

## 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 Effective Date or after the Termination Date, except in those instances noted in this Certificate;
3. Any Service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 5 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:
  - a. the change or maintenance of vertical dimension;
  - b. restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards);
  - c. splinting;
  - d. correction of attrition, abrasion, erosion or abfraction;
  - e. bite registration; or
  - f. 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 Orthodontia Services;
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, implant supported crowns, implant abutments, and removal of implants, unless such procedures are listed as Covered Procedures;
14. Charges for precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments;
15. 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;
16. Prescription drugs, premedication, pharmaceuticals, or analgesia;
17. 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;
18. Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
19. Any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if You did not purchase the coverage that is available to You;
20. 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 Plan Year.
21. The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a Natural Tooth extracted while the Person 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 Natural Tooth extracted while the Person 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 Person 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 Person's dental condition;
25. Local, including light 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;
27. Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the 31 day period immediately following the birth of Your Child, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia;
28. Dental care paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the Insured Person has a legal obligation to pay;
29. Dental services performed in a hospital and related hospital fees;
30. Services covered under an existing medical plan;
31. The portion of an expense which is in excess of the reasonable charge;
32. Fees associated with a cancelled or missed appointment;
33. General anesthesia and I.V. sedation