PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®
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DENTAL POLICY
DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE
FORM D-0220.PAL.FL

OUTLINE OF COVERAGE

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.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Dental coverage is designed to provide you with the benefits described in the Benefits section below.

BENEFITS

Co-Pay (per insured person, per calendar year)(no more than 3 Co-Pays per calendar year for any insured person):	$25 Age < 65 $40 Age 65+
Calendar Year Maximum Amount per insured person:	$1,500 / $2,000
Prosthodontics (other than Maintenance Prosthodontics) Lifetime Maximum Amounts per insured person:	$1,000
Orthodontics Lifetime Maximum Amounts per insured person:	$1,000

Benefit Description	Waiting Period (Months)	Network Provider and Non-Network Provider Coinsurance Amount Policy Year 1 / Year 2 / Year 3+
DIAGNOSTIC	0	100% / 100% / 100%
PREVENTIVE	0	100% / 100% / 100%
BASIC CARE	6	50% / 65% / 80%
Maintenance Prosthodontics	6	50% / 65% / 80%
MAJOR CARE		
Oral Surgery	0	0% / 25% / 50%
Restorations	0	0% / 25% / 50%
Endodontics	0	0% / 25% / 50%
Periodontics	0	0% / 25% / 50%
Prosthodontics Care	0	0% / 25% / 50%
Orthodontic Care	0	0% / 25% / 50%

Policy Year means the initial 12 month period of time beginning on the Effective Date of the policy and each consecutive 12 month period thereafter.

NETWORK PROVIDERS AND NON-NETWORK PROVIDERS

Network Providers
It is important that the insured person receives services from a Network Provider to minimize out-of-pocket costs. Network Providers (or Preferred Provider Organization (PPO)) means a provider that holds a valid contract with the network associated with the policy to provide dental services, treatment, and supplies to an insured person. A current list of the Network Providers in the network is available.

Network Providers and Non-Network Providers
The policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

Using a Network Provider May Lower Costs
If an insured person uses the services of a Non-Network Provider, the benefit amount under the policy may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses rendered by a Non-Network Provider may cost the insured person more than Covered Expenses rendered by a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The insured person's responsibility includes the portion of the expense not payable under the policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense.

LIMITATIONS

In the event an insured person incurs Covered Expenses, the company will pay the applicable Coinsurance Amount subject to the following:

Waiting Period – Before benefits for any Covered Expenses for dental services will be paid, the applicable Waiting Period must be satisfied.

Coinsurance Amount – Covered Expenses will be paid at the applicable Coinsurance Amount after any applicable Waiting Period has been satisfied.

Calendar Year Maximum Amount – All Covered Expenses under the policy for each insured person are limited to the Calendar Year Maximum Amount per insured person for each calendar year.

Lifetime Maximum Amount – Some Covered Expenses under the policy for each insured person are limited to the Lifetime Maximum Amount per insured person.

DENTAL COVERED EXPENSES

Diagnostic Care

(1) Intra-Oral Occlusal Film
(2) Bitewing X-rays (up to a set of 4) – limited to 1 per calendar year
(3) Full Mouth X-rays (Panoramic Film or Full Series) – no less than 36 months apart
(4) Periapicals

Preventive Care

(1) Prophylaxis (the cleaning and scaling of teeth) – limited to 1 per 6 months
(2) One topical application of Fluoride for dependent children under age 19 - limited to 1 per calendar year
(3) Routine oral exams – limited to 1 per 6 months
(4) Consultation - other than treating doctor
(5) Comprehensive Oral Exam
(6) Problem Focused Exams
(7) Sealants – limited to dependents under age 14, one treatment per tooth (permanent bicuspids and molars) and no less than 36 months apart
(8) Space Maintainers - the initial appliance for dependent children under age 13, including all adjustments within the 6 month period immediately following installation

Basic Care

(1) Palliative Treatment – if no other service was rendered except x-rays
(2) Amalgam Restorations
(3) Composite Restorations – limited to anterior teeth and bicuspids
(4) Sedative Fillings
(5) Pin Retention - per tooth, in addition to restoration
(6) Simple Extractions
(7) Occlusal Adjustment – limited or complete

Maintenance Prosthodontics
(1) Denture Repairs
(2) Denture Adjustments
(3) Denture Rebase – no less than 24 months apart
(4) Denture Reline - no less than 24 months apart
(5) Two Tissue Conditionings – no less than 24 months apart

Major Care

Oral Surgery
(1) General Anesthesia or I.V. Sedation when administered with oral surgery
(2). Surgical Extractions
(3) Surgical Access of an unerupted tooth
(4) Biopsy

(5) Surgical Repositioning of teeth
(6) Transseptal Fiberotomy
(7) Alveoloplasty
(8) Vestibuloplasty
(9) Surgical Excision of Lesions
(10) Removal of Exostosis and Torus
(11) Incision and Drainage of Abcess
(12) Frenulectomy

Restorations

(1) Inlays
(2) Onlays
(3) Crown – single restorations only
(4) Inlay Recementation
(5) Crown Recementation
(6) Core Build-Up - including any pins
(7) Post and Core – in addition to crown
(8) Veneers – excluding cosmetic; restorative only

Endodontics

(1) Pulp Cap – direct & indirect
(2) Pulpal Therapy - limited to primary teeth
(3) Pulpotomy – limited to primary teeth
(4) Pulpal Debridement
(5) Root Canals
(6) Retreatment of Previous Root Canals
(7) Apexification/Recalcification
(8) Apicoectomy
(9) Retrograde Filling
(10) Hemisection
(11) Root Amputation

Periodontics

(1) Scaling and Root Planing – no less than 24 months apart
(2) Full Mouth Debridement
(3) Periodontal Maintenance Procedure - no less than 6 months apart
(4) Localized Delivery of Chemotheraputic Agents – limited to 3 sites per quad and no less than 24 months apart
(5) Gingivectomy
(6) Gingival Flap Procedure
(7) Apically Positioned Flap
(8) Clinical Crown Lengthening – hard tissue
(9) Osseous Surgery – no less than 24 months apart
(10) Bone Replacement Graft
(11) Biologic Materials to Aid in Tissue Regeneration
(12) Guided Tissue Regeneration
(13) Surgical Revision Procedure - per tooth
(14) PedicleSoft Tissue Grafts
(15) Free Soft Tissue Graft
(16) Subepithelial Connective Tissue Graft
(17) Distal or Proximal Wedge Procedure
(18) Soft Tissue Allograft
(19) Combined Connective Tissue and Double Pedicle

Prosthodontics Care

Prosthodontics Care benefits up to $350 per calendar year. Specific Lifetime Maximums are listed above.

(1) Complete Dentures - including adjustments made within 6 months after installation
(2) Partial Dentures - including adjustments made within 6 months after installation
(3) Fixed Partial Denture - pontics
(4) Fixed Partial Denture - retainers (inlays/onlays and crowns)

Orthodontic Care

Orthodontic treatment benefits up to $350 per calendar year are limited to dependent children under age 19. Orthodontic benefit specific Lifetime Maximums are listed above.

Incurred Dates

Covered Expenses must be incurred while the policy is in force for the insured person. A Covered Expense is considered incurred on:

(1) For full and partial dentures – the date the final 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 the surgery is performed; and
(5) For all other Covered Expenses – the date the service is performed.

Predetermination of Benefits

The Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an insured person. We will predetermine the amount of benefits payable under the policy for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the date the insured person's coverage ends under the policy.

DEFINITIONS

Covered Expenses means expenses for necessary dental services or supplies prescribed by a Dentist. Covered Expenses may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses must be incurred while the policy is in force.

Reasonable and Customary Charge (R&C) means:

(1) With respect to Non-Network Providers, the smallest of:
   a. the Network Providers negotiated rate in effect on the date the Non-Network Provider provides a covered expense;
   b. the actual charge;
   c. the charge usually made for the Covered Expense by the provider who furnishes it; or
   d. the prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing.

(2) With respect to Network Providers, the negotiated rate in effect with a PPO on the date it provides a Covered Expense.

LIMITATIONS AND EXCLUSIONS

Limitations on Optional Services

Optional Services are services that are more expensive than the form of treatment customarily provided under accepted dental practice standards. Optional Services also include the use of specialized techniques instead of standard procedures. For example, an Optional Service would be using a crown where a filling could restore the tooth or an inlay instead of a restoration. If an insured person receives Optional Services, benefits under the policy will be based on the lower cost of the customary service or standard procedure instead of the higher cost of the Optional Service. The insured person will be responsible for the difference between the higher cost of the Optional Service and the lower of the customary service or standard procedure.

Exclusions

Claims will not be paid under the policy for:

(1) Any loss resulting from war, declared or undeclared;
(2) Any intentionally self-inflicted injury;
(3) Any loss resulting from an insured person's involvement in a felonious occupation or activity;
(4) Any expense for which payment is provided under Medicare;
(5) Any Experimental or Investigational procedure or treatment;
(6) Any expense incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required to be provided in your state;
(7) Prescribed drugs, medication or pain killers;
(8) Charges in excess of Reasonable and Customary Charges;
(9) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law;
(10) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of disorder of the teeth) and anodontia (congenitally missing teeth);
(11) Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example: equilibration, periodontal splinting, occlusal adjustment;
(12) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility;
(13) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services;
(14) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues);
(15) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision;
(16) For treatment rendered by a person who ordinarily resides in the insured person's household or who is related to the insured person by blood, marriage or legal adoption.

RENEWAL, TERMINATION AND PREMIUM PAYMENT PROVISIONS

The policy is guaranteed renewable to age 85, subject to the company's right to discontinue or terminate the coverage as provided in the policy.

Your premium for the policy is $_____ annually. If your premium is not annual, it is $_____for_____ months. The policy provides a 31-day grace period during which period the policy will remain in force. Premiums are subject to change.