Blue Edge Dental

SCHEDULE OF BENEFITS, EXCLUSIONS AND LIMITATIONS - VALUE

A. BENEFITS

Annual Deductible Per Insured Person	$0 Per Calendar Year	
Annual Maximum Per Insured Person	$500	
Covered Services:	**Policy Pays**	**Elimination Period**
Oral Evaluations (Exams)	100%	None
Radiographs (All X-Rays)	100%	None
Prophylaxis (Cleanings)	100%	None
Palliative Treatment (Emergency)	100%	None
Fluoride Treatments	0%	None
Sealants	0%	None
Space Maintainers	0%	None
Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures and Dentures	0%	None
Basic Restorative (Fillings, etc.)	60%	6 Months
Simple Extractions	60%	None
Surgical Extractions	60%	None
Complex Oral Surgery	60%	12 Months
Endodontics (Root canals, etc.)	60%	12 months
General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%	None
Nonsurgical Periodontics	0%	None
Periodontal Maintenance	0%	None
Surgical Periodontics	0%	None
Crowns, Inlays, Onlays	0%	None
Prosthetics (Fixed Partial Dentures, Dentures)	0%	None
Adjustments and Repairs of Prosthetics	0%	None
Implant Services	0%	None
Consultations	0%	None
Orthodontics	0%	None

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

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Subsections B (Exclusions) and C (Limitations) describes services, supplies or charges that are excluded from coverage (Exclusions), or for which coverage is limited by age or frequency (Limitations), subject to any other applicable provisions of this Policy. Only American Dental Association procedure codes may be billed under this Policy.

B. EXCLUSIONS - The following services, supplies or charges are excluded:

1. Subject to Subsection B. TIME LIMIT ON CERTAIN DEFENSES of SECTION GP - GENERAL PROVISIONS of the Policy, for Services, including multi-visit procedures started prior to a Policyholder's or Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken.

2. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).

3. That are covered by Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member(s) is entitled to payment under an automobile insurance policy. The Plan's benefits would be in excess to the third-party benefits and therefore, the Plan would have right of recovery for any benefits paid in excess.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

6. Which are Cosmetic in nature as determined by the Plan (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

7. Elective procedures (e.g. the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn Dependent child.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated on the Schedule of Benefits

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Policy. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

11. For treatment of fractures and dislocations of the jaw.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which, in the absence of insurance, the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

21. For treatment and appliances for bruxism (e.g. night grinding of teeth).

22. For any claims submitted to the Plan by the Member or on behalf of the Member in excess of twelve (12) months after the date of service, unless such claims are submitted to the Plan as soon as reasonably possible.

23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

24. Procedures that are:

    a. part of a service but are reported as separate services
    b. reported in a treatment sequence that is not appropriate
    c. misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Fluoride treatments, space maintainers, sealants and prefabricated stainless steel crowns.

28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply.

C. LIMITATIONS - Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the Member reaches any stated age:

1. X-rays and films (full mouth, bitewing, periapical and occlusal):

    a. Full mouth x-rays - one (1) every 5 years.

    b. Bitewing x-rays - one (1) set every twelve (12) months under age nineteen (19) and one (1) set every eighteen (18) months age nineteen (19) and older.

    c. Periapical x-rays - four (4) every twelve (12) months.

    d. Occlusal films - two (2) every 24 months under age eight (8).

2. Oral Evaluations (comprehensive, periodic and other covered evaluations):

    a. Comprehensive and periodic - two (2) of these services every twelve (12) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more years.

    b. Other Evaluations (limited or detailed dental problems and consultations) - one (1) limited problem (specific dental problem or complaint) per dentist per patient every twelve (12) months and one (1) detailed problem focuses (extensive complex problem requiring extensive diagnostic) per dentist per patient every twelve (12) months per eligible diagnosis.

3. Prophylaxis - one (1) every twelve (12) months. One (1) additional for Member under the care of a medical professional during pregnancy.

4. Replacement of anterior resin-based composite restorations and posterior amalgam restorations - one (1) of these restorations per tooth, per surface, every five (5) years when they are not and cannot be made serviceable.

5. Pulpal therapy - one (1) per eligible tooth per lifetime.

6. Root canal retreatment - limited to permanent teeth, one (1) per tooth per lifetime.

7. Palliative Treatment - one (1) per twelve (12) months.

8. Tooth removal is limited to:

    a. Coronal remnants of primary teeth;

    b. Erupted teeth or exposed roots, simple extraction;

    c. Surgical removal of erupted teeth; and

    d. Surgical removal of residual roots, cutting procedures.

9. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP. This limitation does not apply to covered implantology services.