



**VOLUNTARY  
DENTAL & VISION INSURANCE PLANS  
FOR  
OSTEOPATHIC MEDICAL  
STUDENTS**

**Respectfully Submitted By:  
Mass Marketing Insurance Consultants, Inc.  
14616 John Humphrey Drive  
Orland Park, IL 60462**

## DENTAL PROGRAM

<b>Dental benefits are provided through a stand-alone group dental insurance policy.</b>		
	In-Network \$1,500 \$25/\$75	*Out-of-Network \$1,500 \$25/\$75
<ul style="list-style-type: none"> <li>• Contract Year Maximum per Covered Person</li> <li>• Contract Year Deductible per Covered person/Family – Class I exempt</li> </ul>		
<b>Class I Dental Plan Payment (no waiting period or deductible)</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• All Xrays</li> <li>• Cleanings</li> <li>• Fluoride Treatments</li> <li>• Sealants</li> <li>• Palliative Treatment</li> </ul>	100%	100%
<b>Class II Dental Plan Payment (no waiting period, deductible applies)</b> <ul style="list-style-type: none"> <li>• Space Maintainers</li> <li>• Basic Restorative</li> <li>• Non-surgical Periodontics</li> <li>• Repairs of Crowns, Inlays, Onlays, Bridges and Dentures</li> <li>• Simple Extractions</li> </ul>	90%	90%
<b>Class III Dental Plan Payment (six-month waiting period, deductible applies)</b> <ul style="list-style-type: none"> <li>• Endodontics</li> <li>• Surgical Periodontics</li> <li>• Complex Oral Surgery</li> <li>• General Anesthesia</li> <li>• Inlays, Onlays, Crowns</li> <li>• Prosthetics</li> </ul>	50%	50%
<b>Orthodontics</b>	Not Covered	Not Covered
* Plan payment percentages are based on the insurance company's Maximum Allowable charge. Network dentists accept their contracted Maximum Allowable Charge as payment in full for covered services		

**Underwritten by:  
United Concordia Insurance Company**

## VISION PROGRAM

**Vision Benefits are provided through a stand-alone Vision program**

Benefit	Frequency (based on service year)	Copayment	Coverage from a Network Doctor	Out-of-Network Reimbursement
<b>Eye Care Wellness</b> - Regular exams are essential for protecting your visual wellness				
<b>Exam</b>	12 Months	\$20	Covered in full	Up to \$25 allowance
<b>Prescription Eyewear</b> - You may choose between glasses or contacts. Remember if you choose contacts, you will not be eligible to receive glasses (lenses and frame) in the same service period.				
<b>Lenses</b>	12 Months	\$20 (applied to lenses & frame)	Single vision, lined bifocal lenses, lined trifocal lenses and tints are covered in full	Single vision up to \$30 allowance Lined bifocal up to \$35 allowance Lined trifocal up to \$45 allowance Tints up to \$5 allowance
<b>Frame</b>	12 Months		Covered up to \$150 allowance	Up to \$45 allowance
<b>Contact Lenses</b>	12 Months	None	Covered up to \$150 allowance	Up to \$105 allowance

Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

**Value Added Discounts**

**Laser VisionCare** - The Vision Coverage Company has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers.

**Contact Lenses** - Valuable savings are available on annual supplies of certain brands of contacts. You can receive these member preferred prices, even if you use your coverage for glasses.

**Prescription Glasses** - Receive 20 percent savings when you purchase non-covered pairs of prescription glasses, including prescription sunglasses from the same in-network doctor within 12 months of your last eye exam.

1. Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at member preferred pricing. Ask your doctor for details.
2. If you choose a frame valued at more than your allowance, you'll save 30% on your out-of-pocket costs for frames.

**Underwritten by:  
Vision Service Plan (VSP)**

## DENTAL EXCLUSIONS

No coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.
2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan. This exclusion does not apply to Group Policies and Certificates issued and delivered in California.
3. Stated prior to the Member's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays and dentures.
4. Services or supplies that are not deemed generally accepted standards of dental treatment.
5. For hospitalization costs.
6. That are the responsibility of Worker's Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.  
For Group Policies and Certificates issued and delivered in Georgia, Missouri, and Virginia, only services that are the responsibility of Workers Compensation or employer's liability insurance shall be excluded from this Plan.  
For Group Policies and Certificates issued and delivered in Texas, only services that are the responsibility the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.
7. For prescription or non-prescription drugs, vitamins, or dietary supplements.
8. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.
9. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

This exclusion does not apply to Group Policies and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury. This exclusion does not apply to Group Policies issued and delivered in New Jersey for Cosmetic services for newborn children of Members as defined in the definition of Dependent.

10. Elective procedures including but not limited to the prophylactic extraction of third molars.
11. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
12. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.  
For Group Policies and Certificates issued and delivered in Arizona, Kentucky, and Pennsylvania this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including adoptive children, regardless of age.  
For Group Policies issued and delivered in Colorado, this exclusion shall not apply to orthodontic or dental services for a newly born Dependent with cleft lip or cleft palate and shall be covered as listed on the Schedule of benefits.  
For Group Policies and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.
13. For dental implants including placement and restoration of implants unless specifically covered under a rider to the Certificate. This exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
14. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if

the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to Group Policies issued and delivered in Georgia when such services are medically necessary.

15. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under a Rider to the Certificate. These jaw point problems include but are not limited to such conditions as temporomandibular joint disorder (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. For Group Policies and Certificates issued in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for Treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.
16. For treatment of fractures and dislocations of the jaw. This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.
17. For treatment of malignancies or neoplasms.
18. Services and/or appliances that alter the vertical dimension, including but not limited to full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method. This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.
19. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
20. For broken appointments.
21. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics. This exclusion does not apply to Group Policies and Certificates issued and delivered in Maryland.
22. For house or hospital calls for dental services.
23. Replacement of existing crowns, onlays, bridges and dentures that are or can be made serviceable.
24. Preventive restorations in the absence of dental disease.
25. Periodontal splinting of teeth by any method.
26. For duplicate dentures, prosthetic devices or any other duplicate device.
27. For services determined to be furnished as a result of a referral to an entity in which the referring dentist, or the dentist's immediate family; (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's spouse, parent, spouse's parent, sibling or sibling's spouse of the dentist or that dentist in combination.
28. For which in the absence of insurance the Member would incur no charge.
29. For plaque control programs, oral hygiene, and dietary instructions.
30. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the guard or in the armed forces of any country or international authority. This exclusion does not apply to Group Policies and Certificates issued and delivered in Oklahoma.
31. For training and/or appliance to correct or control harmful habits, but not limited to muscle training therapy (myofunctional therapy).
32. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
33. Which are not Dentally Necessary as determined by the Company. This exclusion does not apply to Group Policies and Certificates in California and Maryland.

## DENTAL LIMITATIONS

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays - one every five years.
2. One set(s) of bitewing x-rays per six months through age thirteen, and one set(s) of bitewing x-rays per twelve months for age fourteen and older.
3. Periodic oral evaluation - one per six months.
4. Limited oral evaluation (problem focused) - limited to one per dentist per twelve months.
5. Prophylaxis - one per six months.
6. Fluoride treatment - one per six months through age eighteen.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy - two per twelve months in addition to routine prophylaxis.
11. Periodontal scaling and root planing - per two year period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures - one within five years of their placement.
13. Denture relining, rebasing or adjustments - are included in

the denture charges if provided within six months of insertion by the same dentist.

14. Subsequent denture relining or rebasing - limited to one every three year(s) thereafter.
15. Surgical periodontal procedures - one per two year period per area of the mouth.
16. Sealants - one per tooth per three year(s) through age fifteen on permanent first and second molars.
17. Pulpal therapy - through age five on primary anterior teeth and through age eleven on primary posterior molars.
18. Root canal treatment and retreatment - one per tooth per lifetime.
19. Recementations by the same dentist who initially inserted the crown or bridge during the first twelve months are included in the crown or bridge benefit, then one per twelve months thereafter; one per twelve months for other than the dentist who initially inserted the crown or bridge.
20. Replacement restorations - limited to one per twelve months.
21. Contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration.
22. Posts are only covered as part of a post buildup.
23. An Alternate Benefit Provision (ABP) will be applied if a 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 for the ABP.
24. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

## VISION LIMITATIONS & EXCLUSIONS

As a plan designed to meet the typical visual needs of its members, we limit or do not cover some materials and certain elective options chosen for cosmetic purposes. We also do not cover medical or surgical eye care services, with the except of discounts available for laser vision correction services. The following lists materials and services with either limited or no coverage under the Standard Plan.

### Cosmetic Options

- Blended lenses\*
- Contact lenses (except as noted elsewhere)
- Scratch resistant coating \*
- Anti-reflective coating \*
- UV protected lenses
- Oversized lenses (over 60 mm)\*
- Progressive multifocal \*
- Photochromic or tinted lenses other than Pink 1 or 2
- Other coated or laminated lenses \*
- Certain limitations on low vision care
- Optional cosmetic processes

### Exclusions (services and materials not covered)

- Orthoptics or vision training and any associated supplemental testing.
- Non-prescription lenses
- Two pairs of glasses instead of bifocals
- Complete pairs of glasses furnished under this program that are lost or broken (except at the normal intervals when services are otherwise available)
- Medical or surgical treatment of the eyes
- Experimental vision services, treatments and materials

- Cosmetic Options: Lens features not covered under the plan and chosen for cosmetic reasons, such as blended/ progressive lenses, special lens tints or coatings are price controlled by VSP. These cost controlled prices can save our members an average of 20% off doctor's usual and customary fees.

## MONTHLY PREMIUM RATES

	VISION PLAN	DENTAL PLAN
Student Only	\$16.00	\$38.00
Spouse Only	\$9.30	\$32.00
Children	\$16.50	\$43.00

- 1) Monthly premium will be charged to MasterCard or VISA Credit Card
- 2) Enroll on line – [www.somainsurance.com](http://www.somainsurance.com)