CANOPY INSURANCE
ROOTED IN ALABAMA
1950 Crestwood Blvd, Suite 2, Birmingham, AL 35210 (205) 451-0451

Group Dental
Certificate of Insurance

About Your Insurance – This Certificate explains the dental insurance coverage under the Policy issued to thePolicyholder. The Policy provides benefits for the Covered Insured. Read it closely to become familiar with Your plan.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate Provisions sections and are capitalized in this Certificate.

Important Notice – Benefits are payable only for listed Covered Procedures that were both started and completed while the Covered Insured is insured under the Policy, and after any applicable Waiting Periods have been served.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Insured who claims rights or benefits under the Policy.

The Policy provides the benefits described in this Certificate for Covered Insured. This Certificate with any attached Riders, Endorsements, Amendments as well as the Application and Enrollment form make up this Certificate of Insurance. It replaces any prior Certificates issued under the Policy.

Canopy Insurance Corporation has signed this Certificate on the Policy's Effective Date.

President

Secretary

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SCHEDULE OF BENEFITS

Policyholder:	ALVMA Health and Welfare Trust
Policyholder Effective Date:	January 1, 2026
Policy Number:	CIC0070236
Policyholder's Address:	2660 Eastchase Lane Ste 300 Montgomery AL 36117
Initial Term:	24 Months
Eligible Classes:	All Actively at Work Eligible Members working at least 30 hours per week, and their Eligible Dependents completing the Eligibility Period
Eligibility Period:	1st of Month Following 30 Days
Mode of Premium Payment:	Monthly
Premium Due Date:	1st of every month
Plan Year:	January 1 - December 31
Deductible:	In Network: 1: $ 25 Individual Deductible 2: $ 75 Maximum Deductible per Family 3: Applies to Class B, & C Out-of-Network: 1: $ 25 Individual Deductible 2: $ 75 Maximum Deductible per Family 3: Applies to Class B, & C
Waiting Periods:	See Schedule of Covered Procedures
Plan Year Benefit Maximum:	In-Network: Year 1 Year 2 Year 3 & Forward $ 1,500.00 $1,500 $1,500 Out-of-Network: Year 1 Year 2 Year 3 & Forward $1,500 $1,500 $1,500
Takeover Benefits:	Apply
Orthodontic Benefits:	Apply; No Deductible

Percentage of Covered Expense:

Plan Year 1:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
Class A	100%	100%	Yes	None
Class B	80%	80%	Yes	None
Class C	50%	50%	Yes	None
Class D	50%	50%	$ 1,000	$ 1,000

Plan Year 2:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
Class A	100%	100%	Yes	None
Class B	80%	80%	Yes	None
Class C	50%	50%	Yes	None
Class D	50%	50%	$ 1,000	$ 1,000

Plan Year 3 and later:

	In-Network	Out-of-Network	Subject to Plan Year Max Benefit	Maximum Lifetime Benefit
Class A	100%	100%	Yes	None
Class B	80%	80%	Yes	None
Class C	50%	50%	Yes	None
Class D	50%	50%	$ 1,000	$ 1,000

Plan Type: Participating Provider Program: In and Out-of Network Benefits

DEFINITIONS

Active or **Actively at Work** means the Employee is able and available for active performance of all their regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active at Work provided the Employee is able and available for active performance of all his or her regular duties and was working the day immediately prior to the date of his or her absence.

Administrator means the location where this policy is administered. The Administrator is Southland Benefit Solutions, LLC, 2200 Jack Warner Parkway, Suite 150, Tuscaloosa, AL 35401, 800-476-5044, canopyinsurancecorp.com.

Calendar Year Plan means the 12-month period beginning on January 1 and ending on December 31 of the same year. The first year begins on the Policy's Effective Date and ending on December 31 of the same year.

Covered Expense means the lesser of: (1) the actual dental charge or (2) the Maximum Reimbursement for a Covered Procedure.

Covered Insured means the Eligible Employee and Dependents who has qualified for coverage and for whom coverage under the Policy has become effective.

Covered Procedure means the procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatments to a Covered Insured while their coverage under the Policy is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

1. licensed Dentist who is acting within the scope of his or her license;
2. licensed physician performing dental Services within the scope of his or her license; or,
3. licensed Dental Hygienist acting under the supervision and direction of a Dentist.

Dental Hygienist means someone who is licensed to practice dental hygiene and is acting under supervision and direction of a Dentist, if required, and within the scope of his or her license.

Dentist means a practitioner who is trained to practice Dentistry and is operating within the scope of his or her license.

Dependent means:

1. a Primary Insured's Spouse; or
2. a Dependent Child under 26 years of age; and
3. each unmarried child over 26 who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Primary Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to Us within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Dependent Child means: (a) the Primary Insured's natural child from moment of birth; (b) the Primary Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Primary Insured's home pending such an order; (c) any child living with the Primary Insured in a regular parent-child relationship and primarily dependent on the Primary Insured for support and maintenance, or (d) any child for whom We have notice, pursuant to a medical support order, that the Primary Insured must provide support in the form of dental insurance from the date of such notice. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Primary Insured to provide a child financial support in the form of dental insurance.

Eligible Class means a group of people who are eligible for coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify for insurance on the date they complete the required Eligibility Period.

Eligible Employee means an Employee who, is Actively at Work, meets the qualification of an Eligible Class and has completed any Eligibility Period, is eligible for coverage under the Policy.

Eligibility Period means a period of continuously Actively at Work/continuous Membership that an Employee must serve in order to qualify for coverage under this Certificate. The length of any Eligibility Period is shown in the Schedule of Benefits.

Employee means a person permanently employed by the Policyholder for wages or salary and working for the Policyholder on a regular basis.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the Covered Insured's upper or lower arch and which is opposed in the Covered Insured's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement. Third Molars are not considered Functioning Natural Teeth for purposes of the Policy.

In-Network Benefits means dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Late Entrant means an Employee enrolling themselves and their Dependents outside the initial Eligibility Period as shown in the Schedule of Benefits. Benefits may be limited for Late Entrants under the Takeover of Existing Coverage section of this Certificate.

Life Status Change means an event recognized by the Policyholder and Us that qualifies the Primary Insured to make changes in coverage at any time other than during Open Enrollment. The following events are all considered Life Status Changes:

1. marriage; partnership in a civil union; domestic partnership;
2. divorce, annulment or legal separation;
3. birth, adoption, or placement of a child;
4. change in a Dependent Child's eligibility;
5. death of a Dependent;
6. other changes as permitted by Us and the Policyholder.

Maximum Reimbursement means the amount used to determine the Covered Expense. There are two types of Maximum Reimbursements based on the plan that is issued:

1. **Maximum Allowable Charge**: When a Non-Participating Provider performs a Covered Procedure, the Allowable Charge is equal to the lesser of: (a) the actual dental charge; or (b) the "customary charge" for the dental Service. We determine the "customary charge" from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge(s)** (PPMAC): When a Participating Provider performs a Covered Procedure, the Maximum Allowable Charge is the amount that the Dentist has agreed with Us to accept as payment in full for a dental Service. The PPMAC may also be used for Non-Participating Providers.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured). Organic portions of a tooth include the clinical crown, enamel, dentin, cementum, root, and the enclosed pulp (nerve).

Non-Participating Provider means a Dentist who is not a Participating Provider. These Dentists have not entered into an agreement with Us or Our Administrator to limit their charges.

Out-of-Network means dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider(s) means a Dentist who has been selected by Us or Our Administrator for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowable Charges as payment in full for Services rendered. When dental care is given by Participating Providers, the Covered Insured will generally incur less out- of-pocket cost for Services rendered.

Participating Provider Program means Our program to offer a Covered Insured the opportunity to receive dental care from Dentists who are designated by Us as Participating Providers.

Plan Year means the period of time shown in the Schedule of Benefits.

Policy Anniversary means the same month and day as the Policy's Effective Date.

Policy Year means the first year begins on the Policy's Effective Date and ends the day before the next Policy Anniversary. For subsequent years, it is the period of time that begins on the Policy Anniversary and is shown as the Plan Year in the Schedule of Benefits.

Primary Insured means a person who is an Eligible Employee of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

Service(s) means a procedure or supply which is performed by a Dentist or Dental Hygienist in connection with the dental care of a Covered Insured. It is required and appropriate for treatment of the Covered Insured's dental condition according to broadly accepted standards of dental care as determined by Us or Our dental consultants.

Spouse means a lawfully recognized partner of the Primary Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Primary Insured and shares financial obligations and can provide legal proof of marriage. Spouse also includes the Primary Insured's domestic partner or civil union partner as defined by state law. The Primary Insured must provide the Policyholder with proof of such legal domestic partnership or legal civil union partnership required by state law or Us including as applicable, but not limited to, a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

Treatment Plan means the Dentist's report of recommended treatment on a form satisfactory to Us which:

1. itemizes the dental Services; and,
2. lists the charges for each itemized Service; and
3. is accompanied by supporting pre-operative X-rays and other appropriate diagnostic materials required by Us.

We, Us, and Our means Canopy Insurance Corporation.

You and Your mean the Primary Insured.

ELIGIBILITY AND ENROLLMENT

To be eligible for coverage under the Policy, an Employee must:

1. be a person of an Eligible Class of the Policyholder, as shown in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Eligible Employee's Dependents are also eligible for coverage, provided that You are insured under the Policy and that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Employee and their Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Dependent Child may also only be enrolled by one parent. If the Spouse carrying Dependent coverage ceases to be eligible, Dependent coverage automatically becomes effective under the other Spouse's coverage enrollment will default to the Policyholder's rules.

Enrollment. An Employee and their Dependents may enroll for coverage:

1. within 31 days of becoming an Eligible Employee,
2. during Open Enrollment, or
3. within 31 days of a Life Status Change.

Late Entrants: Eligible Employees who do not enroll themselves or their Dependents during Open Enrollment, may not enroll until the next Open Enrollment unless there is a Life Status Change.

Newborn and Adopted Children. Insurance for any newborn Dependent Child automatically becomes effective from the moment of birth. Insurance for that Dependent Child automatically ends 31 days later unless the Primary Insured has other Dependent Children insured under this Certificate or within 31 days, makes a request to continue coverage for that child and pays the required premium when due.

An adopted child of the Primary Insured will be covered on the same basis as a newborn child from the date of placement with the Primary Insured for the purpose of adoption. Coverage continues unless the placement is disrupted, and the child is removed from placement with the Primary Insured.

EFFECTIVE AND TERMINATION DATES

A. Primary Insured's Effective and Termination Dates

Primary Insured's Effective Date. On the Policy's Effective Date, each Employee in one of the Eligible Classes shown in the Schedule of Benefits is eligible to be insured on the Policy's Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

After the Policy's Effective Date, coverage for the Eligible Employee under the Policy begins on the latest of:

1. the Policy's Effective Date shown in the Schedule of Benefits;
2. if no portion of the cost of this insurance is to be paid by the Employee, the date the Employee becomes an Eligible Employee; or
3. if any portion of the cost of this insurance is to be paid by the Employee:
   a. the date We or Our Administrator receives the completed enrollment form; and
   b. the date the required premium is paid; or
   c. the date the Eligible Employee enters an Eligible Class.

Deferred Effective Date: If an Eligible Employee is not Actively at Work on the date insurance would otherwise be effective, it will be effective on the date they return to Actively at Work.

Primary Insured's Termination Date. A Primary Insured's coverage under this Certificate ends on the earliest of:

1. the date the Policy is terminated;
2. the date this Certificate is amended or changed to exclude coverage for the Eligible Class to which the Primary Insured belongs;
3. the end of the period for which premium is paid;
4. the date the Primary Insured requests, in writing, that coverage be terminated; or
5. the date the Primary Insured ceases to be eligible.

B. Dependent's Effective and Termination Dates

Dependent's Effective Date. A Dependent's coverage under this Certificate begins after written request for coverage has been received and on the latest of:

1. the Primary Insured is eligible, if the Primary Insured has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

In no event will a Dependent be eligible if the Primary Insured is not eligible.

Dependent's Termination Date. A Dependent's coverage will end on the earliest of the date:

1. they no longer meet the Dependent definition;
2. the Primary Insured's coverage ends;
3. the Dependent dies;
4. the date the Primary Insured requests, in writing, that coverage be terminated; or
5. the period ends for which premium has been paid.

Notice Required When Your Coverage Terminates. We must be informed promptly when Your coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the premium for the period for which premiums were paid in error up to a maximum of three Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits after the date Your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to Us.

CONTINUATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that certain Policyholders offer continued coverage for the Primary Insured and their Dependents whose insurance would end due to a qualifying event.

A Covered Insured must be allowed to continue the same insurance which was in force at the time of a qualifying event. All policy provisions applicable to the insurance elected still apply under continuation.

The Covered Insured must elect continuation during an election period and pay the required premium. The Covered Insured's insurance must have ended due to one of the following qualifying events:

1. a reduction in hours;
2. end of employment with the Policyholder for any reason other than gross misconduct;
3. Primary Insured is no longer eligible for an Eligible Class;
4. death of the Primary Insured;
5. divorce or legal separation from the Primary Insured;
6. entitlement of the Primary Insured to Medicare; or
7. loss of dependent status of any Dependent Child.

Items 3. through 6. may be second qualifying events if a Dependent is already on continuation as a result of the Primary Insured's reduction in hours or termination of employment.

A Covered Insured who is totally disabled may extend continuation coverage if:

1. it has been determined the Covered Insured is totally disabled for Social Security purposes; and
2. the Covered Insured notifies the Policyholder within 60 days of the date the determination is made by the Social Security Administration.

Continuation does not apply to any Covered Insured covered under any other group health plan either as a Primary Insured or as a Dependent, or for any Covered Insured entitled to Medicare. Except that a Covered Insured's other group health plan may continue coverage.

Notification Requirements and Election Period. In the case of a Primary Insured's reduction in hours, end of employment, no longer eligible for an Eligible Class, death or entitlement to Medicare the Policyholder must notify Us.

The Primary Insured must notify the Policyholder within 60 days when insurance would end for a Dependent due to divorce, legal separation, or loss of Dependent status for any Dependent Child.

Within 14 days of receiving notification of the qualifying event, the Policyholder must notify the Covered Insured of their right to elect continuation.

The Covered Insured must elect continuation by the later of:

1. 60 days after the Covered Insured's insurance ends; or
2. 60 days after the Covered Insured receives notification from the Administrator of their right of continuation.

End of Continuation. Continuation will end on the earliest of the following dates:

1. 18 months from the date continuation began for the Covered Insured whose coverage ended because of the Primary Insured's reduction in hours, end of employment, or no longer eligible for an Eligible Class;
2. 29 months from the date continuation began for the Primary Insured's whose coverage was extended due to total disability;
3. 36 months from the date continuation began for the Covered Insured whose coverage ended because of the death of the Primary Insured, divorce or legal separation from the Primary Insured, loss of dependent status for any Dependent Child, or the Primary Insured's entitlement to Medicare;
4. 36 months from the date of the original qualifying event if a second qualifying event occurs;
5. the end of the period for which premium is paid if the Covered Insured fails to make a premium payment on the date specified by the Policyholder;
6. the date the Covered Insured becomes covered under any other group health plan;
7. the date the Covered Insured becomes entitled to Medicare; or
8. the date the group health plan ends.

If continuation coverage terminates because the maximum period of continuation is reached, the Policyholder will notify the Covered Insured of any right to conversion coverage within 180 days prior to the end of continuation.

PREMIUMS

Premium Contributions. You may be required to contribute, either in whole or in part, to the cost of the insurance. This is subject to the terms established by the Policyholder. If required, You contribute to the cost of the insurance through:

1. the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

Premium Changes. We may change the premium rates after the Policy has been in force for 12 months, but not more than once in a 12-month period. If We change premium rates, We can only do so for all Certificates under the Policy. The Policyholder will be given notice by mail [31] days prior to any premium change.

BENEFITS

Deductible. The Deductible is the amount of Covered Expense which must be paid in full by You each Plan Year (or lifetime, when applicable) for each Covered Insured (or to the maximum per family limit, when applicable) who incurs a Covered Procedure before any benefits are payable. The Deductible is applied chronologically according to the dates on which the Covered Procedures on a claim were completed. The amount of the Deductible is shown in the Schedule of Benefits.

Percentage of Covered Expense. The Percentage of Covered Expense is the percentage of the Covered Expense that We will pay for a Covered Procedure. The percentage applicable to a Covered Insured may vary by Covered Procedure and the length of time the Covered Insured has been continuously covered for dental insurance. The Percentage of Covered Expense for a Covered Procedure is shown in the Schedule of Benefits.

Plan Year Benefit Maximum. The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for all Covered Procedures completed in a Plan Year. This maximum will apply even if a Covered Insured's coverage is interrupted or if a Covered Insured has been covered both as a Covered Insured and as a Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

Waiting Period. The Waiting Period is the period of time starting on a Covered Insured's effective date before benefits for certain Services become payable. If a Covered Procedure is started before the Waiting Period for that procedure ends, that procedure is not covered under the Policy. If a Covered Insured's coverage under the Policy ends and then later becomes insured again, that Covered Insured's effective date is the most recent effective date unless stated otherwise in the Policy. The Waiting Periods for Covered Procedures are listed in the Schedule of Covered Procedures.

Benefits Payable for Covered Expenses. Upon receipt of Proof of Loss that a Covered Insured has incurred a Covered Procedure, We will determine if benefits are payable.

Before We determine benefits, the Covered Insured must satisfy any Waiting Periods and the Deductible, if applicable. We then pay the Percentage of Covered Expense, subject to the Plan Year Benefit Maximum. Additionally, the benefit payable is subject to the following:

1. The Covered Procedure must start and be completed while the Covered Insured's coverage is in force, except as provided in the "Takeover of Existing Coverage" section of this Certificate.
2. Each Covered Procedure may be subject to specific Frequency Limitations, as shown in the Schedule of Covered Procedures.
3. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" section of this Certificate.

A Covered Insured may choose a Dentist of his choice and may choose the Services of a Dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Covered Insured will generally incur less out-of-pocket cost unless the Policyholder has selected an In-Network only plan.

Date Started. For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed started:

1. for full dentures or partial dentures, on the date the first impression is taken;
2. for fixed partial dentures (including Maryland Bridges), crowns, inlays, onlays and other laboratory prepared restorations, on the date the teeth are first drilled down to receive the restoration;
3. for root canal therapy, on the date the pulp chamber is first opened;
4. for periodontal surgery, on the date the surgery is actually performed; and for all other treatment, on the date the Service is performed.
5. Note: If Orthodontia Services are covered, see the Schedule of Covered Procedures for start dates.

Date Completed. For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed completed for:

1. root canal therapy, on the date the canals are permanently filled;
2. fixed partial dentures (including Maryland Bridges), crowns, inlays, onlays, and other laboratory prepared restorations, on the date the restoration is permanently cemented in place;
3. dentures and partial dentures, on the date that the final completed appliance is first inserted in the mouth (However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.); and
4. all other treatment, on the date the procedure is started.
5. Note: If Orthodontia Services are covered, see the Schedule of Covered Procedures for completion dates.

Pre-Estimation of Benefits. Whenever the charge for any treatment is expected to exceed $[300], We suggest that the Treatment Plan be submitted to Us by the Dentist for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultant's request.

We will notify the Covered Insured's attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the benefit amount payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

Alternate Benefits. There is often more than one Service that can be used to treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. The Covered Insured and their Dentist may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

LIMITATIONS AND EXCLUSIONS

No benefits are payable under the Policy for the Services listed below. In addition, the Services listed below will not be recognized toward the satisfaction of any Deductible:

1. any Services which are not included in the Schedule of Covered Procedures;
2. any Service started or appliance installed before the Covered Insured's effective date or after the Termination Date;
3. any Service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 3 years, as determined by Us;
4. any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
5. crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;

6. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;
7. appliances, Services or procedures relating to: (1) the change or maintenance of vertical dimension; (2) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (3) splinting; (4) correction of attrition, abrasion, erosion or abfraction; (5) bite registration or (6) bite analysis;
8. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
11. for orthodontic treatment unless otherwise listed as a Covered Procedure in the Schedule of Covered Procedures;
12. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain unless such procedure is listed as a Covered Procedure in the Schedule of Covered Procedures;
13. charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments unless such procedures are listed as Covered Procedures in the Schedule of Covered Procedures;
14. athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than Us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
15. prescription drugs, premedication, pharmaceuticals, or analgesia;
16. dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
17. dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
18. any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if the Covered Insured did not purchase the coverage that is available to them;
19. any charge for a Service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of $100 per year;
20. Services performed by a Dentist who is member of the Covered Insured's family. Covered Insured's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents;
21. the initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a Functioning Natural Tooth extracted while the Covered Insured is insured under the Policy;
22. the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the Covered Insured is insured under the Policy, provided that tooth was not an abutment to an existing partial denture. Frequency Limitations for replacement of dentures and bridges are stated in the Schedule of Covered Procedures. Benefits are payable only for the replacement of those teeth which were extracted while the Covered Insured was insured under the Policy;
23. the replacement of teeth beyond the normal complement of 32;
24. the replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the Covered Insured's dental condition;
25. local anesthetic as a separate fee;
26. any Treatment Plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these Services; or,
27. Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the thirty-one (31) day period immediately following the birth of a child to an Employee who is insured hereunder, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia.

CLAIMS

Notice of Claim. Written notice of claim must be received by Us within thirty (30) days from the date of loss or as soon as reasonably possible. If it will not be reasonably possible to give written notice within the 30-day period, We will not deny or reduce any claim filed for this reason if notice is filed as soon as is reasonably possible. Claims should be sent to Our Administrator.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not furnished within fifteen (15) days, the claimant will meet the Proof of Loss requirements by giving Us a statement of the nature and extent of loss within the time limit for filing proofs of loss.

You may use standard American Dental Association (ADA) approved claim forms supplied by Your Dentist or You may request forms from Us. The Claim Form must identify the treatment performed in terms of the ADA Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

Proof of Loss. Written proof of loss must be received by Us within ninety (90) days from the date of loss or as soon as reasonably possible. We will not deny or reduce any claim filed after 90 days from the date of loss if:

1. it was not reasonably possible to file the claim within that 90-day period; and
2. the claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us within one (1) year after it is due, unless You are legally incapable of doing so.

Payment of Claims. All benefits will be paid to the Primary Insured, unless an assignment of benefits has been requested by the Primary Insured or the beneficiary to pay the Provider directly. If You die before all payments due have been made, all remaining amounts payable will be paid to Your beneficiary or Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of such payment.

Time Payment Of Claims. All benefits will be paid promptly as they become payable. No benefits will be paid until the required Proof of Loss has been submitted to Us.

Recovery of Overpayments. We reserve the right to deduct from any benefits properly payable under this Certificate the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a Proof of Loss;
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences;
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Insured if claim payments previously were made with respect to a Covered Insured.

Unbundling. When certain complicated dental Services are performed and other less extensive Services are performed at the same time, they will be considered component parts of the primary Service. For benefit purposes under the Policy, these less extensive Services are considered to be integral components of the primary Service. Even if the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the Benefits Payable for Covered Expenses for the primary Service.

Review of Claim. If We send You a written statement denying Your claim in whole or in part, You may submit a written appeal to Us. A written decision with respect to the appeal shall be sent to You within ninety (90) days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

COORDINATION OF BENEFITS (COB)

This provision applies when a Covered Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

Definitions. The following definitions apply only to this provision of this Certificate.

Allowable Expense means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each Service will be treated as both an Allowable Expense and a benefit paid.

Coordination of Benefits means taking other Plans into account when We pay benefits.

Plan(s) means any plan, including this one that provides benefits or services for dental expenses on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no-fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

Primary Plan means the Plan that, according to the rules for the Order-of-Benefit Determination, pays benefits before all other Plans.

Benefit Coordination. Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Primary Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If a Primary Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable Plan Year Benefit Maximum.

Order-of-Benefit Determination Rules.

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a Covered Insured is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a Covered Insured is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
    a. **Non-Dependent/Dependent**. A Plan that covers a Covered Insured other than as a Dependent will pay before a Plan that covers that person as a Dependent.
    b. **Dependent Child/Parents Not Separated or Divorced.** For a Dependent Child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent child for the longer period will pay first.
    c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a Dependent Child of separated or divorced parents, benefits for the child are determined in the following order:
        a. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
        b. The Plan of the parent with custody of the child;
        c. The Plan of the Spouse of the parent with custody; and
        d. The Plan of the parent without custody of the child.
    d. **Dependent Child/Joint Custody**: If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
    e. **Active/Inactive [Employee].** The Plan which covers the person as an [Employee] who is neither laid off nor retired (or as that [Employee's] Dependent) is Primary over the Plan which covers that person as a laid off or retired [Employee]. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
    f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

Right to Receive and Release Needed Information. We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of or notice to You or any claimant. You are required to give Us information necessary for COB.

Right to Make Payments To Another Plan. COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

Right to Recovery. COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

TAKEOVER OF EXISTING COVERAGE

The following provisions are applicable if this dental plan is replacing an existing group dental plan in force (referred to as "Prior Plan") at the time of application. These are called "Takeover Benefits." The Schedule of Benefits shows if Takeover Benefits apply.

Waiting Period Credit. When We immediately take over an entire dental group from another insurance company, those Covered Insureds of the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period Credit if they are eligible for coverage on the Policy's Effective Date. The Waiting Period Credit does not apply to new Covered Insured, Eligible Dependent add-ons, Late Entrants, or re-enrollees.

Deductible Credits.

1. For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year.
2. For Policy Year plans: The Deductible will begin anew on the Policy's Effective Date, which marks the start of a new Plan Year.

Plan Year Benefit Maximum.

1. For Calendar Year Plans: All paid benefits applied to the Plan Year Benefit Maximum under the Prior Plan will also be applied to Plan Year Benefit Maximum under this Certificate during the current Calendar Year.
2. For Policy Year plans: The Plan Year Benefit Maximum will begin anew on the Policy's Effective Date, which marks the start of a new Plan Year.

If You had orthodontic coverage for Your covered Dependent Child under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Orthodontic Services for this Certificate was not exceeded under the Prior Plan;
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued for Your Dependent Child under this Certificate.

Lifetime Maximum. If You submit the required proof, the Maximum Lifetime Benefit for orthodontic treatment will be the lesser of this Certificate's Maximum Lifetime Benefit for Orthodontic Services or the Prior Plan's orthodontic Maximum Lifetime Benefit. The orthodontic Maximum Lifetime Benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification. The Policyholder's Application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force Certificate, as well as proof of the effective date for each Covered Insured, if insured under the Prior Plan.

Prior Carrier's Responsibility. The prior carrier is responsible for costs for procedures begun prior to the Policy's Effective Date.

Prior Extractions. If: (1) treatment is dentally necessary due to an extraction which occurred before the Policy's Effective Date of this coverage while a Covered Insured was covered under the Prior Plan; and (2) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Procedures under both this Certificate and the Prior Plan.

Coverage for Treatment in Progress. If a Covered Insured was covered under the Prior Plan on the day before the Policy replaced the Prior Plan, the Covered Insured may be eligible for benefits for treatment already in progress on the Policy's Effective Date. However, the expenses must be a Covered Procedures under both this Certificate and the Prior Plan. This is subject to the following:

Extension of benefits under Prior Plan. We will not pay benefits for treatment if:

1. the Prior Plan has an Extension of Benefits provision;
2. the treatment expenses were incurred under the Prior Plan; and
3. the treatment was completed during the extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.

GRIEVANCE PROCEDURES

If a claim for benefits is wholly or partially denied, the Covered Insured will be notified in writing of such denial and of their right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice a Covered Insured may file a grievance and make a written request for review to Us.

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Covered Insured or someone on their behalf also has the right to appear in person to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Covered Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of a Covered Insured regarding dissatisfaction with the administration of claims practices or provision of Services of this panel provider plan relative to the Covered Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

GENERAL PROVISIONS

Conformity with State Laws. The insurance laws of some states require that certain Certificate provisions comply with the law of the state for all permanent residents of the state. Any Certificate provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements. However, any such provision is modified only for a Covered Insured who is a permanent resident of the state at the time Covered Expenses are actually incurred as defined herein.

Entire Contract; Changes. The entire contract consists of the following:

1. the Policy;
2. this Certificate;
3. any riders, endorsements and amendments to the Policy or this Certificate, if any;
4. the application of the Policyholder; and
5. any the enrollment forms.

All statements made in the application and enrollment forms, in the absence of fraud, are representations and not warranties. A copy of the application may be requested at any time. We shall provide a copy to you within 15 days after such request. Only written statements by the Policyholder or a Covered Insured and attached to the Policy or Certificate, will be used to void insurance or deny a claim.

No change in the Policy or this Certificate will be effective until approved by one of Our officers, and unless such approval is endorsed and attached to the Policy or this Certificate. No agent has the authority to change the Policy or this Certificate or to waive any of its provisions.

Fraudulent Information. The Policyholder understands that We may void a Covered Insured's coverage under the Policy for fraud or material misrepresentation by the Covered Insured in applying for coverage.

Incontestability. This Certificate will be incontestable, except for non-payment of premium, after it has been in force for

two years.

Legal Action: No legal action may be brought against Us to recover benefits for at least 60 days after the written proof of loss is submitted to Us. No such action may be brought more than 6 years after the time written proof of loss is required by this Certificate to be given.

SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable Frequency Limitations. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Procedure Class

A	Preventive/Diagnostic
B	Basic
C	Major
D	Orthodontia
NC	Not Covered
CS	Copayment Schedule

Type of Maximum Reimbursement

In-Network
MAC - Participating Provider Maximum Allowable Charge

Waiting Periods

None

Out-of-Network
MAC – Participating Provider Maximum Allowable Charge

Frequency Limitations

a. Maximum of 1 procedure per 12 months
b. Maximum of 1 procedure per 24 months
c. Maximum of 1 procedure per 36 months
d. Maximum of 1 procedure per 4-year period
e. Maximum of 1 procedure per 5-year period
f. Maximum of 1 procedure per 7-year period
g. Maximum of 4 procedures per 6-month period.
h. Maximum of 1 procedure per lifetime
i. Maximum of 2 procedures per plan year
j. Maximum of 2 procedures per 24 months
k. Maximum of 2 procedures per 36 months
q. Maximum of 1 procedure per 6 months
r. Maximum of 1 per tooth per lifetime
t. Maximum of 1 per 10 years
u. 1 additional exam & cleaning per year

1. Limited to Dependent Children under age 12
2. Limited to Dependent Children under age 14
3. Limited to Dependent Children under age 26
4. Limited to Dependent Children under age 19
5. Limited to Participants age 17+
6. Limited to Participants age 19+
7. Limited to Participants age 25+
8. Limited to Participants age 40+
9. Physician statement needed-pregnancy, diabetes, heart disease

l. Applications made to permanent molar teeth only.
m. Minimum of 12 months after initial insertion.
n. Only in conjunction with listed complex oral surgery procedures and subject to review.
o. Premature loss of primary tooth.
p. Replacement of existing only if in place for 24 months
s. Placement for permanent teeth only

Covered Procedures **PREVENTIVE / DIAGNOSTIC**	Procedure Class	Waiting Period Months	Frequency Limitations
Comprehensive Oral Exam or	A	0	I
Periodic Oral Exam	A	0	I
Emergency Palliative Treatment	A	0	
Single Film	A	0	G
Additional Films	A	0	G
Intra-Oral Occlusal Film	A	0	I
Panoramic Film,	A	0	C
Full Mouth X-Ray	A	0	C
Bitewing – Single Film, or	A	0	I
Bitewing – Two Films, or	A	0	I
Bitewing – Three Films, or	A	0	I
Bitewing – Four Films	A	0	I
Prophylaxis	A	0	I
Topical Application of Fluoride	A	0	I,4
Sealant	A	0	C, L, 2
Space Maintainer – Fixed Unilateral	A	0	O, 4
Space Maintainer – Fixed Bilateral	A	0	O, 4
Space Maintainer – Removable Unilateral	A	0	O, 4
Space Maintainer – Removable Bilateral	A	0	O, 4
FILLINGS			
One Surface Amalgam	B	0	A
Two Surface Amalgam	B	0	A
Three Surface Amalgam	B	0	A
Four + Surface Amalgam	B	0	A
One Surface Resin – [Anterior]	B	0	A
Two Surface Resin – [Anterior]	B	0	A
Three Surface Resin – [Anterior]	B	0	A
Four + Surface or Incisal Resin – [Anterior]	B	0	A
Sedative Fillings	B	0	A
ORAL SURGERY			
Extraction, erupted tooth or exposed root	B	0	
Coronal Remnants	B	0	
Surgical Extraction	B	0	
Impacted (soft tissue)	B	0	
Impacted (partial bony)	B	0	
Impacted (complete bony)	B	0	
Surgical Removal of Root	B	0	
Alveolectomy (with extraction) – per quadrant	B	0	
Alveolectomy (without extraction) – per quadrant	B	0	
Incision and Drainage of Abscess – Intraoral	B	0	
General Anesthesia/Intravenous Sedation	B	0	N
CROWN AND BRIDGE REPAIR			
Inlay Recementation	A	0	M
Crown Recementation	A	0	M
Bridge Repair	A	0	M
Crown Repair	A	0	M
Bridge Recementation	A	0	M

DENTURE REPAIR			
Repair Denture Base	A	0	M
Repair Teeth – per tooth	A	0	M
Repair Partial Base	A	0	M
Repair Partial Framework	A	0	M
Repair Broken Clasp	A	0	M
Add Tooth to Existing Partial Denture	A	0	M
Add Clasp to Existing Partial Denture	A	0	M
Replace Teeth – per tooth	A	0	M
Reline Upper Denture	C	0	C, M
Reline Lower Partial Denture	C	0	C, M
Reline Upper Denture (Lab)	C	0	C, M
Reline Lower Denture (Lab)	C	0	C, M
Reline Upper Partial Denture (Lab)	C	0	C, M
Reline Lower Partial Denture (Lab)	C	0	C, M
Rebase Complete Denture – Upper	C	0	C, M
Rebase Complete Denture – Lower	C	0	C, M
Rebase Partial Denture – Lower	C	0	C, M
Tissue Conditioning – Upper	C	0	M
Tissue Conditioning – Lower	C	0	M
PERIODONTICS (Non-surgical)			
Scaling and Root Planning–per quadrant	B	0	B
Periodontal Maintenance Procedure	B	0	1 dental cleaning or 1 perio maintenance procedure per 3 month period and only if at least 3 months since completion of active perio therapy.
ENDODONTICS			
Vital Pulpotomy – primary teeth only	B	0	
Root Canal – Anterior	B	0	B
Root Canal – Bicuspid	B	0	B
Root Canal – Molar	B	0	B
Apicoectomy – Anterior	B	0	
Apicoectomy – Molar	B	0	
Retrograde Filling – per root	B	0	
Root Amputation – per root	B	0	
MISCELLANEOUS			
Occlusal Guard	NC	0	
PERIODONTICS (Surgical)			
Gingivectomy – per quadrant	B	0	C
Gingival Curettage – per quadrant	B	0	C
Osseous Surgery – per quadrant	B	0	C
Soft Tissue Grafts – per quadrant	B	0	C
Gingival Flap Surgery – per quadrant	B	0	C

CROWN			
Crown Resin – resin with high noble metal	C	0	E
Crown Resin – resin with noble metal	C	0	E
Crown Resin – resin with predominately base metal	C	0	E
Crown – porcelain/ceramic substrate	C	0	E
Crown - porcelain fused to high noble metal	C	0	E
Crown – porcelain fused to noble metal	C	0	E
Crown –porcelain fused to predominantly base metal	C	0	E
Crown – full cast high noble metal	C	0	E
Crown – ¾ cast high noble metal	C	0	E
Crown – full cast noble metal	C	0	E
Crown – full cast predominantly base metal	C	0	E
Crown Prefabricated Stainless Steel	C	0	C, 4
Cast Post and Core – In Addition to Crown	C	0	
Prefabricated Post and Core – In Addition to Crown	C	0	
BRIDGE			
Pontic Cast High Noble Metal	C	0	E
Pontic Cast Noble Metal	C	0	E
Pontic Cast Predominantly Base Metal	C	0	E
Pontic Porcelain Fused to High Noble Metal	C	0	E
Pontic Porcelain Fused to Noble Metal	C	0	E
Pontic Porcelain Fused to Predominantly Base Metal	C	0	E
Pontic Resin with High Noble Metal	C	0	E
Pontic Resin with Noble Metal	C	0	E
Pontic Resin with Predominantly Base Metal	C	0	E
Crown Resin with High Noble Metal	C	0	E
Crown Resin with Noble Metal	C	0	E
Crown Resin with Predominantly Base Metal	C	0	E
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	0	E
Crown Porcelain Fused to Noble / High Noble Metal	C	0	E
Crown Porcelain Fused to Predominantly Base Metal	C	0	E
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	0	E
Crown ¾ Cast High Noble Metal	C	0	E
Crown Full Cast Noble Metal	C	0	E
Crown Full Cast Predominantly Base Metal	C	0	E
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	0	
Core Buildup for Retainer, (including any pins)	C	0	
Core Build-up (including any pins)	C	0	
Inlay	C	0	E
Onlay	C	0	E
Veneers – excluding cosmetic;restorative only	C	0	E
DENTURES			
Complete Upper Denture	C	0	E
Complete Lower Denture	C	0	E
Immediate Upper Denture	C	0	E
Immediate Lower Denture	C	0	E
Upper Partial – Resin Base	C	0	E
Lower Partial – Resin Base	C	0	E

Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	0	E
Inlay	C	0	E
Onlays	C	0	E
Upper Partial – Cast Metal Base	C	0	E
Lower Partial – Cast Metal Base	C	0	E
Removable Unilateral Partial Denture	C	0	E
Denture Adjustment – Upper	C	0	A, M
Denture Adjustment – Lower	C	0	A, M
Partial Adjustment – Upper	C	0	A, M
Partial Adjustment – Lower	C	0	A, M
OTHER			
Oral Cancer Screening	A	0	B, 8
Implants	C	0	T, S
Cosmetic	NC	0	
TMJ	NC	0	
Evidence Based Benefits	A	0	U, 9
ORTHODONTIA *			
Initial Orthodontic Examination	D	0	3
Initial Placement of Braces or Appliances	D	0	3
Continuing Treatment for Braces or Appliances	D	0	3

*** Orthodontia Services**

If covered, We will pay benefits for the Orthodontic Services listed above when the date started for the Orthodontic Service occurs while the Covered Insured is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming a Covered Insured except as provided in the Takeover of Existing Coverage provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Percentage of Covered Expenses shown in the Schedule of Benefits. The Maximum Lifetime Benefit payable to each Covered Insured under this Certificate, for Orthodontic Services is shown in the Schedule of Benefits. Those Covered Insureds who are eligible for Orthodontia Benefits are also shown in the Schedule of Benefits. The Maximum Lifetime Benefit will apply even if coverage is interrupted.

We will make a payment for covered Orthodontic Services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered Orthodontic Services will be paid in equal monthly installments over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and monthly installments will be determined as follows:

1. We will determine the lesser of the MAC and the Orthodontist's fee and multiply that amount by the Percentage of Covered Expenses shown in the Schedule of Benefits.
2. The lesser of the amount from number 1 or the Maximum Lifetime Benefit for Orthodontic Services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Maximum Lifetime Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the Maximum Lifetime Benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent monthly payments will be made only if the Covered Insured remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Maximum Lifetime Benefit payable has been paid, no further benefits will be paid.