

Subscription Certificate & Evidence of Coverage

Your Dental Plan & How To Use It



 **FIRST
COMMONWEALTH**
A Wholly Owned Subsidiary of Guardian

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The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

Welcome to First Commonwealth

We at First Commonwealth are pleased that you have become a member of the Plan. We encourage you to maintain your oral health by visiting your Dentist on a regular basis.

To assist you in using your Plan Benefits, we have made this booklet available to you. Please review it carefully and keep it with your other important documents. This booklet is issued in conjunction with a Group Master Policy between your Group and First Commonwealth which contains other details regarding your coverage. Your Group maintains a copy of the Group Master Policy. The Group Master Policy contains contractual provisions that establish rights and obligations concerning you and your Plan Benefits. You may inspect it at any time at the Group's office during normal business hours, or if you prefer, you may contact First Commonwealth.

First Commonwealth
444 N. Wells Street, Suite 600
Chicago, IL 60610
www.firstcommonwealth.net

Administered by:
Guardian Group Administrators
P.O. Box 2459
Spokane, WA 99210-2459
Member Services: (866) 302-4542

First Commonwealth Dental PPO Plan

Under this Dental PPO Plan, your Plan Benefits and out-of-pocket costs may vary depending on whether you receive services from a Participating PPO Dentist or Non-participating Dentist. Coverage for services received from a Non-participating Dentist may be lower than if those services were received from a Participating Dentist. You will also be responsible for amounts billed by the Non-participating Dentist in excess of Usual, Customary and Reasonable Fees or Table of Maximum Plan Payments. In certain cases, depending on the services provided, the associated coverage levels, and the Non-participating Dentist's charges, you may be responsible for a greater share of the billed charge than this Plan.

For Your Information

Under this Dental PPO Plan, your Plan Benefits and out-of-pocket costs may vary depending on whether you receive services from a Participating PPO Dentist or Non-participating Dentist. Your choice of Dentist is made by you at the time of service. Please review the information contained in this booklet to be sure you understand these important differences.

By acceptance of Plan Benefits under the terms of the Group Master Policy, you as the Subscriber authorize every Provider rendering services hereunder to disclose all treatment facts pertaining to you and your enrolled Dependents to us upon request. Furthermore, you as the Subscriber represent to the best of your knowledge or information that information contained in any applications, forms, or statements submitted to First Commonwealth shall be true, correct, and complete, and all rights to Plan Benefits are subject to the condition that all such information shall be true, correct, and complete, as provided in the Group Master Policy.

Please be aware that all rights of you or your enrolled Dependents to receive Plan Benefits are personal and may not be assigned to anyone else.

For Assistance Call (866) 302-4542

Our specially trained Member Services Representatives are available Monday through Friday, from 8:00 am to 7:00 pm (CST), at (866) 302-4542 to assist you. They can answer any questions you may have regarding how your dental Plan works, assist in status changes and handle any inquiries/concerns you may have.

Your Effective Date of Coverage and Eligibility

Your Group determines the effective date of your coverage and who is eligible to participate. This is contained in the Group Application.

As the Subscriber, you may enroll yourself alone, or together with your spouse and eligible and/or Dependent children (subject to age limits, under your Group's program). If you do not enroll your Dependent(s) on the date you enroll, you must wait to add them until the next Open Enrollment.

Newly acquired Dependents will become effective on the date of the qualifying event. Dependents may be added, deleted, or you may change your coverage status on the date of the following qualifying events, provided that First Commonwealth is notified in writing within thirty- one (31) days of the event:

Qualifying Events

1. Marriage
2. Birth
3. Adoption or placement
4. Becoming a legal guardian of a child
5. Divorce
6. Death

Enrollment Period

Your enrollment in this Plan is for a minimum of twelve (12) consecutive months while eligible through your Group. Enrollment into this Plan or voluntary disenrollment from this Plan will only be allowed during Open Enrollment periods which are determined by your Group and First Commonwealth. Persons not enrolled when first eligible may be enrolled only during your Group's next Open Enrollment period.

Identification Cards

You will receive an identification card (one per household). It identifies you as the Subscriber eligible for services. Think of the identification card as a reminder of the Plan Benefits under which you are enrolled. The card is issued for your convenience and is not a guarantee of coverage. The identification card contains the First Commonwealth Member Services Department phone number and the address to send any claim forms or other correspondence to First Commonwealth.

Continuity of Coverage

Members who were covered by the Group's prior group dental insurance plan immediately preceding the Subscriber's Coverage Date will receive credit toward the satisfaction of the Plan Benefit Waiting Period. Such credit will equal the number of months the Member was covered under the Group's prior plan. Evidence of such coverage should be supplied by your group or by you through an Explanation of Benefits statement from the prior carrier.

Benefit Periods

Your dental Benefit Period is a period of twelve (12) months. The Schedule of Benefits indicates whether your Benefit Period is based on a Calendar Year or Plan Year. When you first enroll for coverage, your first Benefit Period begins on your Coverage Date and will end as specified on the Schedule of Benefits.

Deductibles

During each Benefit Period you must satisfy a Deductible. The Schedule of Benefits specifies the dollar amount of the Individual and Family Deductibles and indicates to which Plan Benefits the Deductible applies. After you incur Eligible Charges equal to or greater than the Deductible amount during the Benefit Period, your coverage will begin for these services.

The amount a Member pays for Plan Benefits for which the Deductible amount does not apply, shall not be applied toward satisfying the Deductible.

Benefit Maximums

Benefit Maximums apply to all Plan Benefits. Your Plan Benefits accrue based on this Benefit Period. Benefit Maximums correspond with the Benefit Period, except for Orthodontic dental services, which are subject to a separate Lifetime Benefit Period and Benefit Maximum. Any expenses incurred beyond the Benefit Maximums are your responsibility. Please note that the Plan Maximums contained in the Benefits Summary for services rendered by either Participating PPO Dentists or Non-participating Dentists represents a combined maximum amount.

Choice of Dental Service Providers

Participating Dentists must meet certain standards prior to acceptance in our network. Availability, access to care, license standing, professional liability insurance coverage, emergency care provisions, National Practitioner Data Ban ("NPDB") reports and State Board ("BODEX") histories are some of the factors considered in reviewing an application.

Dentists who participate in First Commonwealth's dental PPO network have agreed to the Fixed Fee Schedule. Reimbursement is on a fee-for-service basis. The fixed fee arrangements are typically below the participating customary fees. Under this plan, you may choose to receive services from a Participating PPO Dentist or a Non-participating Dentist.

If you go to a Participating PPO Dentist, you pay the dentist the copayment amount listed on your Benefit Summary or the coinsurance amount described in your Benefits Summary under "Participating PPO Dentist Plan Benefits", subject to any Deductible, Plan Maximums, and Plan

Limitations and Exclusions. The Explanation of Benefits (EOB) you receive when your claim is processed will illustrate your payment responsibilities based on the Fixed Fee Schedule, along with any applicable Deductibles, Plan Maximums and Limitations and Exclusions.

If you go to a Non-participating Dentist, it is your responsibility to pay the Dentist the coinsurance amount described in your Benefits Summary under "Non-participating Dentist Plan Benefits", subject to any Deductible, Plan Maximums, and Plan Limitations and Exclusions. **Coverage for services received from a Non-participating Dentist may be lower than if those services were received from a Participating Dentist. You will also be responsible for amounts billed by the Non-participating Dentist in excess of Usual, Customary and Reasonable Fees or Table of Maximum Plan Payments. In certain cases, depending on the services provided, the associated coverage levels, and the Non-participating Dentist's charges, you may be responsible for a greater share of the billed charge than this Plan.**

First Commonwealth does not provide your dental care services, but provides coverage in the form of reimbursement to Dentists or you for the Plan Benefits received by you. First Commonwealth is not liable for any act or omission of any Provider or the agent of such Provider, including but not limited to, the failure or refusal to render services to you.

Pre-Estimation of Benefits

In the event that a dental service is started by one Dentist and completed by another, payment of your Plan Benefits will be limited to the amount that would have been paid had only one Dentist performed the entire service.

If your Dentist recommends a Course of Treatment that will cost more than \$300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary x-rays, photographs, models, and periodontal charting, and an estimate of the charges prior to your beginning the Course of Treatment. First Commonwealth will review the report and materials, taking into consideration any appropriate alternative Course of Treatment, and will notify you and your Dentist of the estimated Plan Benefits which will be provided prior to your determining your dental services. This is not a guarantee of payment, but an estimate of the Plan Benefits available for the proposed services to be rendered.

Alternate Benefit Provision

In cases in which there is more than one appropriate Course of Treatment possible, the Plan Benefit payment will be based upon the lowest cost appropriate treatment. If you and your Dentist decide on personalized restorations or to employ specialized techniques for dental service rather than commonly accepted standard dental procedures, the Plan Benefits provided will be limited to the Plan Benefit for the standard procedures for dental services, as reasonably determined by First Commonwealth.

How To File A Claim

In order to obtain Member's dental benefits under the Plan, it is necessary for a Claim to be filed with First Commonwealth. To file a Claim, Members should obtain a claim form from their Human Resources Department or First Commonwealth. Dentists may also have claim forms available. The claim form is also used for pre-estimation of benefits. It is the Member's responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Members must complete and sign Part I - Employee Statement of the claim form. As soon as treatment is ended, Member must ask Dentist to complete and sign Attending Dentist's Statement and mail completed form to:

Guardian
P.O. Box 2459
Spokane, WA
99210-2459

Claims must be filed with First Commonwealth no later than 12 months after the services have been rendered. Claims not filed within the required time period will not be eligible for payment. Should Members have any questions about filing Claims, they should ask their Employee Benefits Department or call First Commonwealth.

Payment of Claims

First Commonwealth will reimburse you for payments you make to the dentist for approved covered services. You may authorize First Commonwealth to make payments directly to your dentist by so indicating on your claim form. Neither this Plan nor a Member's Claim for Plan Benefits are assignable in whole or in part to any person or entity at any time. Coverage under this Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer Plan Benefits or aid or attempt to aid any other person in fraudulently obtaining Plan Benefits.

After you submit a claim, you will receive an explanation of benefits statement outlining what payments have been made and what services are not covered and the reason for any benefit denials. You may also receive a request for additional information. If your claim is denied in whole or in part, you may have your claim reviewed by following the instructions in "Claim Review and Complaint Resolution Procedures" outlined in this certificate.

Time of Payment of Claims

Indemnities payable under this policy for any other 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 on a monthly basis and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims and indemnities shall be paid within 30 days following receipt of due proof of loss. Failure to pay within such period shall entitle you to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You will be notified of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

Emergency Care

Emergency Care may be provided by either a Participating PPO Dentist or a Non-participating Dentist. If services are provided by a Non-participating Dentist, coverage for Emergency Care services shall be at the same benefit level as if the service had been rendered by a Participating PPO Dentist.

Claim Review & Complaint Resolution Procedures

First Commonwealth is committed to providing quality services in a convenient and timely fashion. It is our commitment to do that in a manner which continually meets your expectations. Claims you or your dentist submit are routinely reviewed for appropriateness of services.

If your Claim is denied (in whole or in part) or if you have any questions, concerns, comments or Complaints about services or personnel, please contact us, Guardian, P.O. Box 2457, Spokane, WA 99210, or call our Member Services Department at (866) 302-4542.

Our internal service standards require, where possible, to resolve all Members' inquiries and concerns immediately. If, however, resolving the issue will require additional time, the Member will be given the best estimate of the amount of time needed for resolution. If your Complaint has not been resolved to your satisfaction, you have the right to appeal our decision. You may do so by submitting, in writing, the reasons why you disagree with our decision, along with any additional information you wish us to consider. This appeal should be submitted no later than 30 days from the date of our decision. You will receive an acknowledgment of our receipt of the appeal advising you of when to expect a written response.

The appeal will then be sent to the President of First Commonwealth for a final review and decision. The President, at his sole discretion, may advise you of a hearing date to review the Complaint and consider all the facts. You must attend the hearing (up to three dates will be considered). If following the outcome of the appeal process you are still dissatisfied with the resolution, you may choose to notify the Illinois Department of Insurance at:

Consumer Service Department
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767

or

Illinois Department of Insurance
100 West Randolph, Suite 15-100
Chicago, IL 60601-3251

Coordination of Benefits

Plan Benefits under this Plan are coordinated with those of other plans. If you have other coverage, your combined benefits from all the plans will pay up to, but not more than, 100% of Usual Customary and Reasonable Expenses. This does not apply to coverage under an individual insurance policy.

If another dental health plan covers you or your family, all of the First Commonwealth dental Plans coordinate benefits in this manner, as more fully set forth in the Group Master Policy:

1. If the other plan has no coordination of benefits rule, that plan pays all covered benefits first.
2. If the other plan has a coordination of benefits rule:
 - a. If you or your family is covered as a Dependent on any dental plan, including this Plan, such plan is secondary.
 - b. The patient's employer's plan provides benefits first for an employee. If you have coverage from two employers, the employer's plan where you have coverage the longest provides benefits first.
 - c. The plan of the parent whose birthday comes first provides benefits for Dependent children first.

3. If the parents are separated or divorced, the plan of the parent responsible under court order for a Dependent's health care provides benefits first.

Some Dentists handle these coordination provisions for you by filing Claims on your behalf. Check with your Dentist and be sure to give information on all dental plans covering you and your Dependents.

Third Party Recovery

If a Member is injured by a third party and First Commonwealth makes payments on the Member's behalf as a result of this injury, then the Member will provide any information regarding the injury that First Commonwealth may request.

Termination of Coverage

Plan Benefits may be terminated for any of the following reasons:

1. Termination of the Group Master Policy.
2. Your (or your eligible enrolled Dependent's) failure to meet the eligibility requirements.
3. Material misrepresentation (fraud) in obtaining Plan Benefits.
4. Failure of Group or individual Member (if applicable) to pay a Premium in a timely manner.

Coverage for a Subscriber and his/her Dependents will terminate according to the terms of the Group Master Policy. In the event coverage is terminated, the Member shall become liable for charges resulting from dental services received after termination.

Extension of Benefits

If your Plan Benefits should terminate, Plan Benefits will continue for dental service(s), except Periodontal services, which were begun prior to the date your Plan Benefits terminated and were completed within 30 days of your termination date. Plan Benefits will not be provided for Periodontal treatment after the termination of your coverage under this Plan.

Definitions

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your Plan Benefits. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions, because they will help you understand some of the limitations or special conditions that may apply to your Plan Benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in alphabetical order.

Benefit Maximum means the total dollar amount of Plan Benefits any one Member is eligible to receive as specified in the Schedule(s) of Benefits. Benefit Maximums correspond to the Benefit Period.

Benefit Period means the continuous period of time in which the Member is eligible for Plan Benefits as specified in the Schedule of Benefits.

Calendar Year means the twelve month period which begins January 1 and ends December 31.

Claim means notification in a form acceptable to First Commonwealth that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Dentist, an

itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which First Commonwealth may request in connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Dentist's charge for service rendered to you.

Claim Payment means the Plan Benefit payment calculated by First Commonwealth, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for services rendered to you.

Coinsurance means the percentage of the Eligible Charge, as specified in the Schedule of Benefits, which must be paid by you.

Complaint means any dissatisfaction about First Commonwealth, Plan Benefits, or contracted Providers (if any) expressed verbally by the Member.

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Coverage Date means the date on which your coverage under this Plan begins.

Deductible means the amount of Eligible Charges as specified on the Schedule of Benefits, which must be incurred and paid by the Member before Plan Benefits are available.

Dentist means a duly licensed Dentist working within the scope of his/her license.

Dependent means your spouse (unless legally separated) and/or unmarried children up to the age of 20. Eligible children may include natural or adopted children, children placed for adoption, stepchildren, and foster children for whom you or your spouse are the legal guardian. Eligibility may be extended up to the age of 26 to any of your children who are registered students in full-time attendance at an accredited school, college, or university. Eligibility will also be extended to any child past the age of 20 who is handicapped and dependent on you or other care providers for support.

Eligible Charge means the part of the expense incurred which is for Medically Necessary dental work, a covered service, and also does not exceed the Usual, Customary, and Reasonable fee for this service.

Emergency Care means the provision of dental care for the sudden and unexpected onset of a dental condition which reasonable requires the Member to seek immediate dental care under circumstances or at locations which reasonably preclude the Member from obtaining needed dental care from a Participating PPO dentist.

First Commonwealth means First Commonwealth Insurance Corporation, an Illinois domiciled Life, Accident and Health Insurance Company that is also licensed as a limited health services organization. First Commonwealth has entered into a Group Master Policy with your Group to provide eligible Subscribers and Dependents with the Plan Benefits described in this booklet.

First Commonwealth of Illinois, Inc. is an Illinois corporation, registered with the Illinois Department of Insurance as a Preferred Provide Administrator, who markets Dental PPO services to First Commonwealth.

Group means your employer, labor union, trust, association, partnership, or other organization to which we issue a Group Master Policy, and through which you have become entitled to the Plan Benefits described in this booklet.

Group Master Policy means the contract issued to the Group that contains provisions on coverage.

Medically Necessary means that a specific procedure provided to you is required, in the reasonable judgment of First Commonwealth, for the treatment or management of a dental symptom or condition. The fact that a Dentist may prescribe, order, recommend or approve a service or supply does not of itself make such a service or supply Medically Necessary.

Member means you or a covered Dependent who is actually enrolled in this Plan.

Non-Participating Dentist means any licensed dentist acting within the scope of their license who is not a Participating PPO Dentist.

Open Enrollment means the enrollment period for the Group as mutually determined by the Group and First Commonwealth, during which an employee, member, or beneficiary of the Group may enroll in, change, or terminate their or their Dependent's coverage hereunder.

Participating PPO Dentist means a licensed dentist acting within the scope of their license who has entered into a Participating PPO Dentist contract with First Commonwealth of Illinois, Inc.

Plan means this dental Plan underwritten by First Commonwealth.

Plan Benefit(s) means a dental service or supply, except as expressly limited or excluded by this Plan, set forth in the Schedule of Benefits.

Plan Year means the twelve month period which begins each year on the day and month of the Coverage Date.

Premium means the amount you the Subscriber, or the Group (on your behalf), pays to us to maintain coverage according to the terms of the Group Master Policy. You have agreed to have any required contributions toward Premium be collected by the Group and remitted to us.

Provider means any Dentist or Dental Hygienist working within the scope of their license.

Subscriber means you, an employee, member, or beneficiary of the Group whom the Group has reported to First Commonwealth as eligible for Plan Benefits and is enrolled hereunder.

Subscription Certificate means this Certificate which, together with the Group Master Policy, constitutes your dental Plan and which contains a Schedule of Benefits and provisions on coverage, limitations and exclusions.

Usual, Customary and Reasonable Fee means the fee as reasonably determined by First Commonwealth, which is based on the fee which the Dentist who renders the particular service usually charges his patients for the same service and the range of usual fees other Dentists, in a similar geographic area, charge their patients for the same service, under similar or comparable circumstances. First Commonwealth relies on third party sources for the range of usual fees by geographic area and reserves the right to determine the fee range designated as reasonable. If First Commonwealth reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for service shall mean the Reasonable fee as determined by First Commonwealth.

Waiting Period means the time period after the Coverage Date, as specified on the Schedule of Benefits, in which Plan Benefits are not available.

BENEFIT & COVERAGE SUMMARY

The amount the plan pays and the amount you pay the dentist for covered services whether you go to a participating PPO dentist or a non-participating dentist is listed here. The deductible, annual limitation on benefits and all other limitations will be administered on a Calendar year basis.

	Services Rendered by a Participating PPO Dentist ⁽¹⁾		Services Rendered by a Non-Participating PPO Dentist ^(1,2)	
	Plan Pays ⁽³⁾	You Pay ⁽³⁾	Plan Pays ⁽⁴⁾	You Pay ⁽⁴⁾
Diagnostic & Preventive Services Oral examinations; Dental Prophylaxis; Topical Fluoride; Dental X-Rays; Emergency Oral Exams; Palliative Treatment; Sealants; Space Maintainers	100%	0%	100%	0%
Basic or Minor Restorative Restorative Services; Oral Surgery; Endodontics; Minor Periodontics	80%	20%	80%	20%
Major Dental Services Major Periodontics; Inlays, Onlays, Crowns & Labial Veneers; Fixed Bridgework; Full & Partial Removable Dentures; Recementation & Repairs of Crown & Bridgework; Post & Core & Core Build-Ups	50%	50%	50%	50%
Orthodontic Services Diagnostic Services; Orthodontic Banding; Monthly Maintenance & Retention Treatment	50%	50%	50%	50%

1. You pay all amounts for services not covered by the plan including deductible and amounts in excess of any annual or lifetime limitations on coverage.
2. You pay all amounts in excess of usual, customary and reasonable (UCR) charges. Information regarding reimbursement rates payable to providers is available from your employer.
3. Payment amount based on contracted fee.
4. Payment based on covered charges subject to Usual, Customary and Reasonable limitations.
5. The deductible applies to coverage under Basic and Major dental services and is a combined deductible for these categories. The deductible is also combined for services rendered by participating PPO dentists and non-participating dentists.
6. The annual maximum benefit limitation represents the total combined maximum benefit provided regardless of whether services are rendered by a participating or non-participating dentist.

BENEFIT & COVERAGE SUMMARY (CONTINUED)

	Services Rendered by a Participating PPO Dentist ⁽¹⁾		Services Rendered by a Non-Participating PPO Dentist ^(1,2)	
	<u>Plan Pays</u> ⁽³⁾	<u>You Pay</u> ⁽³⁾	<u>Plan Pays</u> ⁽⁴⁾	<u>You Pay</u> ⁽⁴⁾
Individual Deductible ⁽⁵⁾		\$50.00		\$50.00
Family Deductible Limit ⁽⁵⁾		3 x \$50.00		3 x \$50.00
Annual Maximum Benefit Limitation ⁽⁶⁾	Up To \$1,000.00 Per Person	100% Over \$1,000.00 Per Person	Up To \$1,000.00 Per Person	100% Over \$1,000.00 Per Person
Waiting Period for Major Services	Not Applicable		Not Applicable	
Lifetime Orthodontic Benefit Limitation (per child)	Up To \$750.00	100% Over \$750.00	Up To \$750.00	100% Over \$750.00
Lifetime Orthodontic Benefit Limitation (per adult)	Not Covered		Not Covered	
Dependent Child Orthodontic Age Limit	Covered Up to age 19		Covered Up to age 19	

1. You pay all amounts for services not covered by the plan including deductible and amounts in excess of any annual or lifetime limitations on coverage.
2. You pay all amounts in excess of usual, customary and reasonable (UCR) charges. Information regarding reimbursement rates payable to providers is available from your employer.
3. Payment amount based on contracted fee.
4. Payment based on covered charges subject to Usual, Customary and Reasonable limitations.
5. The deductible applies to coverage under Basic and Major dental services and is a combined deductible for these categories. The deductible is also combined for services rendered by participating PPO dentists and non-participating dentists.
6. The annual maximum benefit limitation represents the total combined maximum benefit provided regardless of whether services are rendered by a participating or non-participating dentist.

Limitations

1. Oral examinations, prophylaxis (routine or periodontal maintenance) and fluoride applications are limited to once every six months .
2. Fluoride applications are covered for Dependent children under the age of 19.
3. Full-mouth or panoramic x-rays are limited to one every 36 months. Additional bite-wings and periapicals are allowable once every 12 months.
4. Emergency oral exams will be covered only if no other services, other than palliative treatment, are billed for the same treatment session.
5. Periodontal scaling and/or root planing is limited to once every 12 months.
6. If more than one periodontal service is performed per quadrant on the same day, only the more complex procedure will be a covered dental benefit.
7. Benefits for fillings are limited to silver amalgam, silicate, and plastic. Temporary restorations, bases, or sedative fillings are not covered.
8. Pulp vitality tests are limited to one every 12 months per tooth.
9. This Plan provides for crowns and replacement of missing teeth with complete or partial dentures or fixed bridges using standard procedures. Treatment involving the use of the following procedures or materials is considered optional and, if performed, the responsibility of the patient to pay the fee for:
 - a. Noble and high noble metal for crowns and removable or fixed appliances.
 - b. Precision partials, precision attachments to any appliance, and copings.
 - c. Implants and related services.
 - d. Personalization or characterization of any prosthetic.
10. Crowns will be provided only if there is insufficient tooth structure to retain an amalgam, silicate, or plastic restoration.
11. Crowns and bridgework will be provided in the presence of sufficient breakdown or decay, and adequate bone support.
12. Benefits for laboratory relining of prosthetic appliances will be limited to once every 36 months.
13. Benefits for general anesthesia are limited to professional fees and payable only when Medically Necessary and administered with a covered dental procedure by a person who is licensed to administer general anesthesia. For the purpose of this limitation only, "Medically Necessary" refers to instances where the health of a patient would be compromised if not administered and documentation to that effect from a medical physician is provided.

Exclusions

1. Experimental dental care procedures or procedures which are not Medically Necessary, which do not have uniform professional endorsement or which are for cosmetic purposes only.
2. Any amount over the Usual, Customary, and Reasonable Fee or Benefit Maximums established by this Plan.
3. Treatment rendered by someone other than a licensed Dentist except when such services are rendered under the supervision and guidance of a Dentist.

4. Sealants which are:
 - a. Not applied to a permanent bicuspid or molar.
 - b. Applied after the patient attains age 17.
 - c. Reapplied to a bicuspid or molar tooth within three years from the date of the last application.
5. Educational programs, including but not limited to, plaque control programs, oral hygiene instruction, and nutritional counseling.
6. Procedures, appliances, or restorations, other than fillings, that are necessary to alter, restore or maintain occlusion. Excluded services shall include, but not be limited to:
 - a. Increasing vertical dimension.
 - b. Periodontal splinting.
 - c. Realignment of teeth.
 - d. Orthognathic recordings.
 - e. Replacing or stabilizing tooth structure loss by attrition.
7. Procedures, appliances, or restorations to correct congenital or developmental malformations, except for congenital malformations which would prevent normal dental functioning and that would respond to dental treatments listed as Plan Benefits.
8. Treatment for cleft palate, except benefits for dental procedures would be covered.
9. Treatment for mandibular prognathism, micrognathism, anodontia, or temporomandibular joint disorders.
10. Treatment for malignancies, neoplasms, cysts, or genetic malformations.
11. Initial placement of any prosthetic appliance or fixed bridge unless such placement is needed due to extraction of one or more natural teeth while a Member, excluding the extraction of third molars. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
12. Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the last placement date, unless the replacement is required as a result of an accidental bodily injury sustained while the person is insured and provided that benefits are not available from any other policy covering services rendered as a result of accidental injury.
13. Charges incurred for reline and adjustment of a denture within the first six months from the date the denture is installed.
14. Any treatment or procedure initiated after Plan Benefits terminate and any prosthetic dental appliance installed or delivered more than 30 days after Plan Benefits terminate.
15. Any treatment or procedure rendered prior to the Member's Coverage Date.
16. A charge for services and expenses incurred for such treatment started prior to the Member's Coverage Date for any of the following:
 - a. An appliance, or modification of one, if an impression for it was made.
 - b. An inlay, onlay, crown, or bridgework, if a tooth has been prepared.
 - c. Root canal therapy, if the pulp chamber was opened.
 - d. Any charges for an Orthodontic procedure if an active appliance for that Orthodontic procedure has been installed.
17. Replacement of damaged, lost, or stolen appliances.
18. Any facing to a crown, abutment, or pontic, or any plastic, composite, or resin restoration on a tooth posterior to the second bicuspid.

19. Temporary bridges, dentures, or crowns.
20. Subgingival curettage and/or root planing (ADA codes 4220, 4341, and 4345), unless the presence of periodontal disease is confirmed by x-rays and periodontal charting of pocket depths for each tooth involved.
21. Night guards, mouth guards, or habit controlling appliances.
22. Charges for home medicaments, prescribed drugs, premedication, analgesia, or local anesthesia.
23. Completion of Claim forms or charges for broken or missed appointments.
24. Dental services performed in a hospital or in any outpatient facility other than a Dentist's office, and all charges related to such services.
25. Services and/or supplies for which a person is not liable or for which payment would not have been made had no insurance been in force, or for which payment is not legal where the person is living at the time expenses are incurred.
26. For any procedure not shown on the list of covered dental procedures, or for which satisfactory results cannot be obtained.
27. Charges for any procedure not completed, or any prosthetic appliance unless appliance is actually inserted or delivered.
28. Crowns and bridgework supported by implants are not covered.
29. Permanent crowns and bridgework on deciduous teeth are not covered.

