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Prepaid Dental Plan
Regulatory and Technical Information Guide

Questions
For general questions about the plan, please call our Customer Care Department at 1-800-342-5209 or visit our website at www.compbeneﬁts.com.

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
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 VIII, Paragraph C of the Agreement and Certificate of Beneﬁts.
2. 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.

Company does not provide coverage for the following services:
1. Cost of hospitalization and pharmaceuticals, drugs or medications.
2. Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of beneﬁts.
6. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia.

State Specific Limitations and Exclusions

Florida
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 VIII, Paragraph C of the Agreement and Certificate of Beneﬁts.
2. 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.

Company does not provide coverage for the following services:
1. Cost of hospitalization and pharmaceuticals, drugs or medications.
2. Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of beneﬁts.
6. Services for injuries and conditions which are paid under Workers' Compensation or Employers' Liability laws.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia.

Kansas
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 VIII, Paragraph C of the Agreement and Certificate 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.

Company does not provide coverage for the following services:

1. Cost of hospitalization and pharmaceuticals, drugs or medications.
2. Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.
6. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia.

Texas

1. No service of any dentist other than a Participating Dentist will be covered by the Plan, except emergency care as provided in this Handbook.
2. 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.

The Plan does not provide coverage for the following services:

3. Cost of hospitalization and pharmaceuticals, drugs or medications.
4. Services which, in the opinion of the Participating Dentist, are not Necessary Treatment to establish and maintain Member's optimal dental health and appearance.
5. Any service that is not consistent with the normal and/or usual services provided by the Participating Dentist or which, in the opinion of the Participating Dentist, would endanger the health of the Member.
6. Any service or procedure which the Participating Dentist is unable to perform because of the general health or physical limitations of the Member.
7. Any dental procedure started prior to the Member's Effective Date.
8. Services for injuries and conditions, which are, covered under Workers' Compensation or Employers' Liability laws.
9. Treatment for cysts, neoplasms and malignancies.
10. General anesthesia.

Louisiana

1. Subscribers may select the dentist of their choice subject to the Benefits as defined in the Certificate. Any non-participating provider that meets the Company eligibility requirements, willing to accept the same compensation amounts as a participating provider, may furnish services to the Member.
2. 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.

Company does not provide coverage for the following services:

1. Cost of hospitalization and pharmaceuticals, drugs or medications.
2. Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.
6. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia.

The Prepaid Dental Plan is underwritten by the following Humana companies: CompBenefits of Alabama, Inc., American Dental Providers of Arkansas, Inc., CompBenefits Company, a Prepaid Limited Health
Service Organization licensed under Chapter 636 of the Florida Statutes, CompBenefits of Georgia, Inc., CompBenefits Dental, Inc., CompBenefits Insurance Company, American Dental Plan of North Carolina, Inc. and DentiCare, Inc. (d/b/a CompBenefits).
EPO Plan
Regulatory and Technical Information Guide

Questions
For general questions about the plan, please call our Customer Care Department at 1-800-342-5209 or visit our website at www.compbenefits.com.

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
1. Major restorative services will be subject to the following:
   a. Denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate; however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
   b. The replacement of a partial denture, full denture, or the addition of teeth to a partial denture if:
   c. Replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge;
   d. Replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge;
   e. Replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or
   f. Replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
   g. The replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if:
      h. The replacement occurs at least eight years after the initial date of insertion; and
      i. They are not serviceable and cannot be restored to function;
      j. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
      k. The replacement of teeth up to the normal complement of 32; and
      l. Denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.

2. 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 VIII, Paragraph B of the Certificate of Group Dental Benefits.

3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.

4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member’s Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.

5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.

6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.

7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

Company does not provide coverage for the following services:

1. Pharmaceuticals, drugs or medications.

2. Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are:
   a. not necessary;
   b. not appropriate for the given condition or not customarily used for dental care;
   c. do not have uniform professional endorsement or do not meet the standards set by the American Dental Association;
   d. experimental or investigational in nature;
   e. for which the Member has no legal obligation to pay; or
f. for which a charge would have been made in the absence of insurance.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.
6. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits:
   a. pain control, unless documented allergy to local anesthetic;
   b. anxiety;
   c. fear of pain;
   d. pain management; or
   e. emotional inability to undergo surgery.
9. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company.
10. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
11. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.
12. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
13. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.
14. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
15. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.
16. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.
17. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.
18. Dental implants and related services.
19. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.
20. Resin bonded bridges, including associated retainers and pontics.
21. Charges for travel time, transportation costs, or professional advice given on the phone.
22. Procedures performed by a dentist who is a member of Your immediate family.
23. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
24. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.
25. Charges for treatment rendered;
   a. in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or
   b. by an employee of any Member.
26. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.
27. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

State Specific Limitation and Exclusions

Georgia

1. Major restorative services will be subject to the following:
a. Denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Policy replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Policy without a break in coverage, provided:

b. The prosthetic replaces teeth that were extracted while insured under the prior policy; and
c. The prosthetic work is completed within 12 months of the extraction;
d. The replacement of a partial denture, full denture, or the addition of teeth to a partial denture if:
e. replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge;
f. replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge;
g. replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or
h. replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
i. The replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if:
j. replacement occurs at least eight years after the initial date of insertion; and
k. they are not serviceable and cannot be restored to function;
l. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
m. The replacement of teeth up to the normal complement of 32; and
n. Denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.

2. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by CompBenefits, except out of area emergency care as provided in Section X, Paragraph B of the Certificate of Group Dental Benefits.

3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.

4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member’s Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.

5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.

6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.

7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

CompBenefits does not provide coverage for the following services:

1. Pharmaceuticals, drugs or medications.

2. Services which in the opinion of the Participating General Dentist, Participating Specialist or CompBenefits are
   a. not necessary;
   b. not appropriate for the given condition or not customarily used for dental care;
   c. do not have uniform professional endorsement or do not meet the standards set by the American Dental Association;
   d. experimental or investigational in nature;
   e. for which the Member has no legal obligation to pay; or
   f. for which a charge would have been made in the absence of insurance.

3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

4. 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 the Member.

5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.

6. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.

7. Treatment for cysts, neoplasms and malignancies.

8. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the
Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits:

a. pain control, unless documented allergy to local anesthetic;
b. anxiety;
c. fear of pain;
d. pain management; or
e. emotional inability to undergo surgery.
9. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient’s dental condition for a period of at least three years, as determined by CompBenefits.
10. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
11. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.
12. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
13. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.
14. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
15. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.
16. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.
17. Dental implants and related services.
18. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.
19. Resin bonded bridges, including associated retainers and pontics.
20. Charges for travel time, transportation costs, or professional advice given on the phone.
21. Procedures performed by a dentist who is a member of Your immediate family.
22. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
23. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.
24. Charges for treatment rendered:
   a. in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or
   b. by an employee of any Member.
25. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.
26. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

Ohio

1. Major restorative services will be subject to the following:
   a. Denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided:
      a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
   b. The replacement of a partial denture, full denture, or the addition of teeth to a partial denture if:
   c. replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge;
   d. replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge;
   e. replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or
   f. replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is
completed within 12 months of the injury;
g. The replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if:
h. replacement occurs at least eight years after the initial date of insertion; and
i. they are not serviceable and cannot be restored to function;
j. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
k. The replacement of teeth up to the normal complement of 32; and
l. Denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.

2. 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 B of this Certificate unless a covered Dental Care Service is not available through a Participating General Dentist or Participating Specialist as required by O.R.C. 175113(A)(2).

3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.

4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member’s Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.

5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.

6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.

7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

Company does not provide coverage for the following services:

1. Pharmaceuticals, drugs or medications.

2. Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are
   a. not necessary;
   b. not appropriate for the given condition or not customarily used for dental care;
   c. do not have uniform professional endorsement or do not meet the standards set by the American Dental Association;
   d. experimental or investigational in nature;
   e. for which the Member has no legal obligation to pay; or
   f. for which a charge would have been made in the absence of insurance.

3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

4. 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 the Member.

5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.

6. Services for injuries and conditions which are covered under Workers' Compensation or Employers’ Liability laws, or that arises out of or in the course of a job or employment for pay or profit.

7. Treatment for cysts, neoplasms and malignancies.

8. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits:
   a. pain control, unless documented allergy to local anesthetic;
   b. anxiety;
   c. fear of pain;
   d. pain management; or
   e. emotional inability to undergo surgery.

9. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient’s dental condition for a period of at least three years, as determined by Company.

10. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.

11. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.

12. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
13. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.

14. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.

15. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.

16. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.

17. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.

18. Dental implants and related services.

19. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.

20. Resin bonded bridges, including associated retainers and pontics.

21. Charges for travel time, transportation costs, or professional advice given on the phone.

22. Procedures performed by a dentist who is a member of Your immediate family.

23. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.

24. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.

25. Charges for treatment rendered; a. in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or b. by an employee of any Member.

26. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.

27. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

1. Major restorative services will be subject to the following:
   a. Denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided:
      i. the prosthetic replaces teeth that were extracted while insured under the prior policy; and
      ii. the prosthetic work is completed within 12 months of the extraction;
   b. The replacement of a partial denture, full denture, or the addition of teeth to a partial denture if:
      i. replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge;
      ii. replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge;
   c. replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or
   d. replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
   e. The replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if:
      i. they are not serviceable and cannot be restored to function;
      ii. they are extracted while insured under the prior contract; and
      iii. the prosthetic replaces teeth that were extracted while covered under which You were covered, and
      iv. the prosthetic replaces a prior group dental policy without a break in coverage;
   f. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
   g. The replacement of teeth up to the normal complement of 32; and
   h. Denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.

2. 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 VIII, Paragraph C of the Certificate of Group Dental Benefits.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.
4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member’s Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.
5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.
6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.
7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

Company does not provide coverage for the following services:

1. Pharmaceuticals, drugs or medications.
2. Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are
   a. not necessary;
   b. not appropriate for the given condition or not customarily used for dental care;
   c. do not have uniform professional endorsement or do not meet the standards set by the American Dental Association;
   d. experimental or investigational in nature;
   e. for which the Member has no legal obligation to pay; or
   f. for which a charge would have been made in the absence of insurance.
3. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
4. 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 the Member.
5. Any dental treatment started prior to the Member's effective date for eligibility of benefits.
6. Services for injuries and conditions which are paid under Workers' Compensation or Employers' Liability laws.
7. Treatment for cysts, neoplasms and malignancies.
8. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits:
   a. pain control, unless documented allergy to local anesthetic;
   b. anxiety;
   c. fear of pain;
   d. pain management; or
   e. emotional inability to undergo surgery.
9. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient’s dental condition for a period of at least three years, as determined by Company.
10. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
11. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.
12. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.
13. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.
14. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
15. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.
16. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.
17. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.
18. Dental implants and related services.
19. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.
20. Resin bonded bridges, including associated retainers and pontics.
21. Charges for travel time, transportation costs, or professional advice given on the phone.
22. Procedures performed by a dentist who is a member of Your immediate family.
23. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
24. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.
25. Charges for treatment rendered:
   a. in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or
   b. by an employee of any Member.
26. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.
27. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

Texas

Limitations and Exclusions

1. Major restorative services will be subject to the following:
   a. A denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided:
   b. the prosthetic replaces teeth that were extracted while insured under the prior policy; and
   c. the prosthetic work is completed within 12 months of the extraction;
   d. The replacement of a partial denture, full denture, or the addition of teeth to a partial denture if:
   e. replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge;
   f. replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge;
   g. replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or
   h. replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
   i. The replacement of crowns, cast restorations, inlays, onlays, fixed partial dentures or other laboratory prepared restorations only if:
   j. (i) replacement occurs at least eight years after the initial date of insertion; and
   k. (ii) they are not serviceable and cannot be restored to function;
   l. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person’s dental condition;
   m. The replacement of teeth up to the normal complement of 32; and
   n. Denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.
2. No service of any dentist other than a Participating Dentist will be covered by the Plan, except emergency care as provided in the Handbook/EOC.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits or enjoy any of the other privileges of a Member in good standing.
4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member’s Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.
5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.
6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.
7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

The Plan does not provide coverage for the following services:

1. Pharmaceuticals, drugs or medications.
2. Services which, in the opinion of the Participating Dentist or Company are
   a. not necessary;
   b. not appropriate for the given condition or not customarily used for dental care;
   c. do not have uniform professional endorsement or do not meet the
standards set by the American Dental Association;

d. experimental or investigational in nature;

e. for which the Member has no legal obligation to pay; or (f) for which a charge would have been made in the absence of insurance.

3. Any service that is not consistent with the normal and/or usual services provided by the Participating Dentist or which, in the opinion of the Participating Dentist, would endanger the health of the Member.

4. Any service or procedure which the Participating Dentist is unable to perform because of the general health or physical limitations of the Member.

5. Any dental procedure started prior to the Member’s Effective Date.

6. Services for injuries and conditions, which are, covered under Workers’ Compensation or Employers’ Liability laws, or that arises out of or in the course of a job or employment for pay or profit.

7. Treatment for cysts, neoplasms and malignancies.

8. General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits:

   a. pain control, unless documented allergy to local anesthetic;
   b. anxiety;
   c. fear of pain;
   d. pain management; or
   e. emotional inability to undergo surgery.

9. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient’s dental condition for a period of at least three years, as determined by Company.

10. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.

11. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.

12. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.

13. Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.

14. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.

15. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.

16. Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.

17. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.

18. Dental implants and related services.

19. Restoration of teeth that have been damaged by attrition, abrasion, or erosion.

20. Resin bonded bridges, including associated retainers and pontics.

21. Charges for travel time, transportation costs, or professional advice given on the phone.

22. Procedures performed by a dentist who is a member of Your immediate family.

23. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.

24. Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.

25. Charges for treatment rendered;

   a. in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or
   b. by an employee of any Member.

26. Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.

27. Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

The EPO Plan is underwritten by the following Humana companies: CompBenefits of Alabama, Inc., CompBenefits Company, a prepaid Limited Health Service Organization licensed under Chapter 636 of the
Florida Statutes, CompBenefits Dental, Inc.,
CompBenefits 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;
   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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
    a. Is not a dental 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.

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, 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.

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 calendar year deductible.

State Specific Limitation and Exclusions
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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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.


10. Any service that we determine:
    a. Is not a dental 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.

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, 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.

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 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 for cosmetic dentistry, unless such service is necessary as a result of an accidental bodily injury sustained while you are covered
under this policy. The following are considered cosmetic dentistry:

- 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.

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.


10. Any service which:

- a. Is not a dental necessity;
- b. Does not offer a favorable prognosis;
- c. Does not have uniform professional endorsement; 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, 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.

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 calendar year deductibles.

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 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 malformations;
- c. Any service performed primarily to improve appearance; or
- d. Characterizations and personalization of prosthetic devices.

7. Infection control, including but not limited to sterilization techniques.

8. Fees for treatment by other than a dentist, except when lawfully rendered by a licensed dental hygienist. Services performed by a dental hygienist must be rendered under the direct supervision and guidance of the dentist except as specifically allowed by the Colorado Professions and Occupations code permitting dental hygienists to practice unsupervised dental hygiene.


10. Any service that we determine:
In addition to the limitations and exclusions listed in Your Florida deductibles.

Payments made by the other insurer will be credited against the other insurer for Dental expenses we pay.
your behalf, you agree to assign to us any right you have and conditions of this Policy. If payment is made by us on paid, we will process your claim according to the terms If your claim against the other insurer is denied or partially coverage is described as primary, excess or contingent.

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.

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.

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;
   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, unless the service is for treatment of a covered newborn as allowed under the Additional benefits for newborns section of Your plan benefits;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
    a. Is not a dental 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.

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, temporary dental services, study dentistry procedures:
   a. Characterizations and personalization of prosthetic devices.
   b. Any service performed primarily to improve appearance; or
   c. Any service to correct congenital malformation, unless the service is for treatment of a covered newborn as allowed under the Additional benefits for newborns section of Your plan benefits;
   d. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.

   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).

   Services provided by someone who ordinarily lives in your home or who is a family member.

   Charges exceeding the reimbursement limit for the service.

   Treatment resulting from any intentionally self-inflicted injury or bodily illness.
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.

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 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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.
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 we determine:
    a. Is not a dental 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.
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, temporary dental services, study models, diagnostic casts, 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. General anesthesia unless administered by a dentist in conjunction with covered surgical procedures for the treatment of jaw joint problems as provided in this Certificate. Patient management or apprehension does not constitute medical necessity.
17. Services that are generally considered to be medical services, except those specifically listed in the covered expenses.

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 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 malformations;
   or
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
    a. Is not a dental 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.

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, 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.

**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, unless you are a partner or sole proprietor of the group plan, and you did not elect to be covered by the 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 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:
   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 malformations;
   or
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental, investigational or for research purposes.

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, 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.

16. Sickness or bodily injury for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage. Payments made by any other coverage will be credited toward any applicable calendar year deductible and coinsurance for the year the sickness or bodily injury was initially sustained.

**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 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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
    a. Is not a dental 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.

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, 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.

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, and 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 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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.
7. Infection control, including but not limited to sterilization techniques.
8. Fees for treatment performed by someone other than a dentist or other health care practitioner practicing within the scope of his/her license. A licensed dental hygienist may perform scaling and teeth cleaning, and the topical application of fluoride. The treatment must be provided 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 we determine:
    a. Is not a dental 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.
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, 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.

Kansas
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 
malformations;
   c. Any service performed primarily to 
improve appearance; or
   d. Characterizations and personalization of 
prosthetic devices.
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 we determine:
    a. Is not a dental 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.
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, 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.

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 
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 
malformations;
   c. Any service performed primarily to 
improve appearance; or
   d. Characterizations and personalization of 
prosthetic devices.
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 we determine:
   a. Is not a dental 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.

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, 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.

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 calendar year deductibles.

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 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.

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.

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 by other than a dentist, or other health care practitioner practicing within the scope of their license. Scaling or cleaning of the teeth and topical application of fluoride may be performed by a licensed dental hygienist 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 anesthetist.

12. Prescription drugs or pre-medications, whether dispensed or prescribed.
14. Any service that we determine:
   a. Is not a dental 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.
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.
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.

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 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.
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.
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. Fee 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 anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
14. Any service that we determine:
   a. Is not a dental 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.
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.
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. Services which were provided as a result of a Prohibited Referral. For this provision, a Prohibited Referral is any referral prohibited by Ins s. 1-302 or as amended, of the Health Occupations Article.

**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 calendar year deductibles.

**Minnesota**

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

1. 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;
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 with the dentist.
5. 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, unless you are a covered dependent child;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.
6. 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.
7. 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.

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 anesthetist.
11. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service that we determine:
   a. Is not a dental 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.
15. 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).
16. Services provided by someone who ordinarily lives in your home or who is a family member.
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, 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.

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 while you are confined in a hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected sickness or bodily injury, unless you are legally required to pay in the absence of insurance.
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.
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.
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 we determine:
   a. Is not a dental 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.
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.
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.

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 caused or contributed by:
   a. War or any act of war, whether declared or not;
   b. Any act of international armed conflict;
   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 bicuspids.
   b. Any service to correct congenital malformation; unless you are a covered dependent child who has been covered under the policy since birth or since placement in the adoptive or foster home.
   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, 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.
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 we determine:
   a. Is not a dental 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.

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.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniofacial 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.

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 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.

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.

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 we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental 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.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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.

**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 calendar year deductibles.

**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;
   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

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.

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.


14. Any service that we determine:
   a. Is not a dental 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.

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.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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.

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:
   a. 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 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.

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.

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 we determine:
   a. Is not a dental 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.

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.


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.

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 calendar year deductibles.

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 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 bicuspids.
   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, 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.
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.
14. Any service that we determine:
   a. Is not a dental 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.
15. Orthodontic services, regardless of why services are recommended or treatment is provided, 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.
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.

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 calendar year deductibles.

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;
   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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.

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 we determine:
    a. Is not a dental 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.

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, 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.

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;
   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 malformations;
c. Any service performed primarily to improve appearance; or
d. Characterizations and personalization of prosthetic devices.
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 we determine:
   a. Is not a dental 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.
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, 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.

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 calendar year deductibles.

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 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 malformations;
   c. Any service performed primarily to improve appearance; or
   d. Characterizations and personalization of prosthetic devices.
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 we determine:
    a. Is not a dental 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.
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, 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.

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 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 malformations;
   c. Any service performed primarily to improve appearance;
   d. Characterizations and personalization of prosthetic devices.

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.


10. Any service that we determine:
    a. Is not a dental 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.

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, 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.

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.
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 not;**
   - **Any act of international armed conflict;**
   - **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:**
   - **Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.**
   - **Any service performed primarily to improve appearance; or**
   - **Characterizations and personalization of prosthetic devices.**

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 we determine:**
    - **Is not a dental necessity;**
    - **Does not offer a favorable prognosis;**
    - **Does not have uniform professional endorsement; 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, 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.**

**Wisconsin**

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:**
   - **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;**
   - **Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or**
   - **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 not;**
   - **Any act of international armed conflict;**
   - **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:**
   - **Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.**
   - **Any service to correct congenital malformations, unless the dependent child has been covered under this policy since birth; or**
   - **Characterizations and personalization of prosthetic devices.**

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.


10. Any service that we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental, investigational or for research purposes.

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, 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.

Excess coverage

No benefits will be payable under this policy on account of any injury or sickness caused by you, your dependent or any other party, for which there is other insurance providing medical or dental pay coverage or medical or dental expense coverage available to you or your coverage as described as being primary, excess or contingent.

We will process your claim according to the provisions of the policy and secure reimbursement from the medical or dental payments or medical or dental expense insurer.

You hereby assign to us any right you have against the other insurer under the medical or dental payments or medical or dental expense coverage for reimbursement of dental expenses we have paid on your behalf.

The Preventive Plus dental plan is underwritten by HumanaDental Insurance Company
Rev. 04.08.08
MTV Standard 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 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.

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.

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 abrasion; 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 we determine:
   a. Is not a dental 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.

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.
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.

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 calendar year deductibles.

State Specific Limitations and Exclusions

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.
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.
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
   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 we determine:
   a. Is not a dental 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.
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.
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.

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 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 for cosmetic dentistry, unless such service is necessary as a result of an accidental bodily injury sustained while you are covered under this Policy. The following are considered cosmetic dentistry:
   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.
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.
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.
14. Any service which:
   a. Is NOT a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental 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.
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.

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 calendar year deductibles.

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 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.
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.
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 by other than a dentist, except when lawfully rendered by a licensed dental hygienist. Services performed by a dental hygienist must be rendered under the direct supervision and guidance of the dentist except as specifically allowed by the Colorado Professions and Occupations code permitting dental hygienists to practice unsupervised dental hygiene.
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.
14. Any service that we determine:
   a. Is not a dental 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.
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.
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.

**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.

**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;
   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, unless the service is for treatment of a covered newborn as allowed under the Additional benefits for newborns section of Your plan benefits;
   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, 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.

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 we determine:
   a. Is not a dental 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.

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.


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.

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);
   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.

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.

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;

**Georgia**

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:
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 we determine:
   a. Is not a dental 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.

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.


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, except as provided in this Certificate.

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, and 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 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.

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.

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 health care practitioner practicing within the scope of his/her license. A licensed dental hygienist may perform scaling and teeth cleaning, and the topical application of fluoride. The treatment must be provided 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 we determine:
   a. Is not a dental 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.
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.
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.

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 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, unless for the treatment of congenital anomalies of a dependent newborn child;
   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, 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.
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 we determine:
   a. Is not a dental 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.
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.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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.

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, unless you are a partner or sole proprietor of the group plan, and you did not elect to be covered by the 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 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:
   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, 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.
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 we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental, investigational or for research purposes.

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.


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. Sickness or bodily injury for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage. Payments made by any other coverage will be credited toward any applicable calendar year deductible and coinsurance for the year the sickness or bodily injury was initially sustained.

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 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.

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.

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 anesthetist 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 we determine:
   a. Is not a dental 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.

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.


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.

Kansas

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.

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.

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 we determine:
   a. Is not a dental 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.

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.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniofacial 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.

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 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.
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.
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.
14. Any service that we determine:
   a. Is not a dental 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.
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.
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.

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 calendar year deductibles.

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 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.
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.
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 by other than a dentist, or other health care practitioner practicing within the scope of their license. Scaling or cleaning of the teeth and topical application of fluoride may be performed by a licensed dental hygienist 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 anesthiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
14. Any service that we determine:
   a. Is not a dental 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.
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.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, cranio-maxillary, cranio-mandibular 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.

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 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;
   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.
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.
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 anesthetist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
14. Any service that we determine:
   a. Is not a dental 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.
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.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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. Services which were provided as a result of a Prohibited Referral. For this provision, a Prohibited Referral is any referral prohibited by Ins s. 1–302 or as amended, of the Health Occupations Article.

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 calendar year deductibles.

Minnesota
In addition to the limitations and exclusions listed in Your Plan Benefits section, this policy does not provide benefits for the following:
1. 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;

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;
   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 with the dentist.

5. 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, unless you are a covered dependent child;
   c. Any service performed primarily to improve appearance;
   d. Characterizations and personalization of prosthetic devices.

6. 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.

7. 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;
   e. 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 anesthetist.

11. Prescription drugs or pre-medications, whether dispensed or prescribed.


13. Any service that we determine:
   a. Is not a dental 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.


15. 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).

16. Services provided by someone who ordinarily lives in your home or who is a family member.

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, 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.


**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 while you are confined in a hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected sickness or bodily injury, unless you are legally required to pay in the absence of insurance.

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
14. Any service that we determine:
   a. Is not a dental 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.

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.


22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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.

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 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; unless you are a covered dependent child who has been covered under the policy since birth or since placement in the adoptive or foster home.
   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, 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.
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 we determine:
   a. Is not a dental 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.
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.
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.

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 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.

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.

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;
   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 we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental 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.


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.

**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 calendar year deductibles.

**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;
   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.

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.

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.


14. Any service that we determine:
   a. Is not a dental 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.

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.


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.

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 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.
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.
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 we determine:
   a. Is not a dental 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.
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.
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.

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 calendar year deductibles.

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 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.

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.

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.


14. Any service that we determine:
   a. Is not a dental 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.

15. Orthodontic services, regardless of why services are recommended or treatment is provided, 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.


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.
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 calendar year deductibles.

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 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.
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.
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 we determine:
   a. Is not a dental 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.
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.
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.

**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. 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.
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.
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 we determine:
   a. Is not a dental 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.
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.
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.

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 calendar year deductibles.

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;
   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.
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.
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 we determine:
   a. Is not a dental 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.

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.
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.

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;
   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.
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.
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.
14. Any service that we determine:
   a. Is not a dental 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.

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.


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.

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 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 performed primarily to improve appearance; or
   c. Characterizations and personalization of prosthetic devices.

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.

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.


14. Any service that we determine:
   a. Is not a dental 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.
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.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniofacial, craniofacial 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.

Wisconsin

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, unless the dependent child has been covered under this policy since birth;
   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, 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.
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.
14. Any service that we determine:
   a. Is not a dental necessity;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional endorsement; or
   d. Is deemed to be experimental, investigational or for research purposes.
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.


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.

Excess coverage

No benefits will be payable under this policy on account of any injury or sickness caused by you, your dependent or any other party, for which there is other insurance providing medical or dental pay coverage or medical or dental expense coverage available to you or your coverage as described as being primary, excess or contingent.

We will process your claim according to the provisions of the policy and secure reimbursement from the medical or dental payments or medical or dental expense insurer.

You hereby assign to us any right you have against the other insurer under the medical or dental payments or medical or dental expense coverage for reimbursement of dental expenses we have paid on your behalf.

The MTV Standard Dental Product is undwritten by HumanaDental Insurance Company.
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 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.


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 or safety eyewear, unless covered under this policy.

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.


27. Non-prescription items.


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

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 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;
In addition to the limitations and exclusions listed in your Florida benefits for the following: "Vision 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;
   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 which:
   a. Is not a visual necessity; or
   b. Does not offer a favorable prognosis.

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. 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.


27. Costs associated with securing materials.

28. Pre- and Post-operative services.

29. Orthokeratology.

30. Routine maintenance of materials.

31. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.

32. 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:
21. Any examination or material required by an employer as a condition of employment or safety eyewear, unless covered under this policy.
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
27. Non-prescription items.
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.

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, and 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. 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 or safety eyewear, unless covered under this policy.
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
27. Non-prescription items.
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.

Louisiana

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. 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;
   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. 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 or safety eyewear, unless covered under this policy.

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. 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.

North 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 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;
   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 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 or safety eyewear, unless covered under this policy.
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. 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

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 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. 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 or safety eyewear, unless covered under this policy.
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. 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

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 anestesiologist 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, except as specifically provided elsewhere in the certificate.

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 or safety eyewear, unless covered under this policy.

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.


27. Non-prescription items.


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

Pennsylvania

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 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.

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. 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 or safety eyewear, unless covered under this policy.
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. 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

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
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 or safety eyewear, unless covered under this policy.
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. 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.

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;
   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. 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 or safety eyewear, unless covered under this policy.
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. 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.

Utah
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;
   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.
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;
   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. Any service we consider cosmetic.

11. Any expense incurred before your effective date or after the date your coverage under this policy terminates.

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. Medical or surgical treatment of eye, eyes, or supporting structures

16. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.

17. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this policy.

18. Two pair of glasses in lieu of bifocals

19. Services or materials provided by any other group benefit plans providing vision care.

20. Corrective vision treatment of an experimental nature

21. Solutions and/or cleaning products for glasses or contact lenses/

22. Contact Lenses

23. Pathological treatment

24. Non-prescription items

25. Costs associated with securing materials

26. Pre- and Post-operative services

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 lens

The EyeMed vision product is underwritten by Humana Insurance Company.
Questions
For general questions about the plan, please call our Customer Care Department at 1-800-865-3676 or visit our website at www.visioncare.com.

Limitations and Exclusions

Limitations
In no event will coverage exceed the lesser of:
1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.
Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.
We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:
1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;
unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions
We will not cover:
1. Orthoptic or vision training and any associated supplemental testing;
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an Employer as a condition of employment;
5. Any injury or illness covered under any Workers’ Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the Policy ends; or (b) the Insured’s coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Contact lenses, except as specifically covered by the Policy;
10. Hi Index, aspheric and non-aspheric styles;
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.
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 any illegal substance. Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level meet or exceed 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 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.
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
1. 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 licensed passenger airline.

4. Commission, or attempt to commit a civil or criminal battery or felony.

5. Services 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 auxiliary 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, Humana Health Insurance Company of Florida, Inc. or Humana Insurance Company of Kentucky.