

## Outline of Coverage for Dental Insurance Policy

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### **DENTAL INSURANCE POLICY**

#### **RETAIN THIS OUTLINE FOR YOUR RECORDS**

#### **THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.**

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. You may also review this guide at [www.Medicare.gov](http://www.Medicare.gov).

#### **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 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**.

#### **Limited Benefit Coverage**

Policies of this category are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

#### **Dental Coverage**

Policies of this category are designed to provide You with coverage for dental services. Coverage is provided for preventive and diagnostic, basic and major dental services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

### **BENEFITS PROVIDED BY THE POLICY**

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations provision. After the Policy Year Deductible is satisfied and subject to any Waiting Periods, We will pay Our Coinsurance amount for the following services up to the Policy Year Maximum Benefit Amount. Please refer to the Policy Schedule and the Benefits section of the policy for a complete description of the benefits.

### **DENTAL BENEFITS**

#### **Diagnostic and Preventive Services**

This benefit pays for evaluations, cleanings and bitewing x-rays.

#### **Basic Services**

This benefit pays for restorations (fillings), x-rays, nonsurgical extractions and palliative care.

#### **Major Services**

This benefit pays for crowns/inlays/onlays, prosthodontic services, endodontic services, periodontal services and oral surgery for an erupted tooth.

### **EXCLUSIONS AND LIMITATIONS**

No benefits will be paid for any expense not identified and included as a covered loss under the policy. You will be fully responsible for payment of any expenses that are not a covered loss. We will not pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. Amounts not reimbursed because of applicable Policy Year Deductible, Coinsurance, benefit maximums, or frequency limitations.
3. Any loss that occurs during a Waiting Period.
4. Amounts in excess of the Reasonable and Customary Charge.

5. Items, treatments or services:
  - a. Not covered under this policy, including any complications arising therefrom;
  - b. That are not prescribed by or performed by or under the direct supervision of a Physician in accordance with generally accepted dental or medical standards, to include services not rendered or that are not rendered within the scope of their license;
  - c. Not Medically Necessary;
  - d. Deemed to be Experimental or Investigational;
  - e. That would not routinely be paid in the absence of insurance; or
  - f. Performed by an Immediate Family member.
6. Separate fees for services that are considered an integral part of an entire service, such as pulp capping, surgical trays, sutures, or pre and post operative care.
7. Services or procedures that have not been completed.
8. Any cosmetic items, treatments or services provided primarily for the purpose of improving appearance, self-esteem or body image, including characterizing and personalizing prosthetic devices, and correction of congenital malformation.
9. Any device, appliance, or service related to:
  - a. Altering vertical dimension;
  - b. Restoring or maintaining occlusion;
  - c. Splinting teeth or stabilizing teeth for periodontal reasons;
  - d. Abrasion, attrition, bruxism, erosion, abfraction;
  - e. Coping;
  - f. Tooth desensitization; or
  - g. Maxillofacial prosthetics.
10. Any surgical or nonsurgical treatments or services, including myofunctional therapy and physical therapy for any jaw joint problems, including, but not limited to: temporomandibular joint disorder (TMJ), craniomandibular disorder, craniomaxillary or other conditions of the joint linking the jaw bone and skull or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to, headaches.
11. Occlusal, athletic, or night guards and related services.
12. Orthodontic treatment or orthognathic surgery and related services.
13. Ridge preservation, augmentation, bone grafts, and tissue regeneration when performed in edentulous sites (toothless areas).
14. Overdentures, precision or semi-precision attachments and related services.
15. Sealants, fluoride treatments, preventive resin restorations, or space maintainers and related services.
16. Supplies, including, but not limited to, services or supplies for temporary or provisional crowns, bridges or dentures, and duplicate or temporary devices, appliances, and prosthetics.
17. Replacing a lost, stolen or missing appliance or prosthetic device.
18. Oral hygiene instructions, behavior modification, diet instruction or infection control, except infections which result from an accidental injury, or infection which results from accidental, involuntary, or unintentional ingestion of a contaminated substance.
19. Sterilization of equipment; disposal of medical waste or other requirements mandated by the Occupational Safety and Health Administration (OSHA) or other regulatory agencies.
20. Treatment or diagnosis received while outside the continental United States, except Hawaii.
21. Work-related sickness or injury for which You are eligible for any workers' compensation, employers' liability or similar laws, whether or not benefits are claimed.
22. Services for which no charge is made or for which You are not legally obligated to pay, including, but not limited to services furnished through:
  - a. Your employer, labor union or similar group, in its dental or medical department or clinic; or
  - b. A facility owned or run by any government body.
23. Services furnished by, or payable under, any public program (except Medicaid), or paid for or sponsored by any government body.
24. Telephone consultations, charges for failure to keep a scheduled appointment, copy fees, sales tax, charges for completion of a claim form, or any take-home supplies. If You use an external discount or coupon, the amount that is reduced from the Billed Charge is not a covered loss under this policy.

25. Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
26. Any loss resulting from:
  - a. War, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent;
  - b. Committing, attempting to commit, or participation in a felony or engaging in an illegal occupation;
  - c. Your participation in a riot, rebellion, or insurrection; or
  - d. An intentionally self-inflicted injury while sane or insane.
27. Impacted teeth.
28. Prescription and non-prescription drugs, whether dispensed or prescribed, including chemotherapeutic agents.
29. Speech therapy for any purpose.
30. Laboratory and pathology tests and examinations, except as specifically listed in the Benefits section of Your policy.
31. Oral surgery and related services, except as specifically listed in the Benefits section of Your policy.
32. Full mouth debridement.
33. Implantology and related services; implants, including removal of implants, and related services.

## **RENEWABILITY AND PREMIUM CHANGES**

### **Renewability**

This policy is renewable at Your option except for the following reasons: nonpayment of premium, fraud or intentional misrepresentation or We choose to nonrenew all policies of this form in Your state of issue. If this occurs We will provide You advance notice and no refusal of renewal will affect an existing claim.

### **Terms Under Which We May Change Premiums**

We can change Your premium only if We do the same to all policies of this form, which are issued to persons of Your class. Your premiums may change due to: age, a change in Your premium payment method, a new rate table being applied, a rating classification change, or a misstatement on the application that results in the proper amount due not being charged. If you have a change in Residence, premiums may change to reflect Your current geographic area. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this policy. If it is necessary to change the premium for Your policy, We will send You written notice in advance of the change in premium.

**TOTAL PREMIUM**      \$ \_\_\_\_\_

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay Your premium. Your policy stays in force during Your grace period.