DENTAL INSURANCE COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES.
OUTLINE OF COVERAGE

I. READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

II. DENTAL INSURANCE COVERAGE. Policies of this category are designed to provide, to persons insured, limited benefits for expenses incurred for Dental Services, such as Preventive Services, including Routine Examinations and X-rays, and Basic Services, such as fillings and sealants, etc., ONLY, subject to any limitations contained in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

III. DENTAL SERVICES COVERED BY THE POLICY.

Eligible Expenses: We will pay for Eligible Expenses the Insured incurs. Expenses must be incurred while the Policy is in force and while the Insured is covered by the Policy. The Eligible Expenses shown in the Benefit Schedule will govern the benefits payable under the Policy.

To be an Eligible Expense, the dental service or procedure must be performed by a Dentist, a Doctor, or a Dental Hygienist.

Expenses Incurred: An Eligible Expense is considered incurred on the following dates:

1. For dentures - the date the first impression is taken.
2. For fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For orthodontic services - the benefit is considered as follows:
   - Records - on the date the service is performed;
   - Initial banding - on the date bands are inserted;
   - Monthly treatments - on the date the service is performed.

   Orthodontic Services are covered by the Policy only if included on the Benefit Schedule.

6. For all other services - the date the service is performed.

Maximum Calendar Year Limit: The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Benefit Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

Deductible: The calendar year Deductible, if any, is shown in the Benefit Schedule. The Deductible is an amount of charges the Insured must incur for him- or herself or on behalf of the Insured's Dependent(s) before We start paying benefits.

Network Dentist Services: Network Dentists accept the Contracted Fee Schedule as payment in full. The negotiated fees are subject to change without notice. Services not listed in the provider’s Contracted Fee Schedule are not available on a fee-for-service basis and are the patient’s full responsibility.

Use of a Network Dentist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.
Network Specialist Services: A Specialist is a licensed Dentist who is board certified in one or more of the following specialties: endodontics, periodontics, pedodontics, prosthodontics, oral surgery, orthodontics, and any other board certified specialty outside of general dentistry.

Network Specialists have agreed to provide services at a discount from their Usual fees. The discounted rate is based on the negotiated agreement in the provider’s contract. Services rendered by a Network Specialist will be reimbursed as stated in the Benefit Schedule.

Use of a Network Specialist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

Out-of-Network Dentist and Specialist Services: Out-of-Network Dentists/Specialists do not accept the Contracted Fee Schedule as payment in full. Services will be reimbursed as stated in the Benefit Schedule.

The fact that a Dentist, Hospital, or other provider may prescribe, order, recommend, or approve a service or supply, does not, of itself, make it Medically Necessary or make the charge an allowable expense. We determine if a service or supply is covered in accordance with established Plan benefits and policies.

Pre-Treatment Review: If the Course of Treatment is expected to exceed $300, We will require prior review. We must be given the Dentist’s treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If the Insured does not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

Alternate Benefit: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

COVERED SERVICES. The following is the list of Covered Services for which benefits are payable under the Policy. Procedures not listed below are not covered. All services are subject to review for necessity; X-rays, charting, and/or records may be required to determine if the procedure is covered.

Class A. Preventive Services Include:
1. routine examinations and cleanings, topical fluoride (up to age 15) – 2 per calendar year (in conjunction with all other exams);
2. panoramic (age 6 or older) or full mouth series x-rays – 1 every 36 months;
3. vertical bitewings x-rays (age 11 or older) – 8 films total per year;
4. periapical x-rays;
5. occlusal x-ray – 1 upper and 1 lower every 24 months.

Class B. Basic Services Include: These services are subject to the Benefit Waiting Period shown in the Benefit Schedule.
1. oral surgery (except periodontics) - simple extraction of teeth; frenectomy, incision and drainage of intraoral abscess; extraction of impacted tooth; surgical exposure of tooth; alveolectomy; alveoplasty; excision of pericoronal gingiva, exostosis, hyperplastic tissue; reimplantation and repositioning of natural tooth;
2. non-routine exams and consultations – 2 per year (in conjunction with all other exams);
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials;
4. pin retention of fillings;
5. space maintainers (up to age 15) to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
6. sealants on permanent bicuspid and molars (up to age 15) – every 36 months.
Class C. **Major Services Include:** These services are subject to the Benefit Waiting Period shown in the Benefit Schedule.

1. endodontic treatment: root canal therapy (age restrictions apply); pulpotomy; pulpal therapy; apicoectomy; apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings;
2. periodontic services: perio maintenance (2 per calendar year in lieu of preventative cleaning); root scaling and planing (once per quadrant of mouth in any 24-month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedical or free soft tissue grafts; full mouth debridement (1 every five years; limited services available on same date of service);
3. crown build-up; post and core;
4. recementing inlays, onlays and crowns and bridges;
5. repair of dentures or bridges;
6. general anesthesia, including intravenous sedation – (i) age 7 & under once per calendar year, up to $150; (ii) age 8 & over for the extraction of impacted teeth, based on necessity, not for anxiety management, up to $150 per year;
7. crowns, bridges, inlays, onlays, dentures and gold fillings - every five years. (Additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the Policy.);
8. addition of teeth to existing partial denture;
9. refining or rebasing of existing removable dentures- 1 per year;
10. occlusal guards for bruxism only – 1 every 2 years;
11. stainless steel crowns - 1 every 2 years.

Class D. **Orthodontia Services:** These services are subject to the Benefit Waiting Period shown in the Benefit Schedule. Orthodontia Services covered by the Policy only if shown on the Benefit Schedule.

We will pay for the Eligible Expenses described below that are incurred by the Insured for orthodontia treatment and services while covered under the Policy. These payments are subject to the Lifetime Maximum Limit shown in the Benefit Schedule. Benefits will be payable when the charges incurred are ordered by a Doctor or Dentist and not otherwise excluded by the Policy.

**Eligible Expenses:** We will pay the amount shown in the Benefit Schedule incurred for the following orthodontia services:

1. 2D cephalometric radiographic image – acquisition, measurement, and analysis;
2. one of the following Eligible Expenses for orthodontic treatment once per lifetime of the Insured for the following: limited orthodontic treatment, interceptive orthodontic treatment, comprehensive orthodontic treatment;
3. appliance therapy (removable or fixed) – once per lifetime of the Insured;
4. pre-orthodontic treatment examination to monitor growth and development, once per lifetime of the Insured;
5. orthodontic treatment or periodic orthodontic treatment, once per calendar month;
6. orthodontic retention (removal of appliances, construction and placement of retainer(s), once per lifetime of the insured. No benefit will be paid if a benefit has been previously paid for limited orthodontic treatment, interceptive orthodontic treatment, comprehensive orthodontic treatment.

There is no coverage for orthodontic treatment which begins prior to the Insured's Effective Date of coverage under this Policy.

IV. **EXCLUSIONS.** No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Benefit Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the Contracted Fee Schedule or the Usual, Customary and Reasonable rate, whichever applies.
5. for any treatment program which begins prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliances within 5 years from the date of last placement.
8. for service or supplies payable under any medical expense, auto or no-fault plan.
9. for any condition covered under any Workers’ Compensation Act or similar law.
10. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
11. for services that are applied toward the satisfaction of a Deductible, if any.
12. for services subject to a Benefit Waiting Period.
13. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
14. for Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, Hospital confinement.
15. for drugs or the dispensing of drugs.
16. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
17. for implants (unless included in covered services); myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
18. for orthodontia, unless included within the Benefit Schedule.
19. for services to replace teeth that are missing (extracted or congenitally) prior to the Effective Date of the Policy. This limitation ends after 36 months of continuous coverage on the Policy. Abutment teeth will be reviewed for eligibility of prosthetic benefits.
20. for composite, resin, or white fillings on posterior primary teeth. Benefits will be reduced to that of an amalgam or silver filling.
21. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
22. for the replacement of retainers.
23. for sealants not applied to permanent bicuspids or molars, applied later than the end of the month in which a child reaches age 15, applied 3 years from a previous sealant application, applied to a decayed tooth.
24. for lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.
25. during travel or activity outside the United States.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

V. TERMINATION OF COVERAGE. Insurance will end on the earliest of:

1. the Termination Date shown in the Benefit Schedule;
2. the date the period ends for which premium is paid.

Termination of this Policy will not affect a claim for loss which occurs while this Policy is in effect.

VI. PREMIUMS. The premium rate for this coverage is: See accompanying Plan Detail Summary for premium rate.