Full-Time Dental Plan

Lowe's provides a comprehensive Dental Plan (the Dental Plan Option) for its regular full-time employees and their dependents. See Plan Overview, Employee Eligibility section for further information. This is a dental PPO type plan (DPPO), meaning that you can visit any licensed dentist or licensed dental specialist you choose. The Cigna's DPPO network is called the Cigna Dental Total PPO Network. Lowe's and its employees share in the cost of the Dental Plan Option. Lowe's offers two plan options, the "High Plan" and the "Low Plan" with differing benefits and premiums.

Here's how to get the most out of your dental care dollars:

- Make your next appointment with a dentist or dental specialist in the Cigna Dental Total PPO network. Visiting a Cigna Dental Total PPO network dentist can help save you money as a result of the discounts Cigna has negotiated with network dentists. In addition, Dental Total PPO network dentists will file your claims for you. You can locate a Dental Total PPO network dentist near you, by visiting www.myCigna.com, or calling 1-800-542-4296.
- Visit your dentist regularly for preventive exams. Regular examinations and cleanings can help you save money now and can prevent costly services in the future. In fact, the American Dental Hygienists' Association says that $1 spent on preventive dental care today can save $8 to $50 in future dental treatment costs (www.adha.org). And with your dental coverage, you'll find that most preventive services are available at low or no cost.
- There's another reason to visit your dentist regularly: the Cigna WellnessPlus feature is part of your Dental Plan. With this feature, preventive care received in one plan year means your ***annual dollar maximum will*** **increase** in the following plan year (up to the level specified in your plan documents), allowing you to build your annual dollar maximum for future services you may need. If covered members do not receive at least one preventive care benefit within one plan year, the annual dollar maximum will decrease in the following plan year (down to the level specified in your plan documents).

The Lowe's Dental Plan Option is self-funded. This means that while Cigna processes your claims and determines benefits, Lowe's pays the covered expenses directly. You can help control costs and limit future contribution increases through conscientious use of your Dental Plan coverage and by following the suggestions above.

This Dental Plan Option description has been prepared to provide an explanation of your Dental Plan Option coverage. If you have questions regarding your coverage under the Dental Plan Option, call Cigna toll-free at 1-800-542-4296. If you are unable to get answers to your questions, please contact HR Shared Services at 1-888-474-6365.

Please take the time to review this material carefully. Key terms used in this text are specifically defined at the back of this section.

Dental Plan Highlights

Highlights of the Low Dental Plan Option Coverage are:

Provisions	**In-Network**	**Out-of-Network** Non-Participating Provider services are paid based on the **Maximum Reimbursement Charge**. For this plan, The Maximum Reimbursement Charge is calculated at the 90th percentile of all provider charges in the geographic area.
Maximum Benefits	Year 1 - $1,300 per covered member per calendar year Year 2* - $1,400 per covered member per calendar year Year 3 and beyond* - $1,500 per covered member per calendar year * Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year. If an employee or covered dependent does not have preventive services, their benefit maximum will be reduced by $100 per year. All employees and covered family members will be guaranteed the first year benefit maximum regardless of their participation in preventive services.	Year 1 - $1,000 per covered member per calendar year Year 2* - $1,100 per covered member per calendar year Year 3 and beyond* - $1,200 per covered member per calendar year * Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year. If an employee or covered dependent does not have preventive services, their benefit maximum will be reduced by $100 per year. All employees and covered family members will be guaranteed the first year benefit maximum regardless of their participation in preventive services.

Deductible	$50 per covered member per calendar year, $150 aggregate family limit	$250 per covered member per calendar year, $750 aggregate family limit
Diagnostic/ Preventive Care (Class A)	Covered at 100%; no deductible	Covered at 100%; no deductible
Basic Services (Class B)	Covered at 80%; deductible applies	Covered at 80%; deductible applies
Major Services (Class C)	Covered at 50%; deductible applies	Covered at 50%; deductible applies
Orthodontia Services* (Class D)	Covered at 50%; no deductible; $1,000 lifetime benefit (for children up to age 26, employees, and spouses)	Covered at 50%; no deductible; $1,000 lifetime benefit (for children up to age 26, employees, and spouses)

*Orthodontic device must be installed while under the Lowe's Dental Plan to qualify for coverage. It may not be preexisting.

Highlights of the High Dental Plan Option Coverage are:

Provisions	**In-Network**	**Out-of-Network**
		Non-Participating Provider services are paid based on the **Maximum Reimbursement Charge**. For this plan, The Maximum Reimbursement Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Maximum Benefits	Year 1 - $1,800 per covered member per calendar year Year 2* - $1,900 per covered member per calendar year Year 3 and beyond* - $2,000 per covered member per calendar year * Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year. If an employee or covered dependent does not have preventive services, their benefit maximum will be reduced by $100 per year. All employees and covered family members will be guaranteed the first year benefit maximum regardless of their participation in preventive services.	Year 1 - $1,300 per covered member per calendar year Year 2* - $1,400 per covered member per calendar year Year 3 and beyond* - $1,500 per covered member per calendar year * Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year. If an employee or covered dependent does not have preventive services, their benefit maximum will be reduced by $100 per year. All employees and covered family members will be guaranteed the first year benefit maximum regardless of their participation in preventive services.
Deductible	$50 per covered member per calendar year, $150 aggregate family limit	$250 per covered member per calendar year, $750 aggregate family limit
Diagnostic/ Preventive Care (Class A)	Covered at 100%; no deductible	Covered at 100%; no deductible
Basic Services (Class B)	Covered at 80%; deductible applies	Covered at 80%; deductible applies
Major Services (Class C)	Covered at 50%; deductible applies	Covered at 50%; deductible applies

Orthodontia Services* (Class D)	Covered at 50%; no deductible; $2,000 lifetime benefit (for children up to age 26, employees, and spouses)	Covered at 50%; no deductible; $2,000 lifetime benefit (for children up to age 26, employees, and spouses)

*Orthodontic device must be installed while under the Lowe's Dental Plan to qualify for coverage. It may not be preexisting.

To find a dentist in the Cigna Dental Total PPO network:

- After you enroll, you can register on www.myCigna.com and search for a network dentist by name, specialty, or location. MyCigna automatically knows which Cigna dental plan and network you belong to. Your home zip code will be entered automatically, but you can change the zip if you are looking for a dentist in another area of town.
- You can also search the online provider directory on www.cigna.com. Just click on "Provider Directory." Then click on "Dental," enter your search criteria and click "next." On the new screen, select "Cigna Dental PPO." In the drop-down boxes, select the Dental Total PPO Network and the dentist type you're looking for.
- Employees may also call 1-800-542-4296 and a customer service representative will help you locate a Dental Total PPO network dentist in your area.

Benefit Cost

Lowe's pays a portion of the cost of the Dental Plan Option and employees pay the remainder.

Comprehensive Dental Benefits

Benefits are payable for covered dental expenses incurred, as described below, but not to exceed the maximum benefits.

CLASS A	Benefits equal to 100% of covered dental expenses incurred.
CLASS B	Benefits equal to 80% of covered dental expenses incurred after satisfaction of the deductible.
CLASS C	Benefits equal to 50% of covered dental expenses incurred after satisfaction of the deductible.

CLASS D	Benefits equal to 50% of covered dental expenses incurred. $1,000 lifetime benefit (for children up to 26, employees, and spouses) for Low Plan and $2,000 lifetime benefit (for children up to 26, employees, and spouses) for High Plan

DEDUCTIBLE	
CLASS A	None
CLASSES B AND C	In-Network: $50 per individual; $150 per family Out-of-Network: $250 per individual; $750 per family
CLASS D	None
PLAN MAXIMUMS	
CLASSES A, B, AND C (Low Plan)	In-Network: *Year 1: $1,300 *Year 2: $1,400 *Year 3: $1,500 Out-of-Network: * Year 1: $1,000 * Year 2: $1,100 * Year 3: $1,200 *Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year.
CLASS D (Low Plan)	$1,000 lifetime benefit (for children up to 26, employees, and spouses)
CLASSES A, B, AND C (High Plan)	In-Network:

	*Year 1: $1,800 *Year 2: $1,900 *Year 3: $2,000 Out-of-Network: * Year 1: $1,300 * Year 2: $1,400 * Year 3: $1,500 *Calendar Year Maximum increases are contingent upon receiving Preventive Services in the preceding Calendar Year.
CLASS D (High Plan)	$2,000 lifetime benefit (for children up to 26, employees, and spouses)

In-Network vs. Passive Network

Remember, using in-network dentists saves you money. Visit the Cigna website to search for providers in the Dental Total PPO network in your area. In the past, you may have received in-network benefits even though your dentist was out-of-network - we refer to this as a "passive" network. This is because your area did not have an adequate number of in-network dentists.

Network status can change on an annual basis, and is determined by Cigna. Call Cigna at 1-800-542-4296 to determine your network status.

Members determined to be in a passive network by Cigna should refer to the in-network schedule of benefits to determine benefit coverage levels.

WellnessPlus Feature Details

When you receive any preventive care in one plan year, your annual dollar maximum will increase in the following plan year, allowing you to build your annual dollar maximum for more services you may need in the future.

- Year after year, when you remain enrolled in the plan and continue to receive preventive care, your annual dollar maximum will increase in the following year, until it reaches $1,500 for in network and

$1,200 for out of network for the Low Plan and $2,000 for in network and $1,500 for out of network for the High Plan.
- In future plan years, different members of the same family may have different annual dollar maximums.
- Family members who receive preventive care in a given plan year will be rewarded with an increase in the following plan year.
- Family members who choose not to receive preventive care during a given plan year will have a decrease in the annual dollar maximum in the following plan year.

Here are some examples of preventive care services: *(Sometimes referred to as Class A Services)*

- Cleanings
- Oral Exams
- X-rays, etc.

Covered Dental Expenses

Covered Dental Expenses are charges for the services and supplies shown. The services or supplies must be both: medically or dentally necessary; and ordered or prescribed by a dentist or physician.

Charges will be covered only to the extent that they: do not exceed the amount allowed under the Alternative Benefit Provision; and do not exceed the usual and customary charges generally made in the same area under similar conditions.

The Covered Dental Expenses are:

Class A: Diagnostic and Preventive Services

- Oral examinations and routine cleaning of teeth, but not more than two times per calendar year.
- Fluoride applied on the teeth of your dependent children under age 26, but not more than two times per calendar year.
- Space maintainers for your dependent children under age 26, to replace teeth prematurely removed or missing.
- Dental X-rays:
    - Full mouth (single or multiple films), but not more than once every 36 months;
    - Bitewings, two times per calendar year; or
    - Other X-rays when needed to diagnose and treat a specific covered condition.
- Emergency palliative treatment and emergency exams to relieve pain when performed in a dentist or doctor's office, but not on the same day as any other service, except X-rays. See the definition of palliative in the section headed "Definitions of Common Dental Terms" on page 9 for more information.

- Application of pit and fissure sealants on the teeth- but not more than one application per tooth every two years.

Class B: Basic Services

- Extraction (removal) of teeth.
- Oral surgery (cutting procedures in the mouth), including impacted teeth.
- Filling* of decayed or fractured teeth, except as listed under Class C: Major Services.
- General anesthetics or IV sedation, when medically necessary and in connection with a covered dental procedure.
- Periodontal cleanings, treatments, or surgery to remove diseased gum tissue or bone.
- Endodontic treatment, including root canal therapy.
- Repairs and recementing of crowns, inlays, bridgework, or dentures.
- Relining or rebasing of dentures, but not more than one of either in a 36-month period.

*The Dental Plan Option covers fillings when amalgam (silver) is used. It may also cover resin/composite (white) for certain teeth. Contact Cigna for more details at 1-800-542-4296.

Class C: Major Services

- Fixed bridgework, and partial or full dentures, but only to replace teeth (excluding third molars) that are extracted after you or your dependents are covered under this Dental Plan Option. No benefits will be allowed for adjustments during the first six months after placement.
- Add teeth to an existing fixed bridge, and partial or full denture, but only to replace teeth that are extracted after you or your dependents are covered under this Dental Plan Option.
- Implants
- Replace an existing fixed bridge with a new bridge, subject to replacement conditions below.
- Replace an existing removable partial denture with a new partial, subject to replacement conditions below.
- Replace an existing full denture with a new denture, subject to replacement conditions below.

Replacement Conditions:

- The replacement is needed to replace teeth that are extracted while you or your dependents are covered under this Dental Option;
- The existing denture or bridgework is certified by the dentist or physician to be at least five years old at the time of replacement and cannot be repaired; or
- The existing denture is certified by the dentist or physician to be an immediate temporary full denture that cannot be made permanent and is replaced with a permanent denture within 12 months of the date it was installed.
- Crowns, inlays, onlays, or gold fillings to restore teeth, but only when:
    - The tooth is fractured or has major decay; and
    - The tooth cannot be restored with fillings such as amalgam, plastic, or composite resin.

Class D: Orthodontic Services

- Orthodontic treatment for you, your spouse or domestic partner, and your dependent children under age 26, if the initial active appliance is placed after coverage is in effect for the covered person.
- Covered expenses will include examinations, X-rays, surgery, extractions, active appliances, and adjustments of the appliances. Speech or myofunctional therapy and athletic mouth guards are NOT covered expenses.
- The dentist must submit to Cigna a complete outline of the orthodontic problem, the proposed treatment, the charges for the treatment, and the length of time for completion of the treatment.
- Charges will be considered, subject to other Dental Plan Option conditions, as follows:
    - 25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed; and
    - The remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the plan maximum is paid, treatment is completed, or eligibility ends.

An expense is considered incurred on the date the service is rendered or the supply furnished, not always the date of billing. The service must be completed in order to be considered a covered dental expense. Special conditions apply to orthodontic treatment, and extended benefits.

In no event will benefits paid to any covered person exceed the maximum benefit.

Disease Management: Cigna Oral Health Maternity Program®

Because every baby deserves a healthy start.

Research shows women with periodontal (gum) disease may be at risk for pre-term babies. That's why we've launched the **Cigna Dental Oral Health Maternity Program®**, which enhances dental benefits for expectant members with Cigna dental coverage. Eligible Lowe's members may receive 100% reimbursement of their coinsurance for these services performed during pregnancy:

- periodontal scaling and root planning
- periodontal maintenance
- treatment of inflamed gums around wisdom teeth

And, recognizing the potential risk for "pregnancy gingivitis," the frequency limitation for cleanings will be waived to include an additional cleaning performed during pregnancy.

How It Works for Eligible Members

Make an appointment with your general dentist. Your dentist may recommend a treatment plan and perform additional dental services as medically needed. The dentist will collect their payment from you. If

the services include scaling and root planning (or other treatments covered under this program), you will request reimbursement from Cigna. Call 1-800-542-4296 and follow the prompts for Dental. Ask for an Oral Health Maternity Benefit form.

The form asks for some basic information, including your expected due date. Complete the form, sign it, and mail it to Cigna at the address on the form. Once received, your reimbursement will be processed. If you need assistance completing the form, one of Cigna's customer service representatives will be happy to assist you.

Benefit Provisions

Benefits will be paid for covered dental expenses incurred by you or your dependent(s) as shown in the sections titled "Dental Plan Highlights" and "Comprehensive Dental Benefits."

Covered dental expenses will be subject to the deductible as shown in the sections titled "Dental Plan Highlights" and "Comprehensive Dental Benefits."

Deductible

The deductible is shown in the section titled "Dental Plan Highlights"

The deductible applies separately to each covered person once each calendar year.

When three or more family members have satisfied a total of $150 in deductibles (In-Network), the family limit is reached. For the remainder of that year, the deductible will no longer apply to covered expenses.

Maximum Benefit

In no event will benefits paid to any covered person exceed the maximum benefit.

The maximum benefit is shown in the section titled "Dental Plan Highlights." It applies separately to covered dental expenses for each covered person. Any benefits paid on behalf of a covered person, whether covered as an employee or a dependent, will be combined for purposes of determining the maximum benefit.

Advance Treatment Review

If a course of treatment will exceed $200, an advance treatment plan should be submitted for review before the work starts. You and the Dentist or Physician will be advised of the estimated benefits payable under this Dental Plan Option, subject to eligibility, coordination of dental benefits, maximum benefits, and all limitations and exclusions. In order to review the treatment plan, a description of each service and charge should be submitted along with all supporting aids such as preoperative X-rays. For your

convenience, this process is outlined on the back of the dental claim form. If you fail to get advance treatment review, service could be denied or may not be covered under the plan

Limitations and Exclusions

Regardless of whether a service or treatment is listed in the sections titled "Dental Plan Highlights" and "Comprehensive Dental Benefits", benefits will NOT be paid on charges for:

- Expenses incurred after the date coverage under the Dental Plan Option ceases for you or your dependents for any reason. This is true even though the expenses relate to a condition that began while you or your dependents were covered. The only exception to this is described under "Extended Dental Benefit Provisions."
- Fixed bridgework or dentures to replace teeth that were missing prior to the date you or your dependents became covered under the Dental Plan Option.
- Services or supplies from anyone other than a dentist or a physician. Routine cleaning of teeth and fluoride application when performed by a licensed dental hygienist under the direct supervision of, and billed by, the dentist or physician will be covered.
- Facings, veneers or similar material placed on molar crowns or pontics (teeth or spaces to the rear of the second bicuspid).
- Services or supplies that are partially or wholly cosmetic in nature, or directed toward a cosmetic end.
- Any service or supply incurred, installed, or delivered before you or your dependents become eligible for benefits or after coverage terminates, except as shown under "Extended Dental Benefit Provisions."
- Replacing a lost, missing, or stolen prosthetic appliance.
- A broken appointment.
- Any services received from a medical department, clinic, or any facility provided or furnished by you or your dependent's employer.
- Any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist or physician.
- Services or supplies that do not meet accepted standards of dental practice, including experimental services or supplies.
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Any duplicate prosthetic appliance except as specifically provided under the sections titled "Dental Plan Highlights" and "Comprehensive Dental Benefits."
- Claim form completion.
- Oral hygiene or dietary instruction, or plaque control programs.
- Wiring or bonding teeth or crowns to act as a splint for any reason.
- An injury arising from any employment or occupation.
- An illness covered by workers' compensation.
- Services or supplies for which you are not required to pay.
- Expenses incurred outside the United States or Canada, unless you or your dependent(s) are a resident of one or the other and the charges are incurred while traveling on business or for pleasure.
- Appliances, restorations, or any procedure to alter vertical dimension or restore occlusion.
- Any service or supply that is covered in whole or in part by another plan provided, or sponsored, by Lowe's.

- Services or supplies not specifically listed under Covered Dental Expenses.
- Charges for prescription medications. These are normally covered under your medical plan.
- Charges for dental services that are performed by you, your spouse, your domestic partner, or a parent, sister, brother, or child of you or your spouse or your domestic partner.

Extended Dental Benefit Provisions

If a covered person is in the process of receiving dental services covered under the Dental Plan Option and this coverage ends, benefits will be considered as follows:

Charges for dentures will be considered if:

- The impression was made prior to the date coverage ends;
- The denture was ordered prior to the date coverage ends; and
- The denture is placed in the mouth within 60 days from the date coverage ends.

Charges for fixed bridgework, crowns, and inlays will be considered if:

- The tooth or teeth were prepared prior to the date coverage ends;
- The impression was taken prior to the date coverage ends;
- The bridgework, crown, or inlay was ordered prior to the date coverage ends; and
- The work is seated in the mouth within 60 days from the date coverage ends.

Charges for endodontic treatment, including root canal therapy, will be considered if:

- The tooth was opened prior to the date coverage ends; and
- The procedure is completed within 60 days from the date coverage ends.

A Word about Charges

Charges are incurred on the date when the service or supplies were provided. Expenses incurred after the date that your coverage (or that of your dependents) expires will NOT be covered. This will be true even though the expenses relate to a condition that began while coverage was in effect.

Filing Claims

Claim forms are available online at Cigna website, www.myCigna.com. Claims can be filed directly or electronically by your dentist or doctor; or you can file them with a dental claim form. You should have your claim filed electronically, if at all possible. For payment status or questions about your claim, call the Cigna Claims Center at 1-800-542-4296.

If your dentist or doctor will not file your claim for you, you must submit proof of each charge, so it is extremely important that you secure copies of bills for all charges. All bills should be itemized.

Benefits for dental charges may be assigned to the dentist or physician, if you wish.

Proof of claim must be furnished to Cigna within 90 days following treatment. However, your claim will still be considered if it was not reasonably possible to furnish proof within this time period and proof was furnished as soon as reasonably possible up to a maximum of two years following treatment.

All benefits provided by the Dental Plan Option will be paid immediately upon receipt of the claim. Benefits will be payable to the dental provider, if assigned, or to the employee or his/her estate.

No action at law or in equity shall be brought to recover on the plan prior to the expiration of 60 days after the claim has been furnished nor should any such action be brought at all unless brought within three years from the expiration of the time within which claims must be furnished.

Cigna at its own expense has the right to examine any person whose loss is the basis for a claim and as often as it may reasonably require.

Send dental claims to:

Cigna Claims Center
P.O. Box 188037
Chattanooga, TN 37422- 8037

Definitions of Plan

To understand the benefits, you should know the following terms:

Advance Treatment Review: If a course of treatment will exceed $200, the treatment plan should be submitted for review before the work starts. You and the dentist or physician will be advised of the estimated benefits payable under this Dental Plan Option, subject to eligibility, coordination of dental benefits, maximum benefits, and all limitations and exclusions. In order to review the treatment plan, a description of each service and charge should be submitted along with all supporting aids such as pre-operative X-rays.

Alternative Benefit Provisions: There is often more than one service or supply that can be used to treat a dental problem or disease. In considering the benefits allowed on a claim or advance treatment review, these different methods of treatment and materials will be considered. The covered dental expense will be limited to the usual and customary charge for the most economical service or material that meets broadly accepted standards of dental care.

Course of Treatment: A planned program to correct a diagnosed dental problem or disease. A course of treatment starts when the dentist or physician first treats the dental problem.

Covered Dental Expenses: These are charges for services and supplies. They must be medically/dentally necessary and ordered or prescribed by a dentist or physician.

Charges will be covered only to the extent they do not exceed the amount allowed under the Alternate Benefit Provision; or Usual and Customary Charges. The full list of Covered Dental Expenses is shown earlier in this section.

Dentist: A person who has a license to practice as a dentist in the state where the service is performed.

Physician: A person who has a license to practice as a physician or surgeon in the state where the service is performed.

Proof of Claim: In order to determine the benefits payable under this Dental Plan Option, diagnostic aids, such as preoperative X-rays and other support documents, will be required. If these aids are not sent or are not available, then it may not be possible to provide a benefit for the claim, or you may receive a lesser benefit than would have been allowed if the required proof had been provided.

Maximum Reimbursable Charge: The lesser of:

(1) The providers normal charge for a similar service or supply; or

(2) The policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursement Charge, the nature or severity of the injury or sickness must be considered.

Cigna uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The Percentile used to determine the Maximum Reimbursable Charge is listed in the Schedule.

Additional information about the Maximum Reimbursable Charge is available upon request.

Definitions of Common Dental Terms

Abutment: A tooth or root that retains or supports a fixed bridge or a removable prosthesis.

Acid Etch: The etching of a tooth with a mild acid to aid in the retention of composite filling material.

Acrylic: Plastic materials used in the fabrication of dentures and crowns and occasionally as a restorative filling material.

Amalgam: A metal alloy usually consisting of silver, tin, zinc, and copper combined with liquid pure mercury and used as restorative material in operative dentistry.

Anesthesia:

- **General,** the condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.
- **Local**, the condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body.

Appliance: A device used to provide function, therapeutic (healing) effect, space maintenance, or as an application of force to teeth to provide movement or growth changes as in orthodontics.

- **Fixed,** one that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient.
- **Prosthetic,** used to provide replacement for a missing tooth.
- **Removable,** one that can be taken in and out of the mouth by the patient.

Bitewing: A type of dental X-ray film that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called decay detecting X-rays because they show decay better than other X-rays.

Bridgework or Prosthetic Appliance: Fixed pontics or replacement teeth retained with crowns or inlays cemented to the natural teeth, which are used as abutments.

- **Fixed,** removable, one that the dentist can remove but the patient cannot.
- **Removable,** a partial denture retained by attachments that permit removal of the denture. Normally held by clasps.

Caries: A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

Composite: Tooth colored filling materials primarily used in the anterior teeth.

Crown: A natural crown is the portion of a tooth covered by enamel. An artificial crown (cap) restores the anatomy, function, and esthetics of the natural crown.

Dental Hygienist: A person who has been trained to clean teeth, and provide additional services and information on the prevention of oral disease.

Denture: A device replacing missing teeth. The term usually refers to full or partial dentures, but it actually means any substitute for missing natural teeth.

Endodontic Therapy: Treatment of diseases of the dental pulp and their sequelae.

Fluoride: A solution of fluorine that is applied topically to the teeth for the purpose of preventing dental decay.

Implant: A device surgically inserted into or onto the jaw-bone. It may support a crown or crowns, partial denture, complete denture, or may be used as an abutment for a fixed bridge.

Impression: A negative reproduction of a given area. It is made in order to produce a positive form or case of the recorded teeth and/or soft tissues of the mouth.

Inlay: A restoration usually of cast metal made to fit a prepared tooth cavity and then cemented into place.

Malocclusion: An abnormal contact and/or position of the opposing teeth brought together.

Onlay: A cast restoration that covers the entire chewing surface of the tooth.

Orthodontic: The branch of dentistry primarily concerned with the detection, prevention, and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

Palliative: An alleviating measure. To review, but not to cure. Any services listed under basic, major, or orthodontic services are NOT considered palliative.

Partial Denture: A prosthesis replacing one or more, but less than all, of the natural teeth and associated structures; may be removable or fixed, one side or two sides.

Pedodontics: The specialty of children's dentistry.

Periodontics: The science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

Pontic: The part of a fixed bridge that is suspended between the abutments and that replaces a missing tooth or teeth.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

Rebase: A process of refitting a denture by the replacement of the entire denture base material without changing the occlusal relationship of the teeth.

Reline: To resurface the tissue-borne areas of a denture with new material.

Restoration: A broad term applied to any inlay, crown, bridge, partial dentures, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth or teeth.

Root Canal Therapy: The complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

Scaling: The removal of calculus (tartar) and stains from teeth with special instruments.

Sealant: A resinous agent applied to the grooves and pits of teeth to reduce decay.

Silicate: A relatively hard and translucent restorative material that is used primarily in the anterior teeth.

Splinting: Stabilizing or immobilizing teeth to gain strength and/or facilitate healing.

Topical: Painting the surface of teeth as in fluoride treatment, or application of an anesthetic formula to the surface of the gum.

Vertical Dimension: The degree of jaw separation when the teeth are in contact.