Schedule of Dental Benefits

SoloCare Individual Plans with Dental Benefits

SCHEDULE OF DENTAL BENEFITS
SOLOCARE INDIVIDUAL PLANS WITH DENTAL BENEFITS
01/01/2023 – 12/31/2023

This document is called the Schedule of Dental Benefits and only applies to Allliant Health Plans' (Alliant) SoloCare medical plans with dental benefits. Please refer to this schedule whenever you require dental services. It describes how to access dental care, what dental services are covered by Alliant, what limits apply to covered services, and what portion of the dental care costs you are required to pay.

Sometimes, Alliant may send you documents that are amendments, endorsements, attachments, inserts, or riders. When you receive these documents, they become a part of your **SoloCare** Certificate of Coverage.

The Dental Benefits Within Your Plan Are Not Limited by Provider Network
Your Plan allows you the freedom to select the Dentist of your choice.

The Dental Benefits Herein Accumulate to Your Plan's Out-of-Pocket Maximum.
The dental benefits herein are subject to your medical plan's Deductible and Coinsurance. These dental benefits accumulate to the Out-Of-Pocket Maximum for your medical plan. Please check your Summary of Benefits and Coverage for specific Deductible, Coinsurance, Copayments, and Out-Of-Pocket Maximums for your Plan.

Thank you for choosing **SoloCare**.

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SCHEDULE OF DENTAL BENEFITS

The Schedule of Dental Benefits is a Schedule of the benefit maximums, Covered Services, and exclusions that apply when you receive care from a Dentist. Please refer to the Covered Services section of this Schedule of Dental Benefits for a more complete explanation of the specific services covered. All Covered Services are subject to the conditions, exclusions, limitations, terms, and provisions of your Plan, including any attachments or riders.

Coverage Year
One year, January 1 – December 31 (also called year or calendar year). Benefits reset each January 1.

Deductible
The Deductible is the amount you must pay before Alliant begins to pay for Covered Services. You must meet your Deductible every Coverage Year before Alliant will pay for Covered Services. Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

Benefit Maximums
The following benefit maximums are the dollar amount Alliant will pay for Covered Services for each Member, subject to the coverage percentages identified in your Plan's Summary of Benefits and Coverage. If you do not reach your Annual Benefit Maximums, unused amounts will not carry over to the next coverage year. See Summary of Benefits and Coverage.

Service	Pediatric	Adult
All Services (Preventive Dental, Basic Dental, Major Dental, & Dentally Necessary Orthodontia)	Benefit Maximum Not Applicable	$1,000 Annual Benefit Maximum for all services; services not covered for cosmetic care

Coinsurance and Out-of-Pocket Maximums
The portion which you must pay (the Coinsurance) is stated in your Summary of Benefits and Coverage. Your dental benefits accumulate to your Plan's Out-of-Pocket Maximum. Alliant will pay up to the Annual Benefit Maximum for certain benefits. You are responsible for the remainder of your dental services.

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Accidental Dental – is damage to the mouth, teeth, and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances, or prosthetic devises that results from chewing or biting food or other substances.

Covered Services – are services or treatments as described in this Schedule of Dental Benefits which are performed, prescribed, directed or authorized by a Dentist. To be considered a Covered Service, the service must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under your Plan's Certificate of Coverage is in force;
- Not specifically excluded or limited by this Schedule of Dental Benefits; and
- Specifically included as a Covered benefit within this Schedule of Dental Benefits.

Cosmetic Care – are services that are primarily for the purpose of improving appearance including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- Characterizations and personalization of prosthetic devices.

Dentally Necessary Orthodontic Care – Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Qualifying Conditions:

- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Dentist – is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Emergency Dental Services –Treatment of a potentially life-threatening dental emergency to stop ongoing tissue bleeding, alleviate severe pain or infection. Some examples of dental emergencies provided by ADA include:

- Uncontrolled bleeding;
- Cellulitis or soft tissue infection with swelling that potentially compromises a patient's airway;
- Trauma to facial bones that may obstruct an airway and make breathing difficult;
- Tooth or jaw pain.

Essential Health Benefits (EHB) –are, for the purposes of this coverage, pediatric dental services that Alliant is required to cover under the Patient Protection and Affordable Care Act and any other applicableregulations. EHB and its provisions apply to Members through age 18 only.

Provider – is any Physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a Hospital, clinical laboratory, Ambulatory Surgery Center, Retail Health Clinic, Skilled Nursing Facility, Long Term Acute Care facility, or Home Health Care Agency holding all licenses required by law to provide health care services.

Plan – refers to the Alliant Health Plans' SoloCare medical health insurance plan you have chosen for the 2023 Calendar year.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You have the freedom to choose the Dentist you want for your dental care. However, your choice of Dentist can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your Dentist does not accept the reimbursement amount determined by Alliant.

Payments are made by Alliant only when the Covered Services have been completed. Your Plan may require additional information from you or your Provider before a claim can be considered complete and ready for processing. In order to properly process a claim, your Provider may be requested to submit a corrected claim. For example, if your Dentistsubmits a claim for an adult dental cleaning when the service performed was a pediatric dental cleaning, Alliant will deny the claim and request that the dentist submit a corrected claim. Duplicate claims previously processed will be denied.

This section describes how Alliant determines the amount of reimbursement for Covered Services. Reimbursement for dental services rendered by a Dentists is based on the Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount is the maximum amount of reimbursement Alliant will pay for Covered Services, as defined in this Schedule, by a Dentist or Member.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. In addition, when you receive Covered Services from a Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges.

When you receive Covered Services from a Dentist, Alliant will apply processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect Alliant's determination of the Maximum Allowed Amount. Here are two examples of scenarios to illustrate when the Maximum Allowed Amount may change, according to claims processing rules.

Example 1: Your Dentist may have submitted a claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the claim will be denied with a remark code to designate the reason for the denial.

Example 2: When multiple procedures are performed on the same day by the same dental Provider or other dental Providers, we may reduce the Maximum Allowed Amount for those additional procedures, because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

Your Plan allows you the freedom to select the Dentist of your choice. There are no network limitations or requirements for referrals for advanced dental services.

DENTISTS

Alliant does not require Dentists to sign a written contractual agreement, but we request that the Dentist accept the Maximum Allowed Amount. For Covered Services you receive from a Dentists, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or the Maximum Allowed Cost (MAC) determined by Alliant as follows:

1. An amount based on our Out-of-Network Dentist fee schedule, referred to as the Maximum Allowed Cost (MAC), which we have established in our discretion, and which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar contracted Providers, and other industry cost, reimbursement and utilization data;
2. An amount based on information provided by a third-party vendor, which may reflect comparable Providers' fees and costs to deliver care;
3. An amount negotiated by us or a third-party vendor which has been agreed to by the Provider.

The Maximum Allowed Cost (MAC) for Emergency Dental Services is calculated as described in Title 33 of the Official Code of Georgia Annotated (OCGA) 33-20E-4; with respect to Emergency Dental Services, we will calculate the MAC as the greater of:

1. The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance.
2. The most recent verifiable amount agreed to by Alliant and the nonparticipating emergency Dentist for the provision of the same services during such time as such dentist was In-Network with Alliant.
3. Such higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided.

The amount paid does not include any amount of Coinsurance, Copayment, or Deductible you may owe. Dentists of emergency dental services may bill you for any Coinsurance, Copayment, or Deductible you may owe according to the terms of your policy. In the event you receive a surprise bill for nonemergency medical services from a Dentist, and you did NOT actively choose the Dentist prior to receiving services, we calculate the MAC as described above. Alliant reserves the right to request documentation from the Dentist to confirm whether you received services through no choice of your own.

Dentists may send you a bill and collect for the amount of the dentist's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amountand the amount the Dentist charges. This amount may be significant.

Client Services is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Dentist. In order for us to assist you, you will need to obtain the specific procedure code(s) from your dentist for the services the Dentist will render. You will also need to know the Dentist's charges to calculate your out-of-pocket responsibility. Although client services can assist you with this pre-service information, the Maximum Allowed Amount for your claim will be based on the actual claim submitted.

MEMBER COST SHARE
For certain Covered Services and depending on your dental program, you may be required to pay a part of the Maximum Allowed Amount (for example, a Deductible and/or Coinsurance). Please see your plan'sSummary of Benefits and Coverage for your cost share responsibilities and limitations or call Customer Service at (866) 403-2785.

PAYMENT OF BENEFITS
You authorize Alliant to make payments directly to Dentists for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law. Once a Provider gives a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Benefits payable under the contract may be paid directly to the Member unless you assign the payment directly to the Provider by indicating so on the claim form.

Explanation of Benefits
After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Alliant to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged forservices/supplies received
- the amount of the charges satisfied by your coverage
- the amount for which you are responsible (if any)
- general information about your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

COVERED SERVICES

Only services listed in this section may be covered under your Plan. All Covered Services are subject to the terms, limitations, and exclusions of your Plan's certificate. See your Summary of Benefits and Coverage for your cost share amounts, such as any applicable Deductibles and/or any Coinsurance.

Your Dental Benefits

Alliant does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Schedule of Dental Benefits. We evaluate the procedures submitted to us on your claim to determine if they are a Covered Service under this Schedule of Dental Benefits.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was dentally necessary orthodontic care. Medicalrecords may be requested and/orrequired for Alliant to determine if the service is Dentally Necessary. See the Orthodontic Care sections for more information.

Your Dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Schedule of Dental Benefits. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your Dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your Dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your Dentist. It provides you and the Dentist with an idea of what your out-of-pocket costs will be for the dental care treatment. This will allow the Dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, endodontic, oral surgery, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for Covered Services.

A pretreatment estimate does not authorize treatment or determine its medical necessity and does not guarantee benefits. The estimate will be based on your current eligibility and your Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Alliant's final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to your Plan may affect our final payment.

You can ask your Dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your Dentist can give you the procedure codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

PEDIATRIC ESSENTIAL HEALTH BENEFITS

The following services are available to pediatric Members through the end of the month in which they turn 19. Once you have met your Deductible, dentalservices will be covered at the listed Coinsurance amounts up to the Maximum Allowed Amount as determined by Alliant for each Covered Service.Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

PREVENTIVE CARE

Oral Exams – Two oral exams are covered each calendar year. If you get two comprehensive exams by
the same dentist, the second is covered as the periodic oral exam.

- Periodic and comprehensive oral evaluations.
- Limited, Problem focused oral evaluations

Periodontal Evaluations – Limit 2 per year. Service covered for Members who have symptoms of periodontal disease and for patients who have risk factors such as smoking, diabetes, or other issues. Not payable when prophylaxis or comprehensive oral evaluation is performed.

Radiographs – The following radiographs are covered:

- Bitewing X-Rays: Limit 2 per year
- Full Mouth X-Rays: Limit 1 series per 3 years
- Panoramic X-Rays: Limit 1 series per 5 years

Dental Cleaning (prophylaxis) – Limit 2 per year. Includes scaling and polishing procedures to remove plaque, tartar, and stain. Covered as child prophylaxis for Members 13 and younger and covered as adult prophylaxis for Members 14 and older.

Fluoride Treatment – Topical Fluoride limited to 2 per year.

Sealants or Preventive Resin Restorations – Limit 1 per tooth per 3 years. Service is for application of sealants to occlusal surface of permanent molars that are free of decay and restoration.

Installation of initial space maintainers for retaining space when a primary tooth is lost – Limit to 1 initial space maintainer. Does not include separate adjustment expenses.

Recementation of space maintainers – Limit to 1 recementation.

Removal of fixed space maintainers

BASIC AND RESTORATIVE SERVICES

Fillings (restorations) – Covered for primary or permanent teeth. Limit once per tooth surface per 2 years. Two types are covered:

- Composite restorations are covered for anterior teeth only. Molar or Bicuspid teeth restorations will be alternative services and paid up to the maximum allowed for an Amalgam filling. Any remaining expenses incurred are the Member's responsibility. One surface having multiple restorations is counted as one restoration.
- Amalgam restorations are a mixture of metals formed to fill cavities that resulted from tooth decay; also known as "silver fillings". One surface having multiple restorations is counted as one restoration.

Emergency Treatment – Service covered for infection or temporary pain relief only if no other services outside of the exam and x-rays were performed on the same date of service.

Radiographs – The following radiograph is covered:

- Other X-Rays (intra-oral periapical and occlusal and extra-oral x-rays): As needed to diagnose specific treatment.

MAJOR AND COMPLEX SERVICES

Pre-fabricated Stainless Steel Crowns – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 5 years.

Resin Based Composite Resin Crown, Anterior – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 5 years.

Initial placements for permanent teeth: Covered when tooth cannot be repaired with direct placement filling material as a result of decay or injury. Includes onlays, crowns, veneers, core build-ups and posts and implant supported crowns and abutments. Limit to 1 per tooth per 5 years.

Replacement of inlays, onlays, crowns or other restorations of permanent teeth – Treatment covered if:

- 5 years have passed since initial placement and is not/cannot be made serviceable.
- Accidental injury has caused damage beyond repair while restoration was in the oral cavity.

Or

- Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Restorative cast post and core build-up – Includes 1 post per tooth and 1 pin per surface. Limit once per 5 years when it is necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Pin Retention – Limit 1 time per 5 years. Covered as an addition to a restoration that is not combined with core build-up.

Endodontic Therapy and Services – Covered on primary or permanent teeth. Limit all root canal treatment to once per tooth/root per lifetime.

- Root Canal therapy and retreatment: includes treatment and fillings. Tests, labs, x-rays,
- intraoperative, tests, or other follow-up care is considered fundamental to the therapy.
- Periradicular surgical procedures: refers to surgery to the external root surface and includes root amputation, tooth reimplementation, apicoectomy, and/or surgical isolation.
- Partial pulpotomy for apexogenesis
- Vital pulpotomy
- Pulp debridement, pulp therapy
- Apexification/recalcification

Periodontic Services

• Scaling and Root Planning: Limit 1 per quadrant per 2 years when tooth pocket is 4 millimeters or deeper.

• Maintenance: any combination of periodontal maintenance and prophylaxis is covered 4 times per year for Members who have completed a previous periodontal treatment (removal of bacteria from gum pockets, scaling/polishing teeth, periodontal evaluation, gum pocket measurements).

- Periodontics Surgical - The most inclusive procedure will be considered if more than one surgical procedure is administered on the same day.

- Separate pre/post-operative care and evaluation fees within 3 months are not considered a part of pediatric dental benefits.
- One type of periodontal surgical procedure per area of mouth (quadrant) every three years
- One bone surgery persingle tooth (or multiple teeth within the same quadrant) per 3 years
- One type of tissue graft per tooth (does not exceed two teeth) per year

• Covered Services
- Osseous surgery
- Bone replacement graft
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Soft tissue allograft
- Combined connective tissue and double pedicle graft
- Distal/proximal wedge – Covered on natural teeth only

Prosthodontic Services
- Initial placement of Bridges, Complete Dentures, and Partial Dentures: Limit 1 per 5 years
  - Includes pontics, inlays, onlays, and crowns: Limit 1 per tooth per 5 years

Replacements/Repairs and Adjustments
- Denture adjustments covered once it has been 6 months since initial installation, or adjustment performed by dental Provider that is not the one who provided the denture.
- Replacement of bridges, complete dentures, and partial dentures. Treatment covered if:
  - 5 years have passed since initial placement and is not/cannot be made serviceable;
  - Accidental injury has caused damage beyond repair while restoration was in the oral cavity;

or
  - Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Recementation of Bridge – Limit once per 5 years.
Tissue Conditioning – Covered once per 2 years.
Relines or Rebases – Covered after 6 months of installation of permanent appliance. Limit 1 time per 3 years.

ORAL SURGERY SERVICES
Simple Extraction – Covered Services include:
- Extraction of coronal remnants of a deciduous tooth
- Extraction of erupted tooth or exposed root for permanent and primary teeth

Surgical Extraction – Any combination of the following are covered once every 6 years. Covered Services include:
- Surgical Removal of Erupted tooth requiring removal of bone
- Removal of residual tooth roots
- Coronectomy
- Tooth reimplant
- Tooth Transplantation
- Exposure of unerupted tooth

- Alveoloplasty
- Vestibuloplasty
- Removal of Lateral Exostosis
- Reduction of Osseous Tuberosity
- Incision and drainage of Abscess
- Suture recent small wounds
- Bone replacemement
- Surgical Replacement of Fibrous Tuberosity
- Excision of pericoronal gingiva

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when administered with covered surgical service.

ORTHODONTIC CARE SERVICES

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront of the treatment and costs. You or your orthodontist should send your pretreatment estimate to Alliant so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontia – These services are available when Dentally Necessary. Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Medical records may be requested and/or required for Alliant to determine if the service is Dentally Necessary.

Qualifying Conditions:

- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Cosmetic Orthodontic Care – These services are not covered.

Orthodontic Treatment may include:

- Limited Treatment – A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment) –This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment – A full kind of treatment that includes all radiographs, diagnostic cast and modes, orthodontic appliances, and office visits.
- Removable Appliance Therapy – Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy – Treatment that uses an appliance that is cemented or bonded to the teeth.

- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth or repositioning of the teeth.

What Orthodontic Care does NOT include – The following is not covered as a part of your orthodontic treatment:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost, broken or stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/orservices for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service);
- Provisional splinting, temporary procedures, or interim stabilization of teeth.

How We Pay for Orthodontic Care – Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. In order for Alliant to continue to pay for your orthodontic care, you must have continuous coverage under your Plan's policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made in six-month intervals until the treatment is finished or coverage under your Plan's policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under your Plan's policy. We will not pay for any portion of your treatment that was given before your effective date under your Plan's policy.

Accidental Dental – Limit once per episode (see definitions).

ADULT DENTAL BENEFITS

The following services are available to adult Members who are 19 years of age and older. Once you have met your Deductible, dental services will be covered at the listed Coinsurance amounts up to the Maximum Allowed Amount as determined by the issuer for each Covered Service. Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

PREVENTIVE CARE

Oral Exams – Two oral exams are covered each calendar year. If you get two comprehensive exams by the same dentist, the second is covered as the periodic oral exam.

- Periodic and comprehensive oral evaluations
- Limited, problem focused oral evaluations

Periodontal Evaluations – Limit 2 per year. Service covered for Member who has symptoms of periodontal disease and for patients who have risk factors such as smoking, diabetes, or other issues. Not payable when prophylaxis or comprehensive oral evaluation is performed.

Radiographs – The following radiographs are covered:
- Bitewing X-Rays: Limit 2 per year
- Full Mouth X-Rays: Limit 1 series per 3 years
- Panoramic X-Rays: Limit 1 series per 5 years

Dental Cleaning (prophylaxis) – Limit 2 per year. Includes scaling and polishing procedures to remove plaque, tartar, and stain.

BASIC AND RESTORATIVE SERVICES

Fillings (restorations) – Covered for primary or permanent teeth. Limit once per tooth surface per 2 years. 2 types are covered:
- Composite restorations are covered for anterior teeth only. Molar or Bicuspid teeth restorations will be alternative services and paid up to the maximum allowed for an Amalgam filling. Any remaining expenses incurred is the Member's responsibility. One surface having multiple restorations is counted as one restoration.
- Amalgam restorations are a mixture of metals formed to fill cavities that resulted from tooth decay; also known as "silver fillings". One surface having multiple restorations is counted as one restoration.

Brush Biopsy – Limit once per 3 years per Member aged 20-39; limit once per year age 40 and above.

Emergency Treatment – Service covered for infection or temporary pain relief only if no other services outside of the exam and x-rays were performed on the same date of service.

Radiographs – The following radiograph is covered:
- Other X-Rays (intra-oral periapical and occlusal and extra-oral x-rays): As needed to diagnose specific treatment.

MAJOR AND COMPLEX SERVICES

Pre-fabricated Stainless Steel Crowns – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 7 years.

Resin Crown, Anterior – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 7 years.

Initial placements for permanent teeth: Covered when tooth cannot be repaired with direct placement filling material as a result of decay or injury. Includes onlays, crowns, veneers, core build-ups, and posts and implant supported crowns and abutments. Limit to 1 per tooth per 7 years.

Replacement of inlays, onlays, crowns or other restorations of permanent teeth – Treatment covered if:
- 5 years have passed since initial placement and is not/cannot be made serviceable.
- Accidental injury has caused damage beyond repair while restoration was in the oral cavity.

Or
- Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Restorative cast post and core build-up – Includes 1 post per tooth and 1 pin per surface. Limit once per 5 years when it is necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Pin Retention – Limit 1 time per 5 years. Covered as an addition to a restoration that is not combined with core build-up.

Endodontic Therapy and Services – Covered on primary or permanent teeth. Limit all root canal treatment to once per tooth/root per lifetime.

- Root Canal therapy and retreatment: includes treatment and fillings. Tests, labs, x-rays,
- intraoperative, tests, or other follow-up care is considered fundamental to the therapy.
- Periradicular surgical procedures: refers to surgery to the external root surface and includes root amputation, tooth reimplementation, apicoectomy, and/or surgical isolation.
- Partial pulpotomy for apexogenesis
- Vital pulpotomy
- Pulp debridement, pulp therapy
- Apexification/recalcification

Periodontic Services

- Scaling and Root Planning: limit 1 per quadrant per 3 years when tooth pocket is 4 millimeters or deeper.
- Full mouth debridement: limit 1 time per lifetime.
- Maintenance: any combination of periodontal maintenance and prophylaxis is covered 2 times per year for Members who have completed a previous periodontal treatment (removal of bacteria from gum pockets, scaling/polishing teeth, periodontal evaluation, gum pocket measurements).
- Periodontics Surgical - The most inclusive procedure will be considered if more than one surgical procedure is administered on the same day.
  - One type of periodontal surgical procedure per area of mouth (quadrant) every three years
  - One Gingivectomy (gum surgery) procedure persingle tooth (or multiple teeth within the same quadrant) per 3 years
  - One Gingival flap (gum surgery) procedure per single tooth (or multiple teeth within the same quadrant) per 3 years
  - One bone surgery persingle tooth (or multiple teeth within the same quadrant) per 3 years
  - One type of tissue graft per tooth (does not exceed two teeth) per year
- Covered Services
  - Gingivectomy/gingivoplasty
  - Gingival flap
  - Apically positioned flap
  - Osseous surgery
  - Bone replacement graft
  - Pedicle soft tissue graft
  - Free soft tissue graft
  - Subepithelial connective tissue graft
  - Soft tissue allograft
  - Combined connective tissue and double pedicle graft
  - Distal/proximal wedge – Covered on natural teeth only

Prosthodontic Services

- Initial placement of Bridges, Complete Dentures, and Partial Dentures: Limit 1 per 7 years for replacement of extracted permanent teeth.

Replacements/Repairs and Adjustments

- Replacement of bridges, Complete Dentures, and Partial Dentures. Treatment covered if:
  - If there is an existing denture or partial, 7 years must pass, and it cannot be repaired or adjusted to be eligible for replacement.
  - Accidental injury has caused damage beyond repair while restoration was in the oral cavity;

or

  - Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).
  - For bridge to be covered, the following must apply:
    - A natural and healthy tooth is available to serve as the anterior and posterior retainer.
    - All teeth are present within the same arch that has been replaced with removable partial denture.
    - The individual teeth of the bridge have not been treated with a crown or cast restoration covered under your Plan within the past 7 years. Denture adjustments covered once it has been 6 months since initial installation, or adjustment performed by a dental Provider, who is not the one who provided the denture. Limit twice per year.
- Repair/Replacement of broken artificial teeth/broken clasp(s) covered twice per 2 years if the appliance is the permanent appliance. Six (6) months must have passed since initial placement and the narrative from the treating Dentist supports the procedure.
- Partial and Bridge adjustments covered twice per 2 years if the appliance is the permanent appliance. Six (6) months must have passed since initial placement and the narrative from the treating Dentist supports the procedure.

Single Tooth Implant Body, Abutment and Crown – Covered once per 5 years. Includes the surgical placement of the implant body, abutment, and supported crown. Your Plan recommends a pretreatment estimate prior to this service.

Recementation of Bridge – Limit once per 5 years.

Tissue Conditioning – Covered once per 2 years.

Relines or Rebases – Covered after 6 months of installation of permanent appliance. Limit 1 time per 3 years.

ORAL SURGERY SERVICES

Simple Extraction – Covered Services include:

- Extraction of coronal remnants of a deciduous tooth.
- Extraction of erupted tooth or exposed root for permanent and primary teeth

Surgical Extraction – Any combination of the following are covered once every 6 years. Covered Services include:

- Surgical Removal of Erupted tooth requiring removal of bone
- Removal of residual tooth roots
- Coronectomy
- Tooth reimplant
- Tooth Transplantation
- Exposure of unerupted tooth
- Alveoloplasty
- Vestibuloplasty

- Removal of Lateral Exostosis
- Reduction of Osseous Tuberosity
- Incision and drainage of Abscess
- Suture recent small wounds
- Bone replacemement
- Surgical Replacement of Fibrous Tuberosity – Covered once per 6 months.
- Excision of pericoronal gingiva

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when administered with covered surgical service.

ORTHODONTIC CARE SERVICES

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront of the treatment and costs. You or your orthodontist should send your pretreatment estimate to Alliant so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontia – These services are available when Dentally Necessary. Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Medical records may be requested and/or required for Alliant to determine if the service is Dentally Necessary.

- Qualifying Conditions:
- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Cosmetic Orthodontic Care – These services are not covered.

Orthodontic Treatment may include:

- Limited Treatment – A treatment usually given for minor tooth movement and is not a full
- treatment case.
- Interceptive Treatment (also known as phase I treatment) –This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment – A full kind of treatment that includes all radiographs, diagnostic cast and modes, orthodontic appliances, and office visits.
- Removable Appliance Therapy – Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy – Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth or repositioning of the teeth.

What Orthodontic Care does NOT include – The following is not covered as a part of your orthodontic treatment:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost, broken or stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/orservices for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service);
- Provisional splinting, temporary procedures, or interim stabilization of teeth.

How We Pay for Orthodontic Care – Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. In order for Alliant to continue to pay for your orthodontic care, you must have continuous coverage under your Plan's policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made in six-month intervals until the treatment is finished or coverage under your Plan's policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under your Plan's policy. We will not pay for any portion of your treatment that was given before your
effective date under your Plan's policy.

Accidental Dental – Limit once per episode (see definitions).

DENTAL INSURANCE: EXCLUSIONS

Alliant will not pay Dental Insurance benefits for charges incurred for:

1. Services that are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which Alliant deems experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services orsupplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn child;
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth;
   - fluoride treatments.
6. Services or appliances which restore or alter occlusion of vertical dimension.

7. Restoration of tooth structure damaged by attrition, abrasion, or erosion, unless caused by disease.
8. Restorations or appliances used for the purpose of periodontalsplinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition, and tobacco.
10. Personal supplies or devices including, but not limited to, water picks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown, or other dental work.
12. Missed or cancelled appointments.
13. Services:
    - overed under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay;
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
    - Performed via Teledentistry.
14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies;
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
    - Dental services arising out of accidental injury (accidental dental) to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
17. Caries susceptibility tests.
18. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured by Plan, except for congenitally missing natural teeth.
19. Other fixed Denture prosthetic services not described elsewhere in this Schedule of Dental Benefits.
20. Precision attachments, except when the precision attachment is related to implant prosthetics.
21. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
22. Addition of teeth to a partial removable Denture to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
23. Addition of teeth to a fixed and permanent Denture to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
24. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
25. Implants to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
26. Implants supported prosthetics to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

27. Fixed and removable appliances for correction of harmful habits.
28. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging.
29. Repair or replacement of an orthodontic device.
30. Duplicate prosthetic devices or appliances.
31. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
32. Intra and extraoral photographic images.

Entire Contract
Your Plan's Certificate of Coverage, the application, any riders, endorsements or attachments, this Schedule of Dental Benefits, and the individual applications of the subscriber and dependents, if any, constitute the entire contract between your Plan and the Member and as of the effective date, supersede all other agreements between the parties. Any and all statements made to your Plan by the Member and any and all statements made to the Member by your Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under your Plan's certificate, shall be used in defense to a claim under your Plan's certificate.

Relationship of Parties (Plan - Dentists)
The relationship between your Plan and Dentists is an independent contractor relationship. Dentists are not agents or employees of your Plan, nor is your Plan, or any employee of your Plan, an employee or agent of Dentists.

Your Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Dentists or in any Dentists' facilities.

Not Liable for Provider Acts or Omissions
Your Plan is not responsible for the actual care you receive from any person. Your Plan's Certificate of Coverage does not give anyone any claim, right, or cause of action against your Plan based on what a Provider of dental care, services or supplies, does or does not do.

Circumstances Beyond the Control of your Plan
In the event of circumstances not within the control of your Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of your Plan, disability of a significant part of a Dentists' personnel orsimilar causes, or the rendering of dental care services provided under your Plan's Certificate of Coverage is delayed or rendered impractical, your Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, your Plan and Dentists shall render dental care services provided under your Plan's Certificate of Coverage insofar as practical, and according to their best judgment; but your Plan and Dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits
Refer to your SoloCare Certificate of Coverage

NOTICE OF NON-DISCRIMINATION

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Client Services at (866) 403-2785.
If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Compliance Officer, PO Box 1128, Dalton, GA 30722, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-403-2785 (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-403-2785 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-403-2785 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-403-2785 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-403-2785（TTY：711）。

ગુજરાતી (Gujarati)
ધ્યાન: જો તમે ગુજરાતી બોલતા હો , તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો 1-866-403-2785 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-403-2785 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-403-2785 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान द यद आप हिंदी बोलते ह ी आपके लए म ु फ्त म भाषा सहायता सेवाएं उपलब्ध ह 1-866-403-2785 (TTY: 711) पर कॉल कर

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-403-2785 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-403-2785 (телетайп: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-403-2785 (رقم هاتف الصم والبكم: (711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-403-2785 (TTY: 711).

فارسی (Farsi)
توجه : اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-866-403-2785 (TTY: 711).

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-403-2785 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-403-2785 (TTY: 711). まで、お電話にてご連絡ください。