Schedule of Benefits	When you go to Participating Providers YOU PAY	When you go to Non-Participating Providers YOU PAY[1]

Diagnostic
• Routine x-rays (full mouth series are limited to once every three years and include eighteen x-rays or four bitewings, two periapicals and a panograph), clinical examinations and diagnostic treatment planning
  • Periodic Oral Evaluation (Once every 6 months for members twelve years and older)
  • Limited Oral Evaluation (Once per patient per dentist/dental office per benefit year for members twelve years and older)
  • Comprehensive Oral Evaluation (Once every 3 years for members twelve years and older)
  • Comprehensive Periodontal Evaluation (Once every 3 years for members twelve years and older)
	Nothing	40% of eligible charges

Preventive • Prophylaxis (routine teeth cleaning) and fluoride treatment is limited to once every 6 months. Sealants for children only up to the age of twelve (12).	Nothing	40% of eligible charges
Basic Restorative • Routine fillings (silver amalgam and anterior composite). Posterior composites are not covered; however, an allowance for a comparable silver amalgam restoration will be made. The difference in fees is the member's responsibility.	20% of eligible charges	40% of eligible charges
Major Restorative • Porcelain, ceramic and/or resin/resin metal inlay, onlay or crowns.	20% of eligible charges	75% of eligible charges
Oral and Maxillofacial Surgery		
▪ Simple Extractions • Simple non-surgical extractions of fully erupted teeth (includes anesthesia and suturing, if needed, and routine follow-up). Extractions solely for the purposes of orthodontic treatment are not covered. Surgical extractions of unerupted or impacted teeth and general anesthesia for such surgery are not covered except as provided for in the Schedule of Benefits under Oral Surgery and Sedation.	20% of eligible charges	40% of eligible charges
▪ Oral Surgery • Surgery for impacted teeth and complicated extractions	20% of eligible charges	40% of eligible charges
Endodontics • Complete root canal therapy (includes pulpectomy and intra-operative radiographs), pulpotomy and pulpal therapy.	20% of eligible charges	40% of eligible charges
Periodontics • Consultation, evaluation and treatment of the soft tissue and bones supporting the teeth, subgingival curettage, gross scaling (excessive calculus removal), subgingival scaling and root planning, periodontal maintenance (applicable only to member's undergoing or who have completed periodontal treatment) and periodontal surgery.	20% of eligible charges	40% of eligible charges
Schedule of Benefits	When you go to Participating Providers	When you go to Non-Participating Providers

[1] Plus any difference between TakeCare's eligible charges and billed amount.

	YOU PAY	YOU PAY[1]
Prosthodontics, Removable • Full and partial dentures, denture retainers and repairs, relining and /or reconstruction of dentures. Porcelain, ceramic and/or resin/resin metal and/or gold crowns and bridges, plastic/stainless steel crowns and space maintainers. Occlusal guards are not covered.	50% of eligible charges	75% of eligible charges
Prosthodontics, Fixed • Full and partial dentures, denture retainers and repairs, relining and /or reconstruction of dentures. Porcelain, ceramic and/or resin/resin metal and/or gold crowns and bridges, plastic/stainless steel crowns and space maintainers. Occlusal guards are not covered.	50% of eligible charges	75% of eligible charges
Maxillofacial Prosthetics • Sectional and complete facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, and cranial prosthesis, facial augmentation implant prosthesis, replacement of nasal, auricular, orbital, and facial prosthesis, surgical, modification and definitive obturator prosthesis, mandibular resection prosthesis with and without guide flange, trismus appliance, speech aid prosthesis, surgical stent, radiation carrier shield, and cone locator, palatal lift prosthesis, commissure and surgical splint, maintenance and cleaning of maxillofacial prosthesis	All Charges	All Charges
Implant Services • Radiographic/surgical implant index, surgical placements, implant remove, debridement, bone graft, implant supported prosthesis, implant maintenance and repair, replacement of precision or semi-precision attachment of implant/abutment supported prosthesis and recement implant for both supported crown and supported fixed partial denture	All Charges	All Charges
Adjunctive General Services		
Anesthesia • Deep sedation/general anesthesia • Nitrous oxide or analgesia (laughing gas/conscious sedation) for members under 13 years old • All anesthesia limited to one (1) dose per member per procedure Emergency • Palliative treatment of dental pain • Fixed partial denture sectioning	20% of eligible charges	40% of eligible charges
Orthodontics • Coverage applies only to orthodontic treatment received during Phase II or the active treatment phase after banding has occurred and applies to children up to the age of seventeen (17). Orthodontic consults, extractions, study models, records, diagnostic fees, x-rays and appliances installed while under a non-TakeCare dental plan are not covered.	All Charges	All Charges
Prescription Drugs • Coverage is limited to prescription drugs dispensed at Kmart and SuperDrug Pharmacies.	All Charges	All Charges
Deductible	None	None
Benefit Year Plan Maximum	$1,000 per member per benefit year additional $500 at FHP Dental Center.	

[1] Plus any difference between TakeCare's eligible charges and billed amount.

General Exclusions

The following services are not covered by TakeCare:

A. (1) All services not specifically included in the "Schedule of Benefits" and/or the Member Handbook.
(2) Services prior to a member's start date of coverage or after the time coverage ends.

B. TakeCare is not responsible for the cost of services rendered by a non-participating dentist when the member has refused treatment provided or authorized through a member's primary dentist.

C. TakeCare is not responsible for the cost of services, which are not necessary or not required in accordance with professionally recognized standards of dental practice.

Plan Exclusions

- All hospital costs and additional fees charged by the dentist for hospital treatment.
- Cultures and/or histologic tests.
- Dental services which are provided to the eligible patient by any federal, local or state government agency or program.
- Experimental procedures.
- Extraction, study models and X-rays solely for orthodontic purposes.
- Extra-oral grafts, implants of any kind including component parts (including but not limited to abutment attachments and special or additional screws).
- Implant related restorative services, procedures and supplies.
- General anesthetic, conscious sedation and other forms of relative analgesia including, but not limited to, IV sedation and oral pre-medication except as provided for in the Schedule of Benefits.
- Oral surgical procedures including, but not limited to, surgical extraction of erupted teeth, impacted teeth and unerupted teeth (including third molars (wisdom teeth).
- Prescription and over-the-counter drugs except as provided for in the Schedule of Benefits.
- Fees for missed appointments and for copies of or transfer of dental records (including x-rays).
- Procedures, appliances or restorations necessary to increase vertical dimensions and/or restore or maintain the occlusion. Such procedures include, but are not limited to, full mouth rehabilitation, equilibration, periodontal splinting, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth.
- Prosthodontic services or devices (including crowns and bridges) of any single procedure started prior to the date the patient became eligible for such services under this Policy.
- Replacement of lost or stolen dentures, bridges or other dental appliances.
- Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to, cleft palate, maxillary and mandibular malformation, and enamel hypoplasia, fluorosis and anodontia.
- Cosmetic dentistry including, but not limited to, bleaching, veneers and posterior composites.
- Temporomandibular joint (jaw) dysfunction and other related diseases.
- Orthognathic surgery and other related services.
- Orthodontia except as provided for in the Schedule of Benefits and the Plan Limitations.
- Treatment and/or removal of oral tumors, treatment of traumatic injuries except of the teeth and adjacent soft tissues as provided in covered benefits.
- Work-related injuries.
- Benefits and services not specified as covered.
- Special orthodontic appliances including but not limited to Invisalign and fast braces.
- Any orthodontic appliances, services or treatment received prior or after eligible member's benefit coverage.
- Any restoration done by the same dentist or dental office on the same tooth within twelve (12) months after the insertion of any crown.
- Replacement of any restoration on the same tooth and surface within twenty-four (24) months.
- Treatment not conforming to accepted dental standards.

Plan Limitations

The following are limitations of the benefits provided in this plan:

- Complete mouth x-rays are covered only once in a three (3) year period unless special need is shown and authorized by TakeCare. Panograph, two (2) periapicals and four (4) bitewing x-rays will be considered a full mouth series. Supplementary bitewing x-rays are provided upon request but no more than once every six (6) months.
- Prophylaxis (routine teeth cleaning) and fluoride are limited to once every six (6) months.
- Crowns, jackets and gold restorations are covered only when other restorative material will not result in an adequate restoration. Replacement will be made only after five (5) years have elapsed following any prior provision of crowns, jackets or gold restorations under a TakeCare plan as provided for in the Schedule of Benefits.
- Prosthodontic appliances (including, but not limited to fixed bridges, partial or complete dentures) will be replaced only after five (5) years have elapsed following any prior provisions of such appliances under any TakeCare plan, except when the plan determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory as provided for in the Schedule of Benefits.
- In all cases in which the member selects a more expensive plan of treatment than is customarily provided, the plan will pay the applicable percentage of the lesser fee. The member is responsible for the remainder of the dentist's fees.
- Posterior resin restorations are not a covered benefit. An allowance for a comparable amalgam restoration will be made. The difference in fees is the member's responsibility. Resin restorations on the facial/cervical surface of any posterior teeth are payable as one (1) surface anterior restoration.
- In the event that more than one (1) dentist furnishes services for one (1) dental procedure, the plan shall pay not more than its liability had one (1) dentist furnished all of the services.
- The orthodontic benefit, if covered under the Plan, is limited to the active orthodontic treatment phase only and applies only to children up to the age of seventeen (17) years who become new orthodontic patients under the TakeCare plan. The benefit does not apply to members whose appliances were installed while under a non-TakeCare dental plan.

Please call the TakeCare Customer Service Department at (671) 647-3526 for any Benefit, Plan Limitation, or Plan Exclusion clarification.