



Dental, Vision & Life
Benefits
Regulatory & Technical
Information

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Prepaid Dental Plan Regulatory and Technical Information Guide

Please note that due to state legislation, providers in certain states are not legally obligated to provide a discount on non-covered services. Check with your participating dentist to see if they provide a discount on non-covered services.

Limitations and Exclusions

Company does not provide coverage for the following services:

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out of area emergency care as provided in Section X, Paragraph C of the Certificate.
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Any dental treatment started prior to a Member's effective date for eligibility of benefits. This does not apply to Orthodontic treatment in progress that was covered under a Contractholder's prior plan. To be covered under this Plan, Orthodontic treatment must be shown on the Schedule of Benefits and must have the subsequent treatment provided by a Participating Provider.
4. Services which in the opinion of the Participating General Dentist, Participating Specialist, or Company are not Necessary Treatment to establish and/or maintain a Member's oral health.
5. Any services that are not appropriate or customarily performed for the given condition, do not have uniform professional endorsement, do not have a favorable prognosis, or are experimental or investigational.
6. Any service that is not consistent with the normal and/or usual services provided by a Participating General Dentist or Participating Specialist or which in the opinion of a Participating General Dentist or Participating Specialist would endanger the health of a Member.
7. Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of a Member.
8. Procedures, appliances or restorations to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); or replacement of lost, missing or stolen appliances.
9. Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on the Schedule of Benefits.
10. Services provided by a Participating Pediatric Dentist are limited to children through age seven.
11. Removal of asymptomatic third molars is not covered unless pathology (disease) exists. Examples of symptomatic conditions include decay, cysts, unmanageable periodontal disease, infection, and resorption of adjacent tooth.
12. Frequency and/or age limitations may apply. See the Schedule of Benefits and Co-payments for details.
13. There are limitations for Worker's Compensation benefits (please see certificate for further details).
14. Crowns, inlays, onlays, or veneers for the purpose of:
 - Altering vertical dimension of teeth;
 - Restoration or maintenance of occlusion;
 - Splinting teeth, including multiple abutments; or
 - Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction)

State Specific Limitations and Exclusions

Texas

Plan does not provide coverage for the following:

1. No service of any dentist other than a Participating General Dentist or Participating Specialty Dentist will be covered by Plan, except for emergency care as described in the Emergency Care section. This does not include Dentally Necessary services performed by Non-Participating Dentists approved by the Plan.
2. Any procedures not specifically listed as a covered benefit on the Schedule of Benefits.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits (except for emergency treatment) or transfer Dental Facilities.
4. Any dental treatment started prior to a Member's effective date for eligibility of benefits. This does not apply to Covered Dental Care Services in progress if such treatment is completed by a Participating Dentist. This also does not apply to Orthodontic treatment in progress that was covered under a Contractholder's prior plan. To be covered under this Plan, Orthodontic treatment must be shown on the Schedule of Benefits and You must have the subsequent treatment provided by a Participating Dentist.
5. Services which in the opinion of a Participating General Dentist, Participating Specialty Dentist, or Plan that are not Dentally Necessary to establish and/or maintain the Member's oral health.
6. Any services that are not appropriate or customarily performed for the given condition, do not have uniform professional endorsement, do not have a favorable prognosis, or are experimental or investigational.
7. Any service that is not consistent with the normal and/or usual services provided by a Participating General Dentist or Participating Specialty Dentist or which in the opinion of the Participating General Dentist or Participating Specialty Dentist would endanger the health of the Member.
8. Any service or procedure which a Participating General Dentist or Participating Specialty Dentist is unable to perform because of the general health or physical limitations of the Member.
9. Procedures, appliances or restorations to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); or replacement of lost, missing or stolen appliances.
10. Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on the Schedule of Benefits.
11. Services provided by a Participating Pediatric Dentist are limited to children through age seven.
12. Removal of asymptomatic third molars is not covered unless pathology (disease) exists. Examples of symptomatic conditions include decay, cysts, unmanageable periodontal disease, infection, and resorption of adjacent tooth.
13. Frequency and/or age limitations may apply. See the Schedule of Benefits and Co-payments for details.
14. There are limitations for Worker's Compensation benefits (please see certificate for further details).
15. Crowns, inlays, onlays, or veneers for the purpose of:
 - Altering vertical dimension of teeth;
 - Restoration or maintenance of occlusion;
 - Splinting teeth, including multiple abutments; or
 - Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction).

The Prepaid Dental Plan is underwritten by the following Humana companies: CompBenefits Company, a Prepaid Limited HealthService Organization licensed under Chapter 636 of the Florida Statutes, Humana Employer's Health Plan of Georgia, Inc., The Dental Concern, Inc., CompBenefits Dental, Inc., HumanaDental Insurance Company, and DentiCare, Inc. (d/b/a CompBenefits).

MTV Preventive Plus Dental Plan Regulatory and Technical Information Guide

Please note that due to state legislation, providers in certain states are not legally obligated to provide a discount on non-covered services. Check with your participating dentist to see if they provide a discount on non-covered services.

Limitations and Exclusions

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. -Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
9. Any service not specifically listed in Your plan benefits.
10. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any expense incurred before your effective date or after the date your coverage under the policy terminates (unless the service is eligible under Extension of Benefits).
12. Services provided by someone who ordinarily lives in your home or who is a family member.
13. Charges exceeding the reimbursement limit for the service.
14. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.

16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year.

State Specific Limitation and Exclusions

Alaska

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any dental *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* considered *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. The following dental procedures are considered cosmetic to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.

13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this certificate. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Arkansas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* *we* consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or

- d. Is deemed to be experimental or investigational in nature.
- 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
- 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
- 13. Charges exceeding the *reimbursement limit* for the *service*.
- 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
- 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
- 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- 17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

California

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

- 1. Any *expenses incurred* for which *you* received benefits from any worker's compensation or occupational disease act or law.
- 2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
- 3. Any loss caused or contributed by:

- a. War or any act of war, whether declared or not;
- b. Any act of international armed conflict; or
- c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. *Your* failure to keep an appointment with the *dentist*.
- 6. Any *service* considered to be *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. Following is a list of what's considered to be *cosmetic* procedures including but not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
- 7. Infection control, including but not limited to sterilization techniques.
- 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
- 9. Any *service* not specifically listed in Your plan benefits.
- 10. Any *service* that is not eligible for benefits based upon *clinical review* as defined in this certificate.
- 11. Is deemed to be experimental or investigational in nature.
- 12. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
- 13. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
- 14. Charges exceeding the *reimbursement limit* for the *service*.
- 15. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
- 16. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal

adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

17. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
18. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Colorado

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

No *benefits* are payable for any *accidental bodily injury* for which there is other insurance providing payments or expense coverage, regardless of whether such other coverage is described as primary, excess or contingent.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this Policy. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* any right *you* have against the other insurer for Dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *calendar year deductibles*.

Connecticut

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* *we* consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.

15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Florida

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any expenses arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are paid under any Workers' Compensation or Occupational Disease Act or Law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not, excluding terrorism;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy.

We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- b. Any *service* to correct congenital malformation;
- c. Any *service* performed primarily to improve appearance;
- d. Characterizations and personalization of prosthetic devices; or
- e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque

control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Georgia

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/ agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures

Iowa

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while you are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Idaho

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth

cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.

9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Illinois

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:

- a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment with the *dentist*.
 6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Indiana

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

- c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
- 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. *Your* failure to keep an appointment with the *dentist*.
- 6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
- 7. Infection control, including but not limited to sterilization techniques.
- 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
- 9. Any *service* not specifically listed in Your plan benefits.
- 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
- 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
- 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
- 13. Charges exceeding the *reimbursement limit* for the *service*.
- 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
- 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
- 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- 17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Kansas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

- 1. *Benefits* will not be provided for *services*, injuries or diseases related to *your* job to the extent *you* are covered or are required to be covered by the Workers' Compensation law. If *you* enter into a settlement giving up *your* right to recover future medical benefits under a Workers' Compensation law, the policy will not pay those medical *benefits* that would have been payable in absence of that settlement.
- 2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Kentucky

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.

5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are

considered an integral part of the entire dental *service*.

16. Preventive control programs including oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Louisiana

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. For which *you* would not be required to pay if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;

- b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment with the *dentist*.
 6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, other than that described in the Coordination of Benefits provision, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Maryland

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* for a job-related *accidental injury* or *bodily injury* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury* as allowed by Maryland §15-602.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.

6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth, except for covered orthodontic services when those are covered under this plan as elected by the policyholder.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *usual and customary fee* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when

charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

16. *Services* which were provided as a result of a Prohibited Referral. For this provision, a Prohibited Referral is any referral prohibited by § 1-302 of the Maryland Code, Health Occupations Article.
17. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
18. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Maine

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy.

We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque

control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Minnesota

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.

5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - Is not eligible for benefits based upon *clinical review*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional acceptance; or
 - Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with

the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Missouri

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - Is not eligible for benefits based upon *clinical review*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional acceptance;
 or
 - Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

North Carolina

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or worker's compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Worker's Compensation Act.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss contributed to, with the exception of loss incurred from an act of terrorism, or cause by:

- a. War or any act of war, whether declared or not;
 - b. Insurrection; or
 - c. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment with the *dentist*.
 6. Any *service* we consider *cosmetic* unless it is necessary to correct a congenital defect or as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* performed primarily to improve appearance;
 - c. Characterizations and personalization of prosthetic devices; or
 - d. Any procedure to change the spacing and/or shape of the teeth.
 7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

North Dakota

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy.

We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque

control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Nebraska

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with

the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

New Hampshire

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.

- b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

New Jersey

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Except as stated below, *illness or injury*, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law. *Exception:* This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
2. *Services:*
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

New York

No coverage is available under this-Certificate-for the following:

A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

C. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in this Certificate.

D. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is

experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

E. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

F. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

G. Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

H. Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.

I. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

J. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

K. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

L. Services not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

M. Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

N. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

O. Services with No Charge.

We do not Cover services for which no charge is normally made.

S. War.

We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Ohio

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while you are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Oklahoma

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by war or any act of war, whether declared or undeclared, while serving in the military service of any auxiliary until attached thereto.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments

made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

Pennsylvania

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any expenses arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which coverage was available under any Workers Compensation or Occupational Disease Act or Law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to;
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense

coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this certificate. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Pennsylvania motor vehicle financial responsibility law

No *benefits* are payable under this Policy until all *benefits* for which *you* are eligible for coverage under the Pennsylvania Motor Vehicle Financial Responsibility Law (or as amended) have been exhausted. Any benefits available to *you* under this policy will be in excess of, and not in duplication of, any coverage available under the Pennsylvania Motor Vehicle Financial Responsibility Law (or as amended).

South Carolina

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* that arose from or were sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any workers' compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*, unless *you* are legally obligated to pay.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* *we* consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.

13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

South Dakota

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* for which *benefits* are paid under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. *Your* failure to keep an appointment with the *dentist*.
5. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury*

sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- b. Any *service* to correct congenital malformation;
- c. Any *service* performed primarily to improve appearance;
- d. Characterizations and personalization of prosthetic devices; or
- e. Any procedure to change the spacing and/or shape of the teeth.
6. Infection control, including but not limited to sterilization techniques.
7. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
8. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
9. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
10. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member* except, if it is the only provider in the area and the provider is acting within the scope of practice.
11. Charges exceeding the *reimbursement limit* for the *service*.
12. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
13. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

14. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
15. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Texas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;

- d. Characterizations and personalization of prosthetic devices; or
- e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
14. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
15. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
16. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Utah

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
17. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

**Virginia
EXCLUSIONS**

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment with the *dentist*.
 6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* performed primarily to improve appearance;
 - c. Characterizations and personalization of prosthetic devices; or
 - d. Any procedure to change the spacing and/or shape of the teeth.
 7. Infection control, including but not limited to sterilization techniques.
 8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 9. Any *service* not specifically listed in Your plan benefits.
 10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 13. Charges exceeding the *reimbursement limit* for the *service*.
 14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 16. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 17. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 18. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Vermont

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/ institution/agency for any *service* connected with *sickness* or *bodily injury*.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
9. Any *service* not specifically listed in Your plan benefits.
10. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
12. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
13. Charges exceeding the *reimbursement limit* for the *service*.
14. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
15. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
16. Temporary dental *services*.
17. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
18. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

MTV Traditional Preferred and PPO Dental Regulatory and Technical Information Guide

Please note that due to state legislation, providers in certain states are not legally obligated to provide a discount on non-covered services. Check with your participating dentist to see if they provide a discount on non-covered services.

Limitations and Exclusions

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Repair and replacement of orthodontic appliances.
22. Temporary dental services
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in the plan.
30. We do not cover services that generally are considered to be medical services except those specifically noted as covered in the certificate.

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year.

State Specific Limitations and Exclusions

Alaska

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any dental *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the *dentist*.
6. Any *service* considered *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while you are covered under this policy. The following dental procedures are considered cosmetic to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any *service* related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

Arkansas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from

- and reimbursable to the U.S. government or any of its agencies as required by law;
- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images;)
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize
 - d. periodontally weakened teeth;
 - e. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - f. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal

adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

California

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any *expenses incurred* for which *you* received benefits from any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any *service* considered to be *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. Following is a list of what's considered to be *cosmetic* procedures, including but not limited to:
 - a. Facings on crowns or pontics posterior to the second bicuspid.
 - b. Any service to correct congenital malformations;
 - c. Any service performed primarily to improve appearance; or

- d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
- a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
- a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any *service* that is not eligible for benefits based upon *clinical review* as defined in this certificate.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
- a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Colorado

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

- 1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
- 2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. Your failure to keep an appointment with the dentist.
- 6. Any *service we* consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices or;
 - e. Any procedure to change the spacing and/or shape of the teeth.
- 7. Charges for:
 - a. Any type of implant and all related services, including crowns or the prosthetic device attached to it.
 - b. Precision or semi-precision attachments.
 - c. Overdentures and any endodontic treatment associated with overdentures.
 - d. Other customized attachments.
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
- 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
- 9. Infection control, including but not limited to sterilization techniques.

10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - Any *services* for orthognathic surgery;
 - Any *services* for destruction of lesions by any method;
 - Any *services* for tooth transplantation;
 - Any *services* for removal of a foreign body from the oral tissue or bone;
 - Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - Pain control unless a documented allergy to local anesthetic is provided.
 - Anxiety.
 - Fear of pain.
 - Pain management.
 - Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

No *benefits* are payable for any *accidental bodily injury* for which there is other insurance providing payments or expense coverage, regardless of whether such other coverage is described as primary, excess or contingent.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this Policy. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* any right *you* have against the other insurer for Dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *calendar year deductibles*.

Connecticut

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services,
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization technique.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:

- a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Temporary dental *service*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches
24. The oral surgery benefits under this plan does not include:
- a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist*

or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- Pain control unless a documented allergy to local anesthetic is provided.
 - Anxiety.
 - Fear of pain.
 - Pain management.
 - Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Florida

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are paid under any Workers' Compensation or Occupational Disease Act or Law.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

- c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not; excluding terrorism;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employers;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that we determine:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service

21. Temporary dental services
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any services for orthognathic surgery;
 - b. Any services for destruction of lesions by any method;
 - c. Any services for tooth transplantation;
 - d. Any services for removal of a foreign body from the oral tissue or bone;
 - e. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered

covered services under the surgical periodontic services in this plan.

30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Georgia

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or

- e. Any procedures to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer policyholder;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services.
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
 24. The oral surgery benefits under this plan does not include:
 - a. Any services for orthognathic surgery;
 - b. Any services for destruction of lesions by any method;
 - c. Any services for tooth transplantation;
 - d. Any services for removal of a foreign body from the oral tissue or bone;
 - e. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
 25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Iowa

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;

- b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer policyholder;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.

10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Idaho

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation.
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance ; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).

17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist or health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Illinois

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage..
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy.

- We consider the following cosmetic dentistry procedures to include, but are not limited to:
- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that :
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
 24. The oral surgery benefits under this plan does not include:
 - a. *Any services* for orthognathic surgery;
 - b. *Any services* for destruction of lesions by any method;
 - c. *Any services* for tooth transplantation;
 - d. *Any services* for removal of a foreign body from the oral tissue or bone;

- e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Indiana

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

- 1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
- 2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 - j.

8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain
 - d. Pain management
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate

Kansas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. *Benefits* will not be provided for *services*, injuries or diseases related to *your* job to the extent *you* are covered or are required to be covered by the Workers' Compensation law. If *you* enter into a settlement giving up *your* right to recover future medical benefits under a Workers' Compensation law, the policy will not pay those medical *benefits* that would have been payable in absence of that settlement.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist or health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Kentucky

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - f. Precision or semi-precision attachments;
 - g. Overdentures and any endodontic treatment associated with overdentures;
 - h. Other customized attachments;
 - i. Any service for 3D imaging (cone beam images);
 - j. Temporary and interim dental services;
 - k. Additional charges related to material or equipment used in the delivery of dental care;
 - l. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - m. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your Plan Benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are

considered an integral part of the entire dental service.

21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist or health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
26. General anesthesia or conscious sedation administered due to the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery
27. Preventive control programs including oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
28. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
29. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
30. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.

31. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year.

Louisiana

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. For which you would not be required to pay if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.

6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments.
 - c. Overdentures and any endodontic treatment associated with overdentures.
 - d. Other customized attachments.
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;

- b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety
 - c. Fear of pain
 - d. Pain management
 - e. Emotional inability to undergo surgery
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any accidental injury, if other insurance will provide payments or expense coverage, other than that described in the Coordination of Benefits provision regardless of whether the other coverage is described as primary, excess or contingent. If your claim against

another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductible.

Maryland

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred for a job-related accidental injury or bodily injury while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury as allowed by Maryland §15-602.
3. Any loss caused or contributed by
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;

- c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth, except for covered orthodontic services when those are covered under this plan as elected by the policyholder.
7. Charges for:
- a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services, unless for *palliative care*;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
- a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist or other licensed health care provider acting within the lawful scope of their license. Scaling or cleaning of teeth and the topical application of fluoride performed by a licensed dental hygienist must be rendered under the direct supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist, unless related to *palliative care* for a *dental emergency*.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
- a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the *usual and customary fee* for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. *Services* which were provided as a result of a Prohibited Referral. For this provision, a Prohibited Referral is any referral prohibited by § 1-302 of the Maryland Code, Health Occupations Article.
25. The oral surgery benefits under this plan does not include:
- a. Any services for orthognathic surgery;

- b. Any services for destruction of lesions by any method;
 - c. Any services for tooth transplantation;
 - d. Any services for removal of a foreign body from the oral tissue or bone;
 - e. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones.
26. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered: Pain control unless a documented allergy to local anesthetic is provided.
- a. Anxiety.
 - b. Fear of pain.
 - c. Pain management.
 - d. Emotional inability to undergo surgery
27. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
28. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
29. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
30. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
31. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Minnesota

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

- 1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law.
- 2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this

insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
- a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation,
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
- a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;

- i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
24. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
29. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

Missouri

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist or health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered: Pain control unless a documented allergy to local anesthetic is provided.

 - a. Anxiety.
 - b. Fear of pain.
 - c. Pain management.
 - d. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year.

North Carolina

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Services or supplies for the treatment of an occupational injury or sickness that are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss contributed to, with the exception of loss incurred from an act of terrorism, or cause by:
 - a. War or any act of war, whether declared or not;
 - b. Insurrection; or
 - c. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary to correct a congenital defect or as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;

- c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services.
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
 24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
 25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered

oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
 30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

North Dakota

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:

- a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments.
 - c. Overdentures and any endodontic treatment associated with overdentures.
 - d. Other customized attachments.
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services.
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial

muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.

24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist or health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered: Pain control unless a documented allergy to local anesthetic is provided.
 - a. Anxiety.
 - b. Fear of pain.
 - c. Pain management.
 - d. Emotional inability to undergo surgery
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense

coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Nebraska

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;

- d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
- a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*
8. Any *service* related to:
- a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization technique.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:
- a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
- a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
 30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

New Hampshire

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
 2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any *service* related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist*

or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety
 - c. Fear of pain
 - d. Pain Management
 - e. Emotional inability to undergo surgery
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
 30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

New Jersey

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Except as stated below, *illness or injury*, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law. *Exception:* This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

2. *Services:*
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any *service* related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the

impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.

21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

New Mexico

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;

- b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any *service* related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any *service* not specifically listed in Your plan benefits.
 14. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
 17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 18. Charges exceeding the *reimbursement limit* for the *service*.
 19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
 21. Temporary dental *services*.
 22. Repair and replacement of orthodontic appliances.
 23. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
 24. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
 25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered

covered services under the surgical periodontic services in this plan.

29. We do not cover services that generally are considered to be medical services except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

New York

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

C. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in this Certificate.

D. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

E. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

F. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

G. Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

H. Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.

I. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

J. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

K. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

L. Services not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

M. Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

N. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

O. Services with No Charge.

We do not Cover services for which no charge is normally made.

S. War.

We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Ohio

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;

- c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your Plan Benefits.
 14. Any service that:
 - a. Is not eligible for benefits upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services.
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
 24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
 25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
 General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered: Pain control unless a documented allergy to local anesthetic is provided.
 - a. Anxiety.
 - b. Fear of pain.

- c. Pain management.
 - d. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
 30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Oklahoma

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
 2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
 3. Any loss caused or contributed by war or any act of war, whether declared or undeclared, while serving in the military service or auxiliary unit attached thereto.
 4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy.
- We consider the following cosmetic procedures to include, but are not limited to:
- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.

12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the year.

Pennsylvania

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expenses arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which coverage was available under any Workers Compensation or Occupational Disease Act or Law.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services, unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim against another insurer is denied or partially paid, we will process *your* claim according to the terms and conditions of this certificate. If we make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

Pennsylvania motor vehicle financial responsibility law. No *benefits* are payable under this Policy until all *benefits* for which *you* are eligible for coverage under the Pennsylvania Motor Vehicle Financial Responsibility Law (or as amended) have been exhausted. Any benefits available to *you* under this policy will be in excess of, and not in duplication of, any coverage available under the Pennsylvania Motor Vehicle Financial Responsibility Law (or as amended).

South Carolina

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred that arose from or were sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any workers' compensation or occupational disease act or law.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury, unless you are legally obligated to pay.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).

17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
 General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered: Pain control unless a documented allergy to local anesthetic is provided.
 - a. Anxiety.
 - b. Fear of pain.
 - c. Pain management.
 - d. Emotional inability to undergo surgery.

26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

South Dakota

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred for which benefits are paid under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Your failure to keep an appointment with the dentist.
5. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy.

We consider the following cosmetic procedures to include, but are not limited to:

- a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
6. Charges for:
- a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
7. Any service related to:
- a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple
 - d. abutments, or any service to stabilize periodontally weakened teeth;
 - e. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - f. Bite registration or bite analysis.
8. Infection control, including but not limited to sterilization techniques.
9. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
10. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
11. Prescription drugs or pre-medications, whether dispensed or prescribed.
12. Any service that:
- a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
13. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
15. Services provided by someone who ordinarily lives in your home or who is a family member except, if it is the only provider in the area and the provider is acting within the scope of practice.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
19. Temporary dental services.
20. Repair and replacement of orthodontic appliances.
21. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
22. The oral surgery benefits under this plan does not include:
- a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;

- e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
23. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided
 - b. Anxiety
 - c. Fear of pain.
 - d. Pain management
 - e. Emotional inability to undergo surgery.
24. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
25. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
26. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
27. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
28. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Texas

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

- 1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
- 2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
- c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

- 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. Your failure to keep an appointment with the dentist.
- 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.
- 7. Charges for:
 - a. Any type of implant and all related, services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
- 8. Any service related to:

- a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your plan benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Charges exceeding the reimbursement limit for the service.
 18. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 19. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 20. Temporary dental services.
 21. Repair and replacement of orthodontic appliances.
 22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
 23. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
 24. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
 25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
 26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
 27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
 28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.

29. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Utah

In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
 - e. Any procedure to change the spacing and/or shape of the teeth.

7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your Plan Benefits.
14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.

15. Orthodontic services unless specified in your Summary of Your Benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan
16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

- a. Pain control unless a documented allergy to local anesthetic is provided.
- b. Anxiety.
- c. Fear of pain.
- d. Pain management.
- e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. *We do not cover services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Virginia

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:

- a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment with the dentist.
 6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any service performed primarily to improve appearance; or
 - c. Characterizations and personalization of prosthetic devices; or
 - d. Any procedure to change the spacing and/or shape of the teeth.
 7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care;
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.
 8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
 9. Infection control, including but not limited to sterilization techniques.
 10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
 11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
 12. Prescription drugs or pre-medications, whether dispensed or prescribed.
 13. Any service not specifically listed in Your Plan Benefits.
 14. Any service that:
 - a. Is not eligible for benefits based upon clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
 15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
 16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
 17. Services provided by someone who ordinarily lives in your home or who is a family member.
 18. Charges exceeding the reimbursement limit for the service.
 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
 21. Temporary dental services.
 22. Repair and replacement of orthodontic appliances.
 23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions,

for symptoms including, but not limited to, headaches.

24. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
30. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Virginia

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment with the *dentist*.
6. Any *service* we consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic* procedures to include, but are not limited to:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - b. Any *service* to correct congenital malformation;
 - c. Any *service* performed primarily to improve appearance;
 - d. Characterizations and personalization of prosthetic devices; or
 - e. Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
 - a. Any type of implant and all related services;
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. Any service for 3D imaging (cone beam images);
 - f. Temporary and interim dental services;
 - g. Additional charges related to material or equipment used in the delivery of dental care.
 - h. Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
 - i. The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.

8. Any *service* related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in Your plan benefits.
14. Any *service* that:
 - a. Is not eligible for benefits based upon *clinical review*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature.
15. Orthodontic *services* unless specified in *your* Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.
16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under Extension of benefits).
17. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
21. Temporary dental *services*.
22. Repair and replacement of orthodontic appliances.
23. The oral surgery benefits under this plan does not include:
 - a. Any *services* for orthognathic surgery;
 - b. Any *services* for destruction of lesions by any method;
 - c. Any *services* for tooth transplantation;
 - d. Any *services* for removal of a foreign body from the oral tissue or bone;
 - e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
 - f. Any separate fees for pre and post-operative care
24. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.
General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
 - a. Pain control unless a documented allergy to local anesthetic is provided.
 - b. Anxiety.
 - c. Fear of pain.
 - d. Pain management.
 - e. Emotional inability to undergo surgery.
25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.
29. We do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Excess coverage

We will not pay benefits for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* claim

against another insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of this certificate. If *we* make a payment, *you* agree to assign to *us* any right *you* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles* for the *year*.

EyeMed Exam Plus Plan Regulatory and Technical Information Guide

Limitations and Exclusions

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are
 - b. received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - c. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - d. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.

13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Any vision materials.
21. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this policy.

State Specific Limitations and Exclusions

California

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you receive benefits under any worker's compensation or occupational disease act or law that results in duplication of benefits.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Your failure to keep an appointment.

5. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any service not specifically listed in Your Plan Benefits.
8. Any service that :
 - a. Is not a visual necessity; or
 - b. Does not offer a favorable prognosis.
9. Orthoptic or vision training
10. Subnormal vision aids and associated testing
11. Aniseikonic lenses
12. Any service we consider cosmetic.
13. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
14. Services provided by someone who ordinarily lives in your home or who is a family member.
15. Charges exceeding the reimbursement limit for the service.
16. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
17. Plano lenses.
18. Medical or surgical treatment of eye, eyes, or supporting structures
19. Any vision materials.
20. Any examination or material required by an Employer as a condition of employment.

Florida

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. *Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law Services:*
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
2. Any loss caused or contributed by:

- a. War or any act of war, whether declared or not;
- b. Any act of international armed conflict; or
- c. Any conflict involving armed forces of any international authority.
3. Any expense arising from the completion of forms.
4. Your failure to keep an appointment.
5. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any service not specifically listed in the Schedule of Benefits.
8. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
9. Orthoptic or vision training
10. Subnormal vision aids and associated testing
11. Aniseikonic lenses
12. Any service we consider cosmetic.
13. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
14. Services provided by someone who ordinarily lives in your home or who is a family member.
15. Charges exceeding the reimbursement limit for the service.
16. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
17. Plano lenses.
18. Medical or surgical treatment of eye, eyes, or supporting structures. Any vision material
19. Any examination or material required by an Employer as a condition of employment.
20. Certain name brands when manufacturer imposes no discount.

Iowa

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, for which you do not apply for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this

insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Your failure to keep an appointment.
 6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
 8. Any service not specifically listed in Your Plan Benefits.
 9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
 10. Orthoptic or vision training
 11. Subnormal vision aids and associated testing
 12. Aniseikonic lenses
 13. Any service we consider cosmetic.
 14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
 15. Services provided by someone who ordinarily lives in your home or who is a family member.
 16. Charges exceeding the reimbursement limit for the service.
 17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 18. Plano lenses
 19. Medical or surgical treatment of eye, eyes, or supporting structures
 20. Any vision materials
 21. Any examination or material required by an Employer as a condition of employment.

Minnesota

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.

1. *Services* that are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
2. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
3. Any expense arising from the completion of forms.
4. *Your* failure to keep an appointment.
5. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any *service* not specifically listed in the Schedule of Benefits.
8. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
9. Orthoptic or vision training.
10. Subnormal vision aids and associated testing.
11. Aniseikonic lenses.
12. Any *service we* consider *cosmetic*.
13. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
14. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
15. Charges exceeding the *reimbursement limit* for the *service*.
16. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
17. Plano lenses.
18. Medical or surgical treatment of eye, eyes, or supporting structures.
19. Any vision materials.

20. Any examination or material required by an Employer as a condition of employment.

North Carolina

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not, excluding terrorism;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider *cosmetic*.

14. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Any vision materials.
21. Any examination or material required by an Employer as a condition of employment.

New York

1. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), and state or Federal workers' compensation, employers liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.
2. Illness, accident, treatment or vision condition arising out of:
 - a. War or act of war, (whether declared or undeclared); participation in a felony, riot or insurrection
 - b. Service in the Armed Forces or units auxiliary thereto;
 - c. Suicide, attempted suicide or intentionally self-inflicted injury.
3. Any expense arising from the completion of forms.
4. *Your* failure to keep an appointment.
5. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any *service* not specifically listed in the Schedule of Benefits.
8. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
9. Any *service we* consider *cosmetic*.
10. Any vision materials.
11. Any examination or material required by an Employer as a condition of employment.

Ohio

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.

2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training
11. Subnormal vision aids and associated testing
12. Aniseikonic lenses
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses
19. Medical or surgical treatment of eye, eyes, or supporting structures

20. Any vision materials
21. Any examination or material required by an Employer as a condition of employment.

Oklahoma

In addition to the limitations and exclusions listed in your “Vision Benefits” section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker’s compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by war or any act of war, whether declared or undeclared, while serving in the military service or auxiliary until attached thereto.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in Your Plan Benefits.
9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training
11. Subnormal vision aids and associated testing..
12. Aniseikonic lenses
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.

15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses
19. Medical or surgical treatment of eye, eyes, or supporting structures
20. Any vision materials
21. Any examination or material required by an Employer as a condition of employment.

South Carolina

In addition to the limitations and exclusions listed in your “Vision Benefits” section, this policy does not provide benefits for the following:

1. Any expenses incurred that arose from or were sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker’s compensation or occupational disease act or law.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury, unless you are legally obligated to pay.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.

8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training
11. Subnormal vision aids and associated testing
12. Aniseikonic lenses
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses
19. Medical or surgical treatment of eye, eyes, or supporting structures
20. Any vision materials
21. Any examination or material required by an Employer as a condition of employment.

South Dakota

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred for which benefits are paid under any worker's compensation or occupational disease act or law.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government- owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
9. Orthoptic or vision training
10. Subnormal vision aids and associated testing
11. Aniseikonic lenses
12. Any service we consider cosmetic.
13. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
14. Charges exceeding the reimbursement limit for the service.
15. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
16. Plano lenses
17. Medical or surgical treatment of eye, eyes, or supporting structures
18. Any vision materials.
19. An examination or material required by an Employer as a condition of employment.

Tennessee

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the

- U.S. government or any of its agencies as required by law;
- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment.
 6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
 8. Any *service* not specifically listed in the Schedule of Benefits.
 9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement.
 10. Orthoptic or vision training.
 11. Subnormal vision aids and associated testing.
 12. Aniseikonic lenses.
 13. Any *service we* consider *cosmetic*.
 14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 16. Charges exceeding the *reimbursement limit* for the *service*.
 17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 18. Plano lenses.
 19. Medical or surgical treatment of eye, eyes, or supporting structures.
 20. Any vision materials.
 21. Any examination or material required by an Employer as a condition of employment.

EyeMed Vision Refresh Plan Regulatory and Technical Information Guide

Limitations and Exclusions

In addition to the limitations and exclusions listed in your “Vision Benefits” section, this policy does not provide benefits for the following:

1. Any *expenses incurred* while *you* qualify for any worker’s compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are
 - b. Received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - c. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - d. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

The EyeMed Vision Refresh product is underwritten by Humana Insurance Company, The Dental Concern, Inc., Humana Health Benefit Plan of Louisiana or Humana Insurance Company of New York.

State Specific Exclusions and Limitations

The limitations and exclusions are revised as follows:

California

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* receive benefits under any worker's compensation or occupational disease act or law that results in duplication of benefits.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. *Your* failure to keep an appointment.
5. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any *service* not specifically listed in the Schedule of Benefits.
8. Any *service* that:
 - a. Is not a *visual necessity*; or
 - b. Does not offer a favorable prognosis.
9. Orthoptic or vision training.
10. Subnormal vision aids and associated testing.
11. Aniseikonic lenses.
12. Any *service* we consider *cosmetic*.
13. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
14. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.

15. Charges exceeding the *reimbursement limit* for the *service*.
16. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
17. Plano lenses.
18. Medical or surgical treatment of eye, eyes, or supporting structures.
19. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
20. Any examination or material required by an Employer as a condition of employment.
21. Non-prescription sunglasses.
22. Two pair of glasses in lieu of bifocals.
23. Services or materials provided by any other group benefit plans providing vision care.
24. Certain name brands when manufacturer imposes no discount.
25. Solutions and/or cleaning products for glasses or contact lenses.
26. Pathological treatment.
27. Non-prescription items.
28. Costs associated with securing materials.
29. Pre- and Post-operative services.
30. Orthokeratology.
31. Routine maintenance of materials.
32. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
33. Artistically painted lenses.

Florida

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.

3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any *service we* consider *cosmetic*.
14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. *Services* or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.

30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

Iowa

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, for which *you* do not apply for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits
9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.

12. Aniseikonic lenses.
 13. Any service *we* consider *cosmetic*.
 14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 16. Charges exceeding the *reimbursement limit* for the *service*.
 17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 18. Plano lenses.
 19. Medical or surgical treatment of eye, eyes, or supporting structures.
 20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
 21. Any examination or material required by an Employer as a condition of employment.
 22. Non-prescription sunglasses.
 23. Two pair of glasses in lieu of bifocals.
 24. Services or materials provided by any other group benefit plans providing vision care.
 25. Certain name brands when manufacturer imposes no discount.
 26. Corrective vision treatment of an experimental nature.
 27. Solutions and/or cleaning products for glasses or contact lenses.
 28. Pathological treatment.
 29. Non-prescription items.
 30. Costs associated with securing materials.
 31. Pre- and Post-operative services.
 32. Orthokeratology.
 33. Routine maintenance of materials.
 34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
 35. Artistically painted lenses.
- a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment.
 6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
 8. Any *service* not specifically listed in the Schedule of Benefits.
 9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
 10. Orthoptic or vision training.
 11. Subnormal vision aids and associated testing.
 12. Aniseikonic lenses.
 13. Any service *we* consider *cosmetic*.
 14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 16. Charges exceeding the *reimbursement limit* for the *service*.
 17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 18. Plano lenses.
 19. Medical or surgical treatment of eye, eyes, or supporting structures.
 20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
 21. Any examination or material required by an Employer as a condition of employment.
 22. Non-prescription sunglasses.
 23. Two pair of glasses in lieu of bifocals.
 24. Services or materials provided by any other group benefit plans providing vision care.
 25. Certain name brands when manufacturer imposes no discount.
 26. Corrective vision treatment of an experimental nature.
 27. Solutions and/or cleaning products for glasses or contact lenses.
 28. Pathological treatment.
 29. Non-prescription items.

Minnesota

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services* that are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service *we* consider *cosmetic*.
14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.

30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

North Carolina

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not, excluding terrorism;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.

9. Orthoptic or vision training.
10. Subnormal vision aids and associated testing.
11. Aniseikonic lenses.
12. Any service we consider *cosmetic*.
13. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
14. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
15. Charges exceeding the *reimbursement limit* for the *service*.
16. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
17. Plano lenses.
18. Medical or surgical treatment of eye, eyes, or supporting structures.
19. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
20. Any examination or material required by an Employer as a condition of employment.
21. Non-prescription sunglasses.
22. Two pair of glasses in lieu of bifocals.
23. Services or materials provided by any other group benefit plans providing vision care.
24. Certain name brands when manufacturer imposes no discount.
25. Corrective vision treatment of an experimental nature.
26. Solutions and/or cleaning products for glasses or contact lenses.
27. Pathological treatment.
28. Non-prescription items.
29. Costs associated with securing materials.
30. Pre- and Post-operative services.
31. Orthokeratology.
32. Routine maintenance of materials.
33. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
34. Artistically painted lenses.

Nebraska

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:

- a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. *Your* failure to keep an appointment.
 6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
 8. Any *service* not specifically listed in the Schedule of Benefits.
 9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
 10. Orthoptic or vision training.
 11. Subnormal vision aids and associated testing.
 12. Aniseikonic lenses.
 13. Any *service we* consider *cosmetic*.
 14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
 16. Charges exceeding the *reimbursement limit* for the *service*.
 17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
 18. Plano lenses.
 19. Medical or surgical treatment of eye, eyes, or supporting structures.
 20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
 21. Any examination or material required by an Employer as a condition of employment.
 22. Non-prescription sunglasses.
 23. Two pair of glasses in lieu of bifocals.
 24. Certain name brands when manufacturer imposes no discount.
 25. Corrective vision treatment of an experimental nature.
 26. Solutions and/or cleaning products for glasses or contact lenses.
 27. Pathological treatment.
 28. Non-prescription items.
 29. Costs associated with securing materials.
 30. Pre- and Post-operative services.
 31. Orthokeratology.
 32. Routine maintenance of materials.
 33. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
 34. Artistically painted lenses.

New York

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), and state or Federal workers' compensation, employers liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.
2. Illness, accident, treatment or vision condition arising out of:
 - a. War or act of war, (whether declared or undeclared); participation in a felony, riot or insurrection
 - b. Service in the Armed Forces or units auxiliary thereto;
 - c. Suicide, attempted suicide or intentionally self-inflicted injury
3. Any expense arising from the completion of forms.
4. *Your* failure to keep an appointment.
5. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.

7. Any *service* not specifically listed in the Schedule of Benefits.
8. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
9. Any *service* we consider *cosmetic*.
10. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
11. Any examination or material required by an Employer as a condition of employment.
12. Non-prescription sunglasses
13. Certain name brands when manufacturer imposes no discount.
14. Corrective vision treatment of an experimental nature.

Oklahoma

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. *Services*:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by war or any act of war, whether declared or undeclared, while serving in the military service or auxiliary until attached thereto.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.

8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any *service* we consider *cosmetic*.
14. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. *Services* or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

South Carolina

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* that arose from or were sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury, unless *you* are legally obligated to pay.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. *Your* failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in the Schedule of Benefits.
9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any *service* *we* consider *cosmetic*.
14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.

16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

South Dakota

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* for which benefits are paid under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

- c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
- 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. *Your* failure to keep an appointment.
- 6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
- 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
- 8. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
- 9. Orthoptic or vision training.
- 10. Subnormal vision aids and associated testing.
- 11. Aniseikonic lenses.
- 12. Any *service* *we* consider *cosmetic*.
- 13. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
- 14. Charges exceeding the *reimbursement limit* for the *service*.
- 15. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- 16. Plano lenses.
- 17. Medical or surgical treatment of eye, eyes, or supporting structures.
- 18. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
- 19. Any examination or material required by an Employer as a condition of employment.
- 20. Non-prescription sunglasses.
- 21. Two pair of glasses in lieu of bifocals.
- 22. Services or materials provided by any other group benefit plans providing vision care.
- 23. Certain name brands when manufacturer imposes no discount.
- 24. Corrective vision treatment of an experimental nature.
- 25. Solutions and/or cleaning products for glasses or contact lenses.
- 26. Pathological treatment.
- 27. Non-prescription items.
- 28. Costs associated with securing materials.

- 29. Pre- and Post-operative services.
- 30. Orthokeratology.
- 31. Routine maintenance of materials.
- 32. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
- 33. Artistically painted lenses.

Tennessee

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

- 1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
- 2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
- 3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
- 4. Any expense arising from the completion of forms.
- 5. *Your* failure to keep an appointment.
- 6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
- 7. Prescription drugs or pre-medications, whether dispensed or prescribed.
- 8. Any *service* not specifically listed in the Schedule of Benefits.
- 9. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement.
- 10. Orthoptic or vision training.
- 11. Subnormal vision aids and associated testing.
- 12. Aniseikonic lenses.
- 13. Any *service* *we* consider *cosmetic*.

14. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in your home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Certain name brands when manufacturer imposes no discount.
25. Solutions and/or cleaning products for glasses or contact lenses
26. Pathological treatment.
27. Non-prescription items.
28. Costs associated with securing materials.
29. Pre- and Post-operative services.
30. Orthokeratology.
31. Routine maintenance of materials.
32. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
33. Artistically painted lenses.

EyeMed Materials Only Plan Regulatory and Technical Information Guide

Limitations and Exclusions

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are
 - b. received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - c. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - d. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any service not specifically listed in the Schedule of Benefits.
6. Any service that we determine:
 - a. Is not a visual necessity;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any service we consider cosmetic.
11. Any expense incurred before your effective date or after the date your coverage under the policy terminates.
12. Charges exceeding the reimbursement limit for the service.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an employer as a condition of employment.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.

21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
30. Artistically painted lenses.

The EyeMed Materials Only product is underwritten by Humana Insurance Company, The Dental Concern, Inc., Humana Health Benefit Plan of Louisiana or Humana Insurance Company of New York.

State Specific Limitations and Exclusions

California

1. Any *expenses incurred* while *you* receive benefits under any worker's compensation or occupational disease act or law that results in duplication of benefits.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any *service* not specifically listed in the Schedule of Benefits.
5. Any *service* that:
 - a. Is not a *visual necessity*; or
 - b. Does not offer a favorable prognosis.
6. Orthoptic or vision training.
7. Subnormal vision aids and associated testing.

8. Aniseikonic lenses.
9. Any service *we* consider *cosmetic*.
10. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
11. Charges exceeding the *reimbursement limit* for the *service*.
12. Plano lenses.
13. Medical or surgical treatment of eye, eyes, or supporting structures.
14. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
15. Any vision examination.
16. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
17. Non-prescription sunglasses.
18. Two pair of glasses in lieu of bifocals.
19. Services or materials provided by any other group benefit plans providing vision care.
20. Certain name brands when manufacturer imposes no discount.
21. Solutions and/or cleaning products for glasses or contact lenses.
22. Pathological treatment.
23. Non-prescription items.
24. Costs associated with securing materials.
25. Orthokeratology.
26. Routine maintenance of materials.
27. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
28. Artistically painted lenses.

Florida

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

- b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Any *service* not specifically listed in the Schedule of Benefits.
 6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
 7. Orthoptic or vision training.
 8. Subnormal vision aids and associated testing.
 9. Aniseikonic lenses.
 10. Any *service we* consider *cosmetic*.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 12. Charges exceeding the *reimbursement limit* for the *service*.
 13. Plano lenses.
 14. Medical or surgical treatment of eye, eyes, or supporting structures.
 15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
 16. Any vision examination.
 17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
 18. Non-prescription sunglasses.
 19. Two pair of glasses in lieu of bifocals.
 20. Services or materials provided by any other group benefit plans providing vision care.
 21. Certain name brands when manufacturer imposes no discount.
 22. Corrective vision treatment of an experimental nature.
 23. Solutions and/or cleaning products for glasses or contact lenses.
 24. Pathological treatment.
 25. Non-prescription items.
 26. Costs associated with securing materials.

27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

Iowa

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, for which *you* do not apply for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any *service we* consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.

13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.
21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

Minnesota

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services* that are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;

- b. Does not offer a favorable prognosis;
- c. Does not have uniform professional endorsement; or
- d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any *service we* consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.
21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

North Carolina

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.

2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not, excluding terrorism;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any *service* *we* consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.

21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

Nebraska

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.

7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any service we consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Certain name brands when manufacturer imposes no discount.
21. Corrective vision treatment of an experimental nature.
22. Solutions and/or cleaning products for glasses or contact lenses.
23. Pathological treatment.
24. Non-prescription items.
25. Costs associated with securing materials.
26. Orthokeratology.
27. Routine maintenance of materials.
28. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
29. Artistically painted lenses.

New York

1. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), and state or Federal workers' compensation, employers liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.
2. Illness, accident, treatment or vision condition arising out of:

- a. War or act of war, (whether declared or undeclared); participation in a felony, riot or insurrection
- b. Service in the Armed Forces or units auxiliary thereto;
3. Suicide, attempted suicide or intentionally self-inflicted injury.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - e. Does not offer a favorable prognosis;
 - f. Does not have uniform professional endorsement; or
 - g. Is deemed to be experimental or investigational in nature.
7. Any service we consider *cosmetic*.
8. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
9. Any vision examination.
10. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
11. Non-prescription sunglasses.
12. Certain name brands when manufacturer imposes no discount.
13. Corrective vision treatment of an experimental nature.

Ohio

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

- c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
 4. Any expense arising from the completion of forms.
 5. Any *service* not specifically listed in the Schedule of Benefits.
 6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
 7. Orthoptic or vision training.
 8. Subnormal vision aids and associated testing.
 9. Aniseikonic lenses.
 10. Any *service* *we* consider *cosmetic*.
 11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
 12. Charges exceeding the *reimbursement limit* for the *service*.
 13. Plano lenses.
 14. Medical or surgical treatment of eye, eyes, or supporting structures.
 15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
 16. Any vision examination, except as otherwise noted on the schedule of benefits.
 17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
 18. Non-prescription sunglasses.
 19. Two pair of glasses in lieu of bifocals.
 20. Services or materials provided by any other group benefit plans providing vision care.
 21. Certain name brands when manufacturer imposes no discount.
 22. Corrective vision treatment of an experimental nature.
 23. Solutions and/or cleaning products for glasses or contact lenses.
 24. Pathological treatment.
 25. Non-prescription items.
 26. Costs associated with securing materials.
 27. Orthokeratology.
 28. Routine maintenance of materials.

29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

Oklahoma

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by war or any act of war, whether declared or undeclared, while serving in the military service or auxiliary until attached thereto.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any *service* *we* consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.

15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.
21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

South Carolina

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* that arose from or were sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury, unless *you* are legally obligated to pay.
3. Any loss caused or contributed by:

- a. War or any act of war, whether declared or not;
- b. Any act of international armed conflict; or
- c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that *we* determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any *service we* consider *cosmetic*.
11. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Services or materials provided by any other group benefit plans providing vision care.
21. Certain name brands when manufacturer imposes no discount.
22. Corrective vision treatment of an experimental nature.
23. Solutions and/or cleaning products for glasses or contact lenses.
24. Pathological treatment.
25. Non-prescription items.
26. Costs associated with securing materials.
27. Orthokeratology.
28. Routine maintenance of materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
30. Artistically painted lenses.

South Dakota

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* for which benefits are paid under any worker's compensation or occupational disease act or law.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement; or
 - d. Is deemed to be experimental or investigational in nature.
6. Orthoptic or vision training.
7. Subnormal vision aids and associated testing.
8. Aniseikonic lenses.
9. Any *service* we consider *cosmetic*.
10. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
11. Charges exceeding the *reimbursement limit* for the *service*.
12. Plano lenses.
13. Medical or surgical treatment of eye, eyes, or supporting structures.
14. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
15. Any vision examination.

16. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
17. Non-prescription sunglasses.
18. Two pair of glasses in lieu of bifocals.
19. Services or materials provided by any other group benefit plans providing vision care.
20. Certain name brands when manufacturer imposes no discount.
21. Corrective vision treatment of an experimental nature.
22. Solutions and/or cleaning products for glasses or contact lenses.
23. Pathological treatment.
24. Non-prescription items.
25. Costs associated with securing materials.
26. Orthokeratology.
27. Routine maintenance of materials.
28. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
29. Artistically painted lenses.

Tennessee

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
 - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.

5. Any *service* not specifically listed in the Schedule of Benefits.
6. Any *service* that we determine:
 - a. Is not a *visual necessity*;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional endorsement.
7. Orthoptic or vision training.
8. Subnormal vision aids and associated testing.
9. Aniseikonic lenses.
10. Any service we consider *cosmetic*.
11. Any *expense incurred* before your effective date or after the date your coverage under this policy terminates.
12. Charges exceeding the *reimbursement limit* for the *service*.
13. Plano lenses.
14. Medical or surgical treatment of eye, eyes, or supporting structures.
15. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
16. Any vision examination.
17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this *policy*.
18. Non-prescription sunglasses.
19. Two pair of glasses in lieu of bifocals.
20. Certain name brands when manufacturer imposes no discount.
21. Solutions and/or cleaning products for glasses or contact lenses.
22. Pathological treatment.
23. Non-prescription items.
24. Costs associated with securing materials.
25. Orthokeratology.
26. Routine maintenance of materials.
27. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
28. Artistically painted lenses.

Accidental Death or Bodily Injury Benefit Regulatory & Technical Information Guide

Limitations and Exclusions

Accidental Death or Bodily Injury insurance does NOT cover loss resulting from:

1. Self-induced sickness, attempted suicide or intentionally self-inflicted bodily injury whether sane or insane.
2. The voluntary taking of any sedative, drug, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner.
3. Being intoxicated or under the influence of any narcotic or hallucinogenic, unless administered on the advice of a qualified practitioner.
4. The travel or flight in a device of any type for aerial navigation, except as a fare-paying passenger of licensed passenger airline.
5. Commission or attempt to commit a civil or criminal battery or felony.
6. Driving while legally intoxicated or under the influence of illegal substance. Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level meet or exceeds the legal presumption of intoxication under the law of the state where the accident took place.
7. The service in any armed forces, except if you are in temporary active duty as a reservist for military training that lasts 30 days or less.
8. Bodily injury or sickness contributed to or causes by:
 - a. war or any act of war, whether declared or not; or
 - b. any act of armed conflict, or any conflict involving armed forces of any authority.
9. Participation in a riot, rebellion, or insurrection. Participation means taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without the authority of law.
10. Driving or operating a motorized vehicle without a valid drivers' license.
11. Driving or operating a motorized vehicle in excess of the legal speed limit.

12. Bodily or mental infirmity or its related surgical or medical treatment or any infection unless the direct result of a bodily injury or unless resulting from accidental ingestion of a contaminated substance.
13. Participation in hazardous sports, including, but not limited to: bungee jumping, motorized vehicle racing, rock climbing, rodeo events, scuba diving, skydiving, parachuting, hang gliding or ballooning.

State Specific Exclusions and Limitations

The limitations and exclusions are revised as follows:

Illinois

2. The voluntary taking of any sedative, drug, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner.
8. Bodily injury or sickness caused by
 - a. war or any act of war, whether declared or not; or
 - b. any act of armed conflict, or any conflict involving armed forces of any authority.

Kentucky

2. The voluntary taking of any sedative, narcotic or hallucinogenic, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner.

Louisiana

2. The voluntary taking of any sedative, narcotic or hallucinogenic, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner.

Maryland

13. Participation in the following hazardous sports: bungee jumping, motorized vehicle racing, rock climbing, rodeo events, scuba diving, sky diving, parachuting, hang gliding or ballooning.

Minnesota

5. Commission or attempt to commit a felony.

Missouri

6. Self-induced sickness, attempted suicide or intentionally self-inflicted bodily injury while sane.

Nebraska

3. Not applicable.

Oklahoma

8. Bodily injury or sickness contributed to or caused by any war or act of war declared, while serving in the military forces or auxiliary unit attached thereto.

South Dakota

1. Not applicable.
2. Not applicable.

The Life product is underwritten by the following Humana Companies: Humana Insurance Company, Humana Health Insurance Company of Florida, Inc. or Humana Insurance Company of Kentucky.

Voluntary Term Life Regulatory And Technical Information Guide

Limitations and Exclusions

Voluntary life insurance benefits will be limited to the premium paid in the event of death caused by self-induced sickness, suicide, or intentional self-inflicted bodily injury, whether sane or insane, within the first year of the insured's effective date under the certificate.

Voluntary Term Life benefits do not cover loss resulting from:

1. Self-induced sickness, attempted suicide or intentional self-inflicted bodily injury, whether sane or insane within the first year of your effective date. Benefits are limited to the premium paid for the employee voluntary term life insurance.
2. The voluntary taking of any sedative, drug, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner within the first year of your effective date. Benefits will be limited to the premium paid for this employee voluntary term life insurance.
3. Travel or flight in a device of any type for aerial navigation, except as a fare-paying passenger of a licensed passenger airline.
4. Commission, or attempt to commit a civil or criminal battery or felony.
5. Service in any armed forces, except if you are in temporary active duty as a reservist for military training that lasts 30 days or less.
6. Bodily injury or sickness contributed to or caused by:
 - a. war or any act of war, whether declared or not; or
 - b. any act of armed conflict, or any conflict involving armed forces of any authority.
7. Participation in a riot, rebellion or insurrection. Participation means taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without the authority of law.

State Specific Limitations and Exclusions

The limitations and exclusions are revised as follows:

Illinois

2. The voluntary taking of any sedative, drug, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner within the first year of your effective date. Benefits will be limited to the premium paid for this employee voluntary term life insurance.
6. Bodily injury or sickness caused by: war or any act of war, whether declared or not; or any act of armed conflict, or any conflict involving armed forces of any authority.

Kansas

The exclusions and limitations are not applicable.

Kentucky

2. The voluntary taking of any sedative, narcotic or hallucinogenic, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner within the first year of your effective date. Benefits will be limited to the premium paid for this employee voluntary term life insurance.

Louisiana

2. The voluntary taking of any sedative, narcotic or hallucinogenic, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a qualified practitioner within the first year of your effective date. Benefits will be limited to the premium paid for this employee voluntary term life insurance.

Minnesota

4. Commission or attempt to commit a felony.

Missouri

1. Not applicable.
2. Not applicable.
3. Not applicable.
5. Not applicable.

Nebraska

1. Self-induced sickness, attempted suicide or intentional self-inflicted bodily injury, whether sane or insane within the first two years of your effective date. Benefits are limited to the premium paid for the employee voluntary term life insurance.
2. Not applicable.
3. Not applicable.
4. Not applicable.
5. Not applicable.

Ohio

1. Not applicable.
2. Not applicable.
4. Not applicable.
7. Not applicable.

Oklahoma

6. Bodily injury or sickness contributed to or caused by any war or act of war declared, while serving in the military forces or auxillary unit attached thereto.

South Dakota

2. Not applicable.

Tennessee

1. Suicide committed while sane or insane within the first year of your effective date. Benefits will be limited to the premium paid for this voluntary term life insurance.
2. Not applicable.
4. Not applicable.
5. Death as a result of service in any armed forces, in time of war, except if you are in temporary active duty as a reservist for military training that last 30 days or less.

Utah

The limitations and exclusions are not applicable.

The Life product is underwritten by the following Humana Companies: Humana Insurance Company, or Humana Insurance Company of Kentucky

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocrportal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá' jiik'éh saad bee áká'ánída'áwo'déé' níká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك