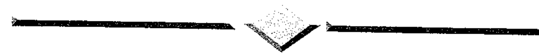
United Concordia Life And Health Insurance Company

4401 Deer Path Road
Harrisburg, PA 17110

Fee For Service Network Dental Plan Certificate of Insurance

This Certificate of Insurance provides detailed information about your dental coverage.
Keep it in a safe place with your other valuable documents and review it to become familiar with your benefits.
Refer to this document when you have a specific question regarding your coverage.



PA9804 (6/99)

TABLE OF CONTENTS

DEFINITIONS 3
ENTIRE CERTIFICATE 5
TERM OF CERTIFICATE 5
AMENDMENT 5
ELIGIBILITY 5
COVERED SERVICES 6
NOTICE OF CLAIM 7
CLAIM FORMS 7
PROOF OF LOSS 7
TIME PAYMENT OF CLAIMS 7
PAYMENT OF CLAIMS 7
PHYSICAL EXAMINATIONS 8
LEGAL ACTIONS 8
EXTENSION OF BENEFITS 8
CONTINUATION OF BENEFITS 8
WORKER'S COMPENSATION & OTHER GOVERNMENT PROGRAMS 8
COORDINATION OF BENEFITS 8
ASSIGNMENT & DELEGATION 11
GOVERNING LAW 11

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

SCHEDULE OF BENEFITS

DEFINITIONS

Certificate Holder(s) - An individual who has submitted an application for dental coverage for him/herself and his/her Dependents for whom Premium payments are due and payable by the Policyholder.

Certificate of Insurance ("Certificate") - This document, including riders and/or endorsements, if any, which describes Member coverage purchased from the Company by the Policyholder.

Coinsurances - Those percentages of the Maximum Allowable Charge as set forth in the Schedule of Benefits that are the responsibility of either the Certificate Holder or his/her enrolled Dependents.

Company - United Concordia Life And Health Insurance Company.

Coordination of Benefits ("COB") - A method of integrating benefits for Covered Services under more than one plan to prevent duplication.

Cosmetic - Those procedures which are not Dentally Necessary and which are undertaken primarily, in the opinion of the Company, to improve or otherwise modify the Member's appearance, when the cause is not related to accidental injury.

Covered Service(s) - A service or supply specified in this Certificate for which benefits will be covered when rendered by a dentist, or if specifically approved by the Company.

Deductible(s) - A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will assume liability.

Dentally Necessary - A dental service or procedure as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the Company. In the event of any conflict of opinion between the dentist and the Company as to when a dental service or procedure is Dentally Necessary, the opinion of the Company shall be final.

Dependent(s) - Unmarried son/daughter, or stepson/stepdaughter of a Certificate Holder or member of the Certificate Holder's household resulting from a court order or placement by an administrative agency, who is enrolled in the Plan until: (a) the end of the month which he/she turns nineteen (19); or (b) the end of the month which he/she turns twenty-five (25) if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or (c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support. For a Dependent who falls into category (b), evidence of his/her student status and reliance on the Certificate Holder shall be furnished to the Company in the form requested within 31 days after said Dependent attains the age of nineteen (19) and, thereafter, not more frequently than semi-annually. For a Dependent who falls into category (c), evidence of his/her reliance on the Certificate Holder due to his/her condition shall be furnished to the Company in the form requested within 31 days after said Dependent attains the age of nineteen (19), or within 31 days after said Dependent attains the age of twenty-five (25) if he/she is a full-time student at an accredited educational institution. Newly born children of a Member shall be considered Dependents from the moment of birth. Adoptive children shall also be considered Dependents from the date of adoption or placement, except for those adopted or placed within 31 days of birth who shall be considered Dependents from the moment of birth. Furthermore, Certificate Holder's spouse or domestic life partner as defined by the Policyholder and/or state law shall also be considered a Dependent.

Effective Date - The date on which coverage for the Policyholder and it's eligible Members begin.

Enrollment/Change Form - A form used to enroll Certificate Holders. Such information may be transmitted from the Policyholder to the Company using any agreed upon form of written or electronic media.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, relying on the advice of the general dental community which includes, but is not limited to dental consultants, dental journals and/or governmental regulations, determines are not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.

Grace Period - A Grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the Policy shall continue in force subject to the right of the Company to cancel in accordance with the cancellation provi sion hereof.

Group Policy - The agreement between the Company and the Policyholder, under which the Certificate Holder is eligible to enroll.

Limitation(s) - The maximum frequency or age set forth in the Schedule of Exclusions and Limitations incorporated by reference into this Certificate.

Maximum(s) - The greatest amount the Company is obligated to pay for Covered Services during a specified period.

Maximum Allowable Charge -The maximum amount the Plan will allow for a Covered Service.

Member(s) - Certificate Holder(s) and their Dependent(s).

Non-Participating Dentist - A dentist who has not signed a contract with the Company or an affiliate of the Company.

Participating Dentist - A dentist who has executed a Participating Dentist Contract with the Company or an affiliate of the Company, under which he/she agrees to provide covered dental care services under this Plan.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Benefits.

Policyholder - Organization that executes the Group Policy.

Pretreatment Estimate - The review by the Plan of a Treatment Plan to determine the eligibility of a Member, the coverage for services in accordance with the Schedule of Benefits, the Schedule of Exclusions and Limitations, and the Plan allowance for such services.

Premium - Fee that the Policyholder must remit to the Company or Company's agent on behalf of its Certificate Holders each calendar month during the term of this Certificate.

Renewal Date - The date on which the Group Policy renews. Also known as anniversary date.

Schedule of Benefits - Attached list of Covered Services, Coinsurance amounts, Deductibles and Maximums.

Termination Date - The date on which the dental benefits are no longer in effect.

Treatment Plan(s) - The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for a Member by a dentist as a result of an examination.

Waiting Period(s) - A period of time a Member must be insured under this Certificate before he/she is eligible for Covered Services. Any Waiting Periods applicable to dental benefits covered under this Plan are shown in the attached Schedule of Benefits.

ENTIRE CERTIFICATE

This Certificate includes and incorporates any and all riders and/or endorsements, Schedule of Exclusions and Limitations and Schedule of Benefits and represents the entire agreement between the parties with respect to the subject matter. However, the failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections hereof. All statements made by the Policyholder or applicant or Member shall, in the absence of fraud, be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in a written instrument and signed by the Policyholder, a copy of which has been furnished to the Policyholder or the Certificate Holder or his/her beneficiary.

TERM OF CERTIFICATE

The term of the Certificate shall begin on the Effective Date identified in the Group Policy and continue in effect for one year, unless terminated in accordance with provisions listed below:

Except as provided in the Extension of Benefits provision, coverage under this Certificate will terminate the first of the month following: (1) for a Certificate Holder and his/her Dependents, the last day of the month for which Premium was paid, or (2) for a Dependent, the date the Dependent ceases to meet the definition of Dependent, or (3) for a Dependent child subject to a court or administrative order, receipt of satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child has been enrolled in comparable coverage through another plan which shall take effect no later than the effective date of disenrollment under this Certificate, or (4) for any Certificate Holder, the date such Certificate Holder voluntarily disenrolls from the Plan, or (5) upon termination of the Policy.

Upon completion of the original term, this Certificate shall automatically be renewed on an annual basis as provided for in the Group Policy.

Coverage shall remain in effect for 31 days after the due date of the Premium. If the Premium is not received within the Grace Period, coverage will be immediately canceled back to the first of the coverage month. The Policyholder shall remain liable to the Company for Premium accrued during the Grace Period. It is the responsibility of the Policyholder to notify all Certificate Holders of the termination of the Policy. The Policyholder shall be responsible to make such notification of termination to the custodial parent of a Dependent child subject to a court or administrative order relating to provision of health care coverage.

AMENDMENT

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing and signed by both the Company and Policyholder and thereafter attached hereto as part of this Certificate.

ELIGIBILITY

Certificate Holders who satisfy the eligibility requirements and who enroll prior to the Effective Date of the Certificate will be covered on the Effective Date. If the age of the Member has been misstated, all benefits payable under this Policy shall be such as the Premium paid would have purchased at the correct age.

Certificate Holders who become eligible after the Effective Date of the Policy and who complete an enrollment form within 30 days of initial eligibility shall be covered on the first day of the month following the date specified by the Policyholder on the Enrollment/Change Form, except for newly born or adopted children who shall be covered from the moment of birth or placement.

A child newly born, adopted, or placed for adoption within thirty-one (31) days of birth shall be considered enrolled from the moment of birth for thirty-one (31) days. In order for coverage to continue beyond the thirty-one (31) day period, notification of birth, adoption, or placement for adoption, and payment of the required Premium shall be furnished to the Company by the Group within the thirty-one (31) day period.

Dependents are eligible upon enrollment of Certificate Holder, or within 30 days of their eligibility, except for adoptive children, due to a change in status such as marriage, and the like. Adoptive children may be enrolled up to 60 days from the date of placement. If Certificate Holders and/or their Dependents are not enrolled within 30 days of eligibility or 60 days for adoptive children, they cannot be enrolled until the open enrollment period conducted for the Policyholder. This restriction shall not apply to Dependent children of a Member subject to a court or administrative order of support relating to the provision of health care coverage. Dependent coverage only may be terminated during open enrollment periods unless a change in status, such as divorce, has occurred.

COVERED SERVICES

Services provided under the Plan will be according to this Certificate and/or the attached Schedule of Exclusions and Limitations, and Schedule of Benefits. Certain services may be subject to Coinsurances, Deductibles, Maximums, Limitations and Waiting Periods as listed in this Certificate and/or Schedule of Exclusions and Limitations and/or the Schedule of Benefits. Coinsurances, Deductibles, Maximums, Limitations and Waiting Periods as listed will be reviewed periodically and may be adjusted.

Participating Dentists have agreed to accept a Maximum Allowable Charge as payment in full for Covered Services and to complete and submit claim forms (proofs of loss) for those Members receiving Covered Services. Upon receipt of a claim from a Participating Dentist, the Plan will reimburse the Participating Dentist directly. Participating Dentists will make no additional charge to Members for Covered Services except in the case of certain Coinsurances or amounts exceeding the Maximums referred to in this Certificate and/or the Schedule of Benefits. When Plan payment of the Maximum has been met, payment to the Participating Dentist will be the responsibility of the Member.

When Covered Services are performed by a Non-Participating Dentist, the Member will be responsible for completing and submitting claim forms.

A Pretreatment Estimate is recommended for extensive treatment and is used by the Company to determine the extent of Covered Services of Members. Substantiating material such as radiographs and study models must be submitted to estimate benefits when requested by the Company. If substantiating material requested by the Company to make a Pretreatment Estimate is not submitted, the Company reserves the right to determine benefits payable, taking into account alternative procedures, services or courses of treatment, based upon accepted standards of dental practice. Any amount estimated by the Company shall be subject to such adjustments by the Company at the time of final payment in order to correct any mathematical errors and to comply with the Member's Plan in effect at the time the Covered Service is completed.

The Company shall not be liable under this Certificate for any Covered Services, including those Covered Services determined by a Pretreatment Estimate, which are performed at a time the Member's Plan is no longer in effect, except as may be provided for in the Extension of Benefits section of this Certificate.

Treatment Plans are required for orthodontic services to set up an appropriate reimbursement schedule to the Orthodontist. Should an Orthodontist not submit a Treatment Plan and a claim is submitted, the company will contact the provider for information that is required to set up the payment schedule.

NOTICE OF CLAIM

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

CLAIM FORMS

The Company, upon receipt of a notice of claim, will furnish to the Policyholder for delivery to such person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

PROOF OF LOSS

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

TIME PAYMENT OF CLAIMS

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS

All benefits under this policy shall be payable to the Participating Dentist or the Insured Person, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

PHYSICAL EXAMINATIONS

The Company at its own expense shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

EXTENSION OF BENEFITS

Coverage for completion of a dental procedure, requiring two or more visits on separate days, will be extended for a period of 90 days after termination by the Company.

CONTINUATION OF BENEFITS

Federal law requires Policyholders to offer continuation of benefits for a specified period of time for Members by direct payment of the required Premium to the Policyholder upon termination of employment or reduction of work hours for any reason other than gross misconduct.

The Member must elect to continue coverage within 60 days from such termination or notification of rights by the Policyholder, whichever is later. The Member may elect to extend Dependent(s') coverage or the Dependent(s) may elect to continue coverage under certain circumstances. Dependent(s) must elect to continue coverage within 60 days from termination or notification by the Policyholder, whichever is later.

WORKER'S COMPENSATION

When a Member is eligible for Worker's Compensation benefits through his/her employer, the Company may exclude expenses for injuries which are covered through his/her Worker's Compensation benefits. Therefore, if the Company provides services which are covered by a Worker's Compensation policy, the Company has the right to obtain reimbursement. The Member must provide the assistance necessary, including providing information and signing necessary documents, for the Company to receive reimbursement. The Member must not do anything which may limit the Company's reimbursement.

COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

a. Shall not be reduced when under the order of benefit determination rules. This Plan determines its benefits before another plan; but

b. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section D, "Effects on the Benefits of This Plan."

B. Definitions

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care treatment:

a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under a. or b. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. "This Plan" is the part of the group contract that provides benefits for dental care expenses.

3. "Primary Plan/Secondary Plan." The order of benefits determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan, and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

C. Order Of Benefit Determination Rules

1. General. When there is a basis for a claim under This Plan and another plan This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

a. The other plan has rules coordinating its benefits with those of This Plan; and

b. Both those rules and This Plan's rules, in Subsection 2 below, require that This Plan's benefits be determined before those of the other plan.

2. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

   a. Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

   b. Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph 2 (c) below, when This Plan and another plan cover the same child as a dependent of different person, called "parents:
      (1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

      (2) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

      However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   c. Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) First, the plan of the parent with custody of the child;

      (2) Then, the plan of the spouse of the parent with the custody of the child; and

      (3) Finally, the plan of the parent not having custody of the child.

      However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

   d. Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (d) is ignored.

   e. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

D. Effect On The Benefits Of This Plan

1. When This Section Applies. This Section D applies when, in accordance with Section C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as " the other plans" in 2. immediately below.

2. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

   a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the Allowable Expense under the other plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give The Company any facts it needs to pay the claim.

F. Facility Of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does The Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right Of Recovery

If the amount of the payments made by The Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ASSIGNMENT & DELEGATION

The Company may assign this Certificate and its rights hereunder and delegate its duties hereunder to any entity into which it is merged or which substantially acquires all its assets.

GOVERNING LAW

This Certificate shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with pertinent laws and regulations of the Commonwealth of Pennsylvania. Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state in which the Member resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

Except as specifically provided in the Certificate, Schedules of Benefits or Riders to the Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.
2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan.
3. Started prior to the Member's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.
4. Services or supplies that are not deemed generally accepted standards of dental treatment.
5. For hospitalization costs.
6. That are the responsibility of Worker's Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Policies and Certificates issued and delivered in Georgia, Missouri, and Virginia, only services that are the responsibility of Workers Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies and Certificates issued and delivered in Texas, only services that are the responsibility the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.
7. For prescription or non-prescription drugs, vitamins, or dietary supplements.
8. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.
9. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

   This exclusion does not apply to Group Policies and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury.

   This exclusion does not apply to Group Policies issued and delivered in New Jersey for Cosmetic services for newly-born children of Members as defined in the definition of Dependent.
10. Elective procedures including but not limited to the prophylactic extraction of third molars.
11. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
12. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.

    For Group Policies and Certificates issued and delivered in Arizona, Kentucky, and Pennsylvania this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.

    For Group Policies issued and delivered in Colorado, Indiana, Missouri, New Jersey, and Virginia, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent.

    For Group Policies issued and delivered in Colorado, this exclusion shall not apply to orthodontic or dental services for a newly born Dependent with cleft lip or cleft palate and shall be covered as listed on the Schedule of Benefits.

For Group Policies and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

13. For dental implants including placement and restoration of implants unless specifically covered under a rider to the Certificate.
14. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth.

    This exclusion shall not apply to Group Policies issued and delivered in Georgia when such services are medically necessary.
15. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under a Rider to the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies and Certificates issued in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.
16. For treatment of fractures and dislocations of the jaw.

    This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.
17. For treatment of malignancies or neoplasms.
18. Services and/or appliances that alter the vertical dimension, including but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

    This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.
19. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
20. For broken appointments.
21. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics.
22. For house or hospital calls for dental services.
23. Replacement of existing crowns, onlays, bridges and dentures that are or can be made serviceable.
24. Preventive restorations in the absence of dental disease.
25. Periodontal splinting of teeth by any method.
26. For duplicate dentures, prosthetic devices or any other duplicative device.
27. For services determined to be furnished as a result of a referral to an entity in which the referring dentist, or the dentist's immediate family; (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's spouse, parent, spouse's parent, sibling, or sibling's spouse of the dentist, or that dentist in combination.
28. For which in the absence of insurance the Member would incur no charge.
29. For plaque control programs, oral hygiene, and dietary instructions.
30. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.
31. For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy).
32. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

33. Which are not Dentally Necessary as determined by the Company.

    This exclusion does not apply to Group Policies and Certificates issued and delivered in California and Maryland..

LIMITATIONS

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays – one every three years.
2. One set(s) of bitewing x-rays per six months.
3. Periodic oral evaluation – one per six months.
4. Limited oral evaluation (problem focused) – limited to one per dentist per twelve months.
5. Prophylaxis – one per six months.
6. Fluoride treatment – one per six months through age eighteen.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy four in any twelve consecutive months per member reduced by the number of routine prophylaxis received during that twelve-month period so that the total prophylaxes for the period does not exceed four.
11. Periodontal scaling and root planing - one per two year period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
13. Denture relining, rebasing or adjustments - are included in the denture charges if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing – limited to one every three year(s) thereafter.
15. Surgical periodontal procedures - one per two year period per area of the mouth.
16. Sealants - one per tooth per three year(s) through age ten on permanent first molars and through age fifteen on permanent second molars.
17. Pulpal therapy – once per tooth per lifetime.
18. Root canal treatment and retreatment – one per tooth per lifetime.
19. Recementations by the same dentist who initially inserted the crown or bridge during the first twelve months are included in the crown or bridge benefit, then one per twelve months thereafter; one per twelve months for other than the dentist who initially inserted the crown or bridge.
20. Replacement restorations – limited to one per twelve months.
21. Contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration.
22. Posts are only covered as part of a post buildup.
23. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP.
24. Payment for orthodontic services shall cease at the end of the month after termination by the Company.
25. Consultations are limited to one per consultant during any one period of hospitalization when the subscribers dental condition requires such consultation.
26. One temporary crown is eligible per tooth per lifetime.