

Dental/Vision Benefit Summary

Dental Covered expenses for this benefit include the following for Covered Dependents under the age of 19

Preventive Dental Services

- **Preventive oral examinations** (cleaning, scaling, polishing), every six months; beginning at age six months
- **Oral examinations** (evaluations), every six months, beginning before age one
- **Bitewing x-rays** once per year
- **Panoramic x-rays** once every three years
- **Fluoride** three times in a twelve-month period for ages six and under; two times in a twelve-month period / for ages seven and older; three times in a twelve-month period during orthodontic treatment
- **Sealant** once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment
- **Space maintainers** for missing primary molars A, B, I, J, K, L, S and T

Basic Dental Services

- **Restorative services using** amalgam, resin and sedative; every two years for the same restoration
- **Periodontics:** scaling and root planning once per quadrant in a two-year period for ages 13 and older, with prior authorization
- **Periodontal maintenance** once per quadrant in a twelve-month period for ages 13 and older, with prior authorization
- **Endodontics:** root canals on baby primary posterior teeth only; Root canals on permanent anterior; bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32
- **Extractions and other oral surgery** including pre-operative and post-operative care, with prior authorization
- **Frenulectomy** or frenuloplasty covered for ages six and under without prior authorization
- **Nitrous Oxide** in conjunction with covered surgical procedures

Major Dental Services

- **Stainless steel crowns** for permanent posterior teeth once every three years
- **Metal/porcelain crowns** and porcelain crowns on anterior teeth once every three years
- One **resin based partial denture**, replaced once within a three-year period
- One **complete denture upper** and lower, and one replacement denture per lifetime after at least five years from the seat date
- **Rebasing and relining** of complete or partial dentures once in a three-year period, if performed at least six month from the seating date

Orthodontia

- Medical necessary orthodontia, with prior authorization

Vision Covered expenses for this benefit include the following for Covered Dependents under the age of 19

Exam

- Eye Exam, once every calendar year
- Exam with refraction

Lenses/Contact Lenses

(contact lens benefit available in lieu of eyeglasses)

- One per calendar year
- Single vision
- Conventional (lined) Bifocal
- Conventional (lined) Trifocal

Frame

- One standard frame, once every other calendar year
- We consider a "standard frame" to be one that does not exceed the price of \$130
- Frames in excess of this amount are considered to be purchased for cosmetic reasons and are Not Covered. However, a medically necessary frame that exceeds \$130 could be covered but requires prior authorization from us and must meet our guidelines