**Hunt & Sons #11005**
**Dental Summary of Benefits**
**Member & Provider Services: 1-844-814-3437**
**Provider Directory: UniCare.com**

| **Calendar Year Maximum Benefits for: Dental** | | | |
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| | **In-Network Anthem DNAS** | **Out-of-Network** | |
| **Annual Deductible** | | | |
| Individual | $0.00 | $50.00 | |
| Family Unit | $0.00 | $150.00 | |
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| **Annual Maximum Benefit (Calendar Year)** | $2,000 | $1,500 | |
| **Orthodontia Lifetime Maximum Benefit** | $2,000 | $2,000 | |
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| **Class I: Preventive Dental Services** *Deductible waived* | | | |
| **Preventive Dental Services** | In-Network Plan Pays | Out-of-Network Plan Pays | Limitations |
| Comprehensive/Periodic Exams | 100% | 100% | Limited to 1 per six-month period |
| Evaluations/Re-Evaluations of Periodontal Evaluations | | | |
| Prophylaxis (cleaning and scaling) for adults and dependent children | 100% | 100% | Limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per six-month period (during the six-month period, benefits under either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both) |
| Topical fluoride treatment for Dependent children under age 14 | 100% | 100% | Limited to 1 per six-month period; Topical fluoride varnish is not covered |
| X-Rays: | | | |
| Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film | 100% | 100% | Limited to 1 per 60-month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year |
| Bitewing x-rays (two or four films) | 100% | 100% | Limited to 1 per 12-month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year |
| Other X-Rays: | | | |
| Intraoral periapical x-rays | 100% | 100% | Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year |
| Intraoral occlusal x-rays | 100% | 100% | Limited to 1 film per arch, per six-month period |
| Extraoral x-rays | 100% | 100% | Limited to 1 film per six-month period |
| Other x-rays (except film related to orthodontic procedures or temporomandibular joint dysfunction) | 100% | 100% | None |
| Sealants | 100% | 100% | Limited to 1 application to an unrestored occlusal surface of a permanent molar tooth per 36-momnth period, for dependent children under age 14 |
| Limited oral exams (emergency oral exams) | 100% | 100% | Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit |
| Space maintainers, including all adjustments made within months of installation | 100% | 100% | Limited to dependent children under age 14 |
| Palliative (emergency) treatment of dental plain | 100% | 100% | Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit |

| **Basic Dental Services (Class II)**<br>*Deductible applies* | | | |
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| **Basic Dental Services** | In-Network Plan Pays | Out-of-Network Plan Pays | Limitations |
| Stainless steel crowns | 90% | 80% | Limited to 1 per 36-month period for teeth not restorable by an amalgam or composite filling for dependent children to age 19 |
| Pulpotomy (primary teeth only) | 90% | 80% | None |
| Root canal therapy (including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care) | 90% | 80% | Limited to 1 time on the same tooth per 24-month period; Limited to permanent teeth only |
| Apicoectomy/periadicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care | 90% | 80% | None |
| Retrograde filling - per root | 90% | 80% | None |
| Root amputation - per root | 90% | 80% | None |
| Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy. | 90% | 80% | None |
| Periodontal scaling and root planing | 90% | 80% | Limited to four teeth or more per quadrant, limited to a minimum of 5mm pockets on at least four teeth per quadrant, 1 time per quadrant per 24-month period; Limited to one to three teeth per quadrant, limited to minimum of 5mm pockets on one to three teeth, limited to 1 treatment per quadrant per 24-month period. Root planning is generally not a benefit in the same quadrant for at least a 24-month period following the completion of active therapy. Under unusual circumstances, additional documentation can be submitted to us for review. Root planing is not a benefit until 36-months after surgery in the same area |
| Periodontal maintenance procedure (following active treatment) | 90% | 80% | Limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6-month period (during the 6-month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both) |
| Periodontal maintenance procedures (periodontal prophylaxis) may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than three-months thereafter. | 90% | 80% | The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary. |
| Periodontal related services as follows: gingival flap procedures; gingivectomy procedures; osseous surgery; pedicle tissue grafts; soft tissue grafts; subepithelial tissue grafts; bone replacement grafts; guided tissue regeneration; crown lengthening procedures - hard tissue | 90% | 80% | Limited to 1 time per quadrant of the mouth in any 36-month period with changes combined for gingivectomy, gingival flap procedure, pedicle grafts, soft tissue grafts, subepithelial tissue grafts, or osseous surgery performed in the same quadrant within the same 36-month period. |
| Oral surgery services as follows: simple extraction; surgical extractions, including extraction of symptomatic third molars (wisdom teeth); alveoloplasty; vestibuloplasty; removal of exostosis (maxilla or mandible); frenulectomy (frenectomy or frenotomy); excision of hyperplastic tissue (per arch) | 90% | 80% | Includes an allowance for local anesthesia and routine post-operative care. |

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| Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus | 90% | 80% | Limited to permanent teeth only. |
| Root removal - exposed roots | 90% | 80% | None |
| Biopsy | 90% | 80% | None |
| Incision and drainage | 90% | 80% | None |
| General anesthesia and intravenous sedation | 90% | 80% | Limited as follows: considered for payment as a separate benefit only when medically necessary (as determined by us) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services, which are covered under the policy. Oral sedation is not a covered benefit |
| Nitrous oxide limited to dependent children through age 6 | 90% | 80% | None |
| Consultation, including specialist consultation | 90% | 80% | Limited as follows: considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date; benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan. |
| Amalgam and composite restorations | 90% | 80% | Limited as follows: multiple restorations on one surface will be considered a single filling; multiple restorations on different surfaces of the same tooth will be considered connected; benefits for replacement of an existing restoration will only be considered for payment if at least 12-months have passed since the existing restoration was placed if the covered person is under age 19, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; or 36-months have passed since the existing restoration was placed if the covered person is age 19 or older, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; additional fillings on the same surface of a tooth in less than 12-months for patients up to age 19 or in less than 36-months for patients age 19 or over, by the same office or same Dentist are not a benefit, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; sedative bases and copalie are considered part of the restorative service and are not paid as separate procedures; composite restorations are also limited as follows: mesial-lingual, distal-lingual, mesial-facial and, distal-facial restorations on anterior teeth will be considered single surface restorations; acid etch is not covered as a separate procedure; benefits limited to anterior teeth only; based on network type, benefits for composite resin restorations on posterior teeth may be limited to the benefits for the corresponding amalgam restoration; pins, in conjunction |
| **Major Dental Services (Class III)**<br>*Deductible applies* | | | |
| **Major Dental Services** | In-Network Plan Pays | Out-of-Network Plan Pays | Limitations |
| Inlays and onlays (metallic) | 60% | 50% | Limited as follows: covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to persons age 16 and above; inlays and onlays on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation |

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| Porcelain restorations on anterior teethe | 60% | 50% | Limited as follows: covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to persons age 16 and above; porcelain restorations on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation |
| Cast crowns | 60% | 50% | Limited as follows: covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to permanent teeth (cast crowns on over-retained primary teeth are not covered); limited to persons age 16 and above; crowns on third molars where adjacent first and second molars are present or where there is no occlusion with opposing are not covered; crowns on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation |
| Crown lengthening | 60% | 50% | Limited to single site when contiguous teeth are involved. |
| Recementing inlays, crowns and bridges | 60% | 50% | Limited to three per tooth. |
| Post and core | 60% | 50% | Covered only for endodontically treated teeth requiring crowns; one post and core is covered per tooth |
| Full dentures | 60% | 50% | Limited as follows: limited to 1 full denture per arch; replacement covered only if five years have elapsed since replacement AND the full denture cannot be made serviceable; service includes any adjustment or reline performed within 12-months of initial insertion; we will not pay additional benefits for personalized dentures or overdentures or associated treatment; benefits for dentures are based on the date of delivery. |
| Partial dentures, including any clasps and rests and all teeth | 60% | 50% | Limited as follows: limited to 1 partial denture per arch; replacement covered only if five years have elapsed since replacement AND the partial denture cannot be made serviceable; service includes any adjustment or reline performed within 12-months of initial insertion; there are no benefits for precision or semi-precision attachments; benefits for partial dentures are based on the date of delivery. |
| Denture adjustment | 60% | 50% | Limited to 1 time per 12-month period, and adjustments made more than 12-months after the insertion of the denture. |
| Repairs to full or partial dentures, bridges and, crowns | 60% | 50% | Limited to repairs and adjustments performed 3 in a lifetime after the initial insertion. |
| Rebasing dentures | 60% | 50% | Limited to 1 time per 12-month period. |
| Relining dentures | 60% | 50% | Limited to 1 time per 12-month period; and relines performed more than 12-months after initial insertion of the denture. |
| Tissue conditioning | 60% | 50% | Limited to repairs and adjustment performed once per 12-month period. |

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| Fixed bridges (including Maryland bridges) | 60% | 50% | Limited as follows: limited to persons age 16 and above; benefits for the replacement of an existing fixed bridges are payable only if the existing bridge is more than five years old and cannot be made serviceable; a fixed bridge replacing the extracted portion of a hemisected tooth is not covered; placement and replacement of cante-lever bridges on posterior teeth will not be covered; benefits for bridges are based on the date of cementation. |
| Recementing bridges | 60% | 50% | Limited to repairs or adjustment performed more than 12-months after the initial insertion. |
| Endodontic endosseous implant and endosseous implant | 60% | 50% | Limited as follows: benefits for the replacement of an existing implant are payable only if the existing implant is more than 60-months old and cannot be made serviceable. |
| Implant supported prosthetics | 60% | 50% | Allowance includes the treatment plan and local anesthetic: abutment supported crown; implant supported crown; abutment supported retainer for fixed partial denture; implant supported retainer for fixed partial denture; implant/abutment supported fixed denture for completely edentulous arch; implant/abutment supported fixed denture for partially edentulous arch. |
| **Class IV: Orthodontia** | | | |
| **Ortho Coverage** | In-Network Plan Pays | Out-of-Network Plan Pays | Limitations |
| Orthodontia Services | 50% | 50% | Orthodontia Lifetime Family Maximum: $2,000 |