



DENTAL AND VISION RIDER

Attaching to and forming part of the Certificate of Insurance shown in the Declaration and the Master Policy, in consideration of additional Premium, and subject to all other Terms of the insurance. All Insured Persons who have elected the Dental and Vision Rider will be entitled to the amended benefits listed below.

The following benefits are added to the **BENEFIT SUMMARY**:

Vision Care	
NOT Subject to Deductible and Coinsurance unless otherwise noted Charges are Subject to Usual, Reasonable, and Customary Maximum Limits per Period of Coverage or if indicated, per Lifetime	
Routine Eye Examination	Maximum Limit every 24 months: \$100
Corrective Lenses, Contacts, Frame	Maximum Limit every 24 months: \$150

The following **DENTAL BENEFIT SUMMARY** is added:

Coverage Limit / Maximum Amount for Eligible Dental Expenses		
Period of Coverage Maximum Limit	\$750	
Deductible	\$50	
<ul style="list-style-type: none"> Applies to Class II and Class III Services 		
Dental Services		
After 6 months of Continuous Coverage		
Class I Routine Services		
NOT Subject to Deductible		
Benefit	Coinsurance	
Diagnostic and Preventative Services	Plan Pays 90%	Insured Pays 10%
Emergency Palliative Treatment	Plan Pays 90%	Insured Pays 10%
Class II Minor Restorative		
Subject to Deductible		
Minor Restorative Services	Plan Pays 70%	Insured Pays 30%
Oral Surgery	Plan Pays 70%	Insured Pays 30%
Endodontics	Plan Pays 70%	Insured Pays 30%
Periodontics	Plan Pays 70%	Insured Pays 30%
Radiographs	Plan Pays 70%	Insured Pays 30%
Class III Major Restorative		
Subject to Deductible		
Major Restorative Services	Plan Pays 50%	Insured Pays 50%
Prosthodontics	Plan Pays 50%	Insured Pays 50%

The following provisions are added:

ELIGIBLE DENTAL EXPENSES: Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and the various limits and sub-limits set forth in the DENTAL BENEFIT SUMMARY and in the EXCLUSIONS provisions, the Company will reimburse the Insured Person for the following costs, Charges and expenses incurred by the Insured Person during the Period of Coverage or any applicable Treatment period with respect to an Illness or Injury suffered or sustained by the Insured Person during the Period of Coverage and while this Certificate is in effect, so long as the Charges are Usual, Reasonable and Customary and are incurred for Treatment or supplies that are Medically Necessary ("Eligible Dental Expenses"):

(1) Routine Services:

- (a) Two (2) prophylaxis per Period of Coverage with at least six (6) months between visits
- (b) Two (2) diagnostic examinations per Period of Coverage with at least six (6) months between visits
- (c) Four (4) bitewing x-rays per Period of Coverage with at least six (6) months between visits
- (d) Palliative treatment
- (e) One (1) fluoride treatment per Period of Coverage for a Child.

(2) Minor Restorative Services:

- (a) One (1) radiograph full mouth x-ray, including panoramic x-rays, per three (3) Periods of Coverage
- (b) Amalgams, plastic and synthetic restorations
- (c) Relines and repairs to prosthetic appliances
- (d) Oral Surgery and extractions
- (e) Endodontics, including root canals
- (f) Periodontics, including Treatment for gum disease
- (g) Minor restorative services including re-cementing crowns, inlays and bridges
- (h) Local and/or general anesthesia determined upon the level or degree of dental procedures being performed.

(3) Major Restorative Services:

- (a) Prosthodontic services, including appliances, bridges, full and partial dentures that replace missing natural teeth that are extracted while the individual is an Insured Person. One (1) full upper and lower denture can be covered during a five (5) year Period of Coverage
- (b) One (1) partial denture, fixed bridge or removable bridge during a five (5) year Period of Coverage except where loss of additional teeth requires construction of a new appliance
- (c) One (1) replacement of denture base material or reline during a three (3) year Period of Coverage
- (d) Major restorative services such as crowns, jackets, gold-related services required when teeth cannot be restored using other filling material. One crown, jacket or inlay on the same tooth during a five (5) year Period of Coverage. Porcelain crowns, porcelain fused to metal or resin processed to metal type crowns is covered only for adults and Children older than twelve (12) years of age.

VISION CARE EXPENSES: Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the BENEFIT SUMMARY and the EXCLUSIONS provision, the Company will reimburse the Insured and/or covered Dependents a maximum of:

- (1) Exam:** Up to the amount shown in the BENEFIT SUMMARY every twenty-four (24) months for a routine eye examination
- (2) Corrective:** Up to the amount shown in the BENEFIT SUMMARY every twenty-four (24) months for corrective lenses, contacts to correct vision and frames.

The following exclusions are deleted in their entirety from the EXCLUSIONS provision:

- Charges incurred for eyeglasses, contact lenses, hearing aids or hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason

- Charges incurred for Dental Treatment, except as specifically provided for hereunder

The following exclusion is added to the EXCLUSIONS provision:

- The following Charges related to Dental Treatment:
 - (a) Fees for Dental Treatment by other than a Dentist / Dental Provider, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision and guidance of a Dentist in accordance with generally accepted dental standards
 - (b) Appliances, restorations or surgical procedures for restoring occlusion, replacing tooth structure, correcting congenital malformations, or esthetics or implantology
 - (c) Sealants
 - (d) prescription drugs, laboratory tests and/or examinations, pre-medications and/or relative analgesia
 - (e) Hospitalization, general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedures, unless specified need is shown
 - (f) Orthognathic surgery
 - (g) Fixed bridges and removable cast partials for Children under sixteen (16) years of age
 - (h) until the Insured Person has maintained coverage for five (5) years, Charges for services and supplies (to include crowns, dentures and bridges) to replace teeth extracted or missing prior to the Insured Person's Effective Date of Coverage
 - (i) Any other charges for Dental Treatment not specifically provided for hereunder.