rays – first film	$14
D0230	Single X-rays – additional films	$12
D0240	Single X-rays – Occlusal	$20
D0250	Extraoral – first film	$34
D0260	Extraoral – each additional film	$18
D0270	Bitewing X-ray – single film	$17
D0272	Bitewing X-ray – two films	$23
D0274	Bitewing X-ray – four films	$33
D0277	Vertical bitewing X-rays	$45
**D0290	Posterior-anterior or lateral skull and facial bone survey film	$75
**D0330	Panoramic X-ray	$73
**D0340	Cephalometric film	$84
D1110	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	$51
D1120	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	$39
D1201	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$56
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	$20
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$63

* Exams are limited to two per Year.

** Full mouth X-rays or its equivalent are limited to one set every three (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 for Your care if You choose a Non-Participating Dentist.

Procedure Code	Description	Maximum Claim Payment (80% of Covered Expense)
D2140	Amalgam filling – one surface, primary or permanent	$49
D2150	Amalgam filling – two surfaces, primary or permanent	$62
D2160	Amalgam filling – three surfaces, primary or permanent	$78
D2161	Amalgam filling – four or more surfaces, primary or permanent	$96
D2330	Resin-based composite filling – one surface, anterior	$58
D2331	Resin-based composite filling – two surfaces, anterior	$74
D2332	Resin-based composite filling – three surfaces, anterior	$100
D2335	Resin-based composite filling – four surfaces, incisal	$116
D2390	Resin-based composite crown – anterior	$180
***D2391	Resin-based composite filling – one surface, posterior	$64
***D2392	Resin-based composite filling – two surfaces, posterior	$80
***D2393	Resin-based composite filling – three surfaces, posterior	$104
***D2394	Resin-based composite filling – four surfaces, posterior	$120

******* 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.

CONDITION OF SERVICES
Services must be provided by a licensed Dentist and must be for treatment of dental disease, defect or injury.

EXCLUSIONS AND LIMITATIONS

No benefits are provided for or in connection with the following. They are considered to be exclusions and limitations, which include, but are not limited to the following:

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 the Yearly Maximum Benefit section or listed in the Benefit Schedule.

Any amounts which exceed the **Covered Expense** as determined by BCBSGA.

Expenses Before Coverage Begins: Services received before Your Effective Date or during an inpatient stay that began 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 Policyholder: Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, 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.

Government Services: Any services provided by a local, state, county or federal government agency including any foreign government except when payment under the Plan is explicitly required by law.

Services From Relatives: Professional services received from a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption.

Cosmetic Dentistry: Any services performed for cosmetic purposes are not covered under this Plan (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

Charges for treatment by other than a licensed Dentist or physician, 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 for patients 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 (3) Year period.

Periapical and bite wing 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 two (2) bite wing x-ray series for standard in a Year will be covered. No more than eight (8) films for vertical bite wings in a 36-month period will be covered.

Correction of congenital or development malformation for an Insured Person including but not limited to 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).

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, cuspids and the facial surface of bicuspids.

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, BCBSGA shall be liable only for the amount it would have been liable for had one Dentist rendered the services.

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

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.

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 planing. **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.