ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106

DENTAL INSURANCE COVERAGE
OUTLINE OF COVERAGE

I. READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

II. DENTAL INSURANCE COVERAGE. Policies of this category are designed to provide, to persons insured, limited benefits for expenses incurred for Dental Services, such as Preventive Services, including Routine Examinations and X-rays, and Basic Services, such as fillings and sealants, etc., ONLY, subject to any limitations contained in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

III. DENTAL SERVICES COVERED BY THE POLICY.

Eligible Expenses: We will pay for Eligible Expenses the Insured incurs. Expenses must be incurred while the Policy is in force and while the Insured is covered by the Policy. The Eligible Expenses shown in the Benefit Schedule will govern the benefits payable under the Policy.

To be an Eligible Expense, the dental service or procedure must be performed by a Dentist, a Doctor, or a Dental Hygienist.

Expenses Incurred: An Eligible Expense is considered incurred on the following dates:

1. For dentures - the date the first impression is taken.
2. For fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For all other services - the date the service is performed.

Maximum Benefit Year Limit: The maximum limit payable for all Eligible Expenses in any Benefit Year is shown in the Benefit Schedule. The Maximum Benefit Year Limit, if any, will apply to each person covered under the Policy.

Deductible: The Benefit Year Deductible, if any, is shown in the Benefit Schedule. The Deductible is an amount of charges the Insured must incur for him- or herself[or on behalf of the Insured's Dependent(s)] before We start paying benefits.

Network Dentist Services: Network Dentists accept the Contracted Fee Schedule as payment in full. The negotiated fees are subject to change without notice. Services not listed in the provider's Contracted Fee Schedule are not available on a fee-for-service basis and are the patient's full responsibility.

Use of a Network Dentist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

Out-of-Network Dentist: Out-of-Network Dentists do not accept the Contracted Fee Schedule as payment in full. Services will be reimbursed as stated in the Benefit Schedule.

The fact that a Dentist, Hospital, or other provider may prescribe, order, recommend, or approve a service or supply, does not, of itself, make the charge an allowable expense. We determine if a service or supply is covered in accordance with established Plan benefits and policies.

Alternate Benefit: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

COVERED SERVICES: The following is the list of Covered Services for which benefits are payable under the Policy. Procedures not listed below are not covered. All services are subject to review for necessity; X-rays, charting, and/or records may be requested to determine if the procedure is covered.

Class A. Preventive Services Include:

Oral Exams

1. Comprehensive oral evaluation – new or established patient, once every 60 months;
2. Limited oral examination – problem focused, once every 12 months;
3. Periodic oral examination – established patient, 2 per 12 month period.

X-Rays

1. Single tooth x-rays, as needed
2. Vertical bitewings x-rays 1 every 12 months;
3. Panoramic or full mouth series x-rays – 1 every 60 months;

Routine Dental Care

1. Routine cleanings, 2 per 12 month period;
2. Periodontal cleanings, once every 3 months after active periodontal treatment, not to exceed twice in 12 months if combined with routine cleanings;
3. Fluoride treatments, twice in 12 months for members under age 19;
4. Sealants for children under 16, once per unrestored permanent molar every 36 months;
5. Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months

Class B. Basic Services Include:

Fillings

1. Amalgam (silver) fillings; one filling per tooth surface every 24 months;
2. Composite resin (white) fittings; one filling per tooth surface every 24 months;
3. Temporary fillings; one filling per tooth

Other Necessary Services

1. Dentalcare to relieve pain (palliative care). 4 occurrences in12 months

Class C. Major Services Include:

Crowns

1. Crowns; once per tooth in 60 months

Implants

1. Endosteal implant (D6010), once per tooth in 84 months;
2. Custom Abutment (D6057), once per tooth in 60 months;
3. Abutment supported porcelain/ceramic crown (D6058), once per tooth in 60 months

Tooth Replacement (Prosthodontics)

1. Removable complete or partial dentures. including services to fabricate;
2. measure. fit. and adjust dentures; once in 60 months;
3. Fixed bridges and crowns (when part of a bridge including services to fabricate, measure, fit, and adjust them; once per tooth in 60 months;
4. Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement and only if the existing appliance cannot be made serviceable;
5. Temporary partial dentures to replace any of the six upper or lower front teeth. but only if they are installed immediately after the loss of teeth and during the period of healing;
6. Single tooth dental endosteal implants when the implant replaces permanent teeth through second molars: once per tooth in 60 months

Root Canal Treatment (Endodontics)

1. Root Canal on permanent teeth, once per tooth Vital pulpotomy, limited to deciduous teeth;
2. Retreatment of prior root canal on permanent teeth, once per tooth after 24 months have elapsed from initial treatment;
3. Root end surgery on permanent teeth, once per tooth;

Gum Treatment (Periodontics)

1. Periodontal scaling and root planing, one per quadrant in 24 months; all four quads can be completed same day;
2. Periodontal surgery, once per quadrant in 36 months;

Prosthetic Maintenance

1. Repair of partial or complete dentures and bridges, once per 12 months after 24 months of initial insertion;
2. Reline or rebase partial or complete dentures, once within 36 months;
3. Replacement of crowns, onlays and bridges, once per tooth;

Oral Surgery

1. Simple tooth extractions, once per tooth;
2. Erupted or exposed root removal, once per tooth;
3. General anesthesia or intravenous sedation for complex surgical procedures

IV. EXCLUSIONS. No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Benefit Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the Contracted Fee Schedule or the Usual, Customary and Reasonable rate, whichever applies.
5. for any treatment program which begins prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliances within 5 years from the date of last placement.
8. for service or supplies payable under any medical expense, auto or no-fault plan.
9. for any condition covered under any Workers' Compensation Act or similar law.
10. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
11. for services that are applied toward the satisfaction of a Deductible, if any.
12. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
13. for Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, Hospital confinement.
14. for drugs or the dispensing of drugs.
15. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
16. for implants (unless included in covered services); myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
17. for orthodontia, unless included within the Benefit Schedule.
18. for services to replace teeth that are missing (extracted or congenitally) prior to the Effective Date of the Policy. This limitation ends after 36 months of continuous coverage on the Policy. Abutment teeth will be reviewed for eligibility of prosthetic benefits.
19. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
20. for the replacement of retainers.
21. for sealants not applied to permanent bicuspids or molars, applied at age 18 or older, applied 3 years from a previous sealant application, applied to a decayed tooth.

22. for lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.
23. during travel or activity outside the United States.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

V. TERMINATION OF COVERAGE. Insurance will end on the earliest of:
1. the Termination Date shown in the Benefit Schedule;
2. the date the period ends for which premium is paid, subject to the end of the Grace Period.

Termination of this Policy will not affect a claim for loss which occurs while this Policy is in effect.

RENEWABILITY. The Policy is conditionally renewable. The Policy is in force for the full term for which the Premium has been paid, subject to Our limited right to terminate coverage as set forth in the provision entitled, "Termination Date of Insurance".

VI. PREMIUMS. The premium rate for this coverage is:

Per Insured:	$47.37 per month
Per Insured & Spouse/Domestic Partner:	$92.94 per month
Per Insured & Child(ren)	$106.59 per month
Per Family:	$166.51 per month

GRACE PERIOD. After the first premium is paid, We will allow a Grace Period of 31 days for the payment of each subsequent premium amount due. During the Grace Period this Policy will remain in force.