



CHOICE

Individual Dental & Vision Insurance

With dental health playing an essential role in your overall health, now is the time to get started in helping protect your smile with our Student Dental Insurance plan. Plus, we offer vision insurance too!

The Choice dental plan allows you to select any dentist or choose a Maximum Care Network participating provider - giving you the option to select a plan that best fits your needs.

What's covered:

Preventive Services

Includes exams and cleanings (2 per year)	
Policy Pays	100%
Waiting Period	None - covered day 1

Basic Services

Includes fillings, x-rays, oral surgery and simple extractions	
Policy Pays	
Year 1	65%
Year 2	65%
Year 3 and thereafter	80%
Waiting Period	None - covered day 1
Calendar Year Deductible	\$50

This dental policy will pay a yearly Maximum Benefit Amount of \$1,000

Optional vision coverage:

Exams - once per year

Policy Pays	100%
Waiting Period	None - covered day 1

Lenses, Frames and Contacts

1 pair every 2 years	
Policy Pays	75%
Waiting Period	15 months
Calendar Year Deductible	\$25 per person

This vision policy will pay a yearly Maximum Benefit Amount of \$200

Choice vision plan is not available in: MD, NJ, NM, NY, PA or WA

*Reasonable & Customary means the usual or regular charges for the area where expenses were incurred.

About the Dental Plan Options:

Indemnity - Choose Your Own Dentist

Choosing this plan gives you the freedom to choose any dentist. Your cost for dental services is dependent on the policy co-insurance amount, the Reasonable and Customary charge and any required deductible on covered services. You are responsible for dental expenses charged by your provider beyond what the insurance pays. Providers not part of a network plan have not agreed to negotiated fees which may result in higher out-of-pocket costs.

The Choice Indemnity dental plan is not available in: AZ, ID, MA, NM, NY, WA

Network - Maximum Care PPO

The Maximum Care PPO Network is part of the Careington dental network providing over 200,000 access points nationwide. You will receive network discounts when you use a Maximum Care provider as well as 5%-50% discounts on other dental services.

Why choose a network plan? In addition to paying lower monthly premiums a network plan can help reduce your out-of-pocket costs. That's because network dentists have agreed to accept a set negotiated and contracted amount for each service as their payment. This amount is typically less than the amount which could be charged by an out-of-network provider. Network dentists cannot charge you the difference between their typical fee and the amount negotiated with the network.

Find a Maximum Care network provider near you at www.careington.com/co/slica

The Choice Network dental plan is not available in: AK, AZ, ID, MA, MT, NJ, NM, NY, NC, RI, WA or PA counties of Adams, Bradford, Cameron, Forest, Huntingdon, Mifflin, Montour, Potter, Tioga and Warren



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DENTAL LIMITATIONS & EXCLUSIONS

The following are not covered or available as an alternative benefit:

- Occlusal, athletic, or night guards.
- Preventive root canal therapy.
- Overdentures or precision attachments.
- Items/treatments/services: not listed as an eligible expense on the Coverage Schedule; not prescribed by/performed by/under the direct supervision of a dental practitioner; not dentally necessary as determined by us; not meeting the accepted standards of dental practice; experimental in nature; that have a questionable prognosis; covered under any medical insurance policy; or performed by a member of your or your spouse's family (includes parents, step-parents, in-laws, spouse or former spouse, domestic partner, children, siblings, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
- Services furnished primarily for cosmetic reasons, including but not limited to: specialized techniques, characterizing and personalizing prosthetic devices; making facings on prosthetic devices for any tooth in back of the second bicuspid; or replacements of restorations performed for cosmetic reasons.
- Charges for any appliance or service that is used to: change vertical dimension; restore or maintain occlusion, except to the extent that this policy covers orthodontic treatment; splint or stabilize teeth for periodontal reasons; or treat disturbances of the temporomandibular joint (TMJ).
- Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
- Implantology and related services; implants and all related procedures, including removal of implants.
- Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
- Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
- Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
- Duplicate or temporary devices, appliances, and services except as listed as an eligible expense.
- Replacing a lost, stolen or missing appliance or prosthetic device.
- Application of chemotherapeutic agents.
- Oral hygiene, plaque control, diet instruction or infection control.
- Non-emergency services performed outside the USA, Canada & Mexico.
- Treatment which is: due to an on-the-job or job-related illness or injury; or a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
- Treatment for which no charge is made or for which you are not legally obligated to pay including, but not limited to, treatment (or charges made) by: your covered employer, labor union or similar group, in its dental/medical department/clinic; a facility owned/run by any government body; or any public program, except Medicaid, paid for/sponsored by any government body.
- Treatment resulting from: your participation in a war or an act of war, declared or undeclared; your attempting to commit, or committing, an assault or felony; your unlawful participation in a riot, rebellion, or insurrection; or an intentionally self-inflicted injury while sane or insane.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Individual Dental Policy Form IP1000 (and any state specific) and Vision Rider IPR1001 (and any state specific), or One Life Group Dental Policy that may be issued to the group voluntary trust, GH-1112 (and any state specific) and Vision Rider GHR-1112 (Vision) (and any state specific). Premium rates may change upon renewal. This policy is renewable at the option of the insured (IP1000) or the Company (GH-1112). This product may not be available in all states and is subject to individual state regulations.

VISION LIMITATIONS & EXCLUSIONS

- The cost of a lens in excess of a standard lens will not be covered. Standard lens fits in a frame with an eye size less than 61mm. Charges for replacement lenses will not be covered, unless there is a change in prescription.
- The cost of a frame in excess of a standard frame will not be covered. Standard frame has a retail value of \$75 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.
- The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

The following are not covered or available as an alternative benefit:

- Two pair of glasses in lieu of bifocals.
- Artistically painted contact lenses.
- Medical or surgical treatment of the eyes.
- Codes that are by report.
- Items, treatments or services: not listed as an eligible expense; not prescribed by or performed by or under the direct supervision of a vision provider; not visually necessary to restore or maintain a patient's visual acuity and health; not meeting the accepted standards of vision practice; experimental in nature; or covered under any medical insurance policy.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a $\pm .50$ diopter power).
- Replacement of lenses, frames/contacts furnished under this policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Corneal refractive therapy or orthokeratology.
- Additional office visits for contact lens pathology.
- Contact lens modification, polishing or cleaning.
- Charges for service agreements or insurance policies.

GENERAL INFORMATION

Eligibility: Individuals 18+, plus their eligible dependents. This is subject to individual state regulations.

Predetermination of Benefits: It is recommended that a treatment plan/course of treatment be submitted when the total cost of eligible expenses for any insured is expected to exceed the amount shown on the coverage schedule. This should be submitted to us before the work is started. If actual services submitted do not agree with the treatment plan, or if a treatment plan is not sent in, we will base our payment on treatment consistent with reasonable and customary charges. Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

Alternate Benefit: If we determine that a less expensive procedure, service, or treatment plan/course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice, then the maximum we will allow will be the charge for the less expensive treatment.

Reasonable & Customary: The usual, customary and regular charges for the area where such expenses are incurred.

The following are not covered or available as an alternative benefit:

- Telephone consultations, charges for failure to keep a scheduled appointment, x-ray copy fees, or charges for completion of a claim form.
- Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
- Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.