



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

**CERTIFICATE AND SUMMARY PLAN DESCRIPTION
GROUP DENTAL INSURANCE**

The Policyholder **EDWARDS CHEVROLET-CADILLAC, INC. DBA EDWARDS AUTO GROUP
EDWARDS AUTO GROUP**

Policy Number **10-59282** **Insured Person**

Plan Effective Date **June 1, 2022** **Certificate Effective Date**
Refer to Exceptions on 9070

Plan Change Effective Date **January 1, 2026**

Class Number 1

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

President

IOWA – NOTICE OF GRIEVANCE PROCEDURES

Please read this Notice carefully. This notice, along with the information on your Explanation of Benefits, contains important information about your rights to appeal, or request a review of, our decision if all or part of a benefit is denied.

You may contact us at the following address:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll Free)
Fax 402-309-2579

I. Definitions

“Adverse Determination” means a determination by us that a dental care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, and the requested service or payment for the service is therefore denied, reduced or terminated in whole or in part. “Adverse Determination” does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

“Final Adverse Determination” means an Adverse Determination involving a covered benefit that has been upheld by us at the completion of our internal grievance process.

II. Levels of Review

You may ask us to review our decisions about your benefits. In general, the following levels of review are available:

A. Internal Review

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we may have consulted who provided advice to us about your claim, and also request at no charge any clinical rationale relied upon by them for any benefit determinations related to clinical necessity.

The appeal review will be conducted by someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your appeal promptly after we receive your request.

B. External Review - Standard

You or your authorized representative may file a written request for an external review with the Commissioner of the Iowa Division of Insurance within four months after any of the following events:

- a. The date of receipt of a Final Adverse Determination;
- b. Our failure to issue a written decision within thirty days following the date you or your authorized representative filed a grievance involving an Adverse Determination; or,
- c. We agree to waive the requirement that our internal grievance procedures must be exhausted before filing a request for external review.

To obtain information about the external review process, contact:

Iowa Insurance Division
601 Locust St. - 4th Floor
Des Moines, IA 50309-3738

Telephone: 515-281-6348
Toll Free: 877-955-1212
Fax: 515-281-3059
eMail: iid.marketregulation@iid.iowa.gov

When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the request for external review.

Within one business day after the date of receipt of a request for external review, the Commissioner shall send a copy of the request to us.

Within five business days following receipt of the request from the Commissioner, we shall complete a preliminary review of the request to determine whether:

- a. You are or were a covered person at the time the service was requested or performed.
- b. The service that is the subject of the Adverse Determination or of the Final Adverse Determination is not covered because it does not meet the requirements for medical necessity, appropriateness, or effectiveness.
- c. You or your authorized representative have exhausted our internal grievance process, unless we agree to waive the requirement that our internal grievance procedures must be exhausted before filing a request for external review.
- d. You or your authorized representative have provided all the information and forms required to process an external review request.

Within one business day after completion of a preliminary review, we will notify the Commissioner, and you and or your authorized representative in writing whether the request is complete and whether the request is eligible for external review. If we determine the request is incomplete, we will notify you or your authorized representative and the commissioner in writing that the request is incomplete, and what materials are needed to make the request complete.

If we determine the request is not eligible for external review, we will issue a notice of initial determination in writing to you or your authorized representative and the commissioner indicating the reasons the request is not eligible for review. We will include a statement in the notice informing you or authorized representative that our initial determination of ineligibility may be appealed to the commissioner.

Within one business day after receipt of notice from us that a request for external review is eligible for external review or upon a determination by the Commissioner that a request is eligible for external review, the commissioner will:

- a. Assign an independent review organization from the list of approved independent review organizations maintained by the commissioner and notify us of the name.
- b. Notify you or your authorized representative in writing that the request is eligible.

C. Expedited External Review

Expedited external reviews are available to you or your authorized representative for any appeals involving a situation where the time frame of an internal review or standard review procedures would seriously jeopardize your life, health, or ability to regain maximum function. Immediately upon receipt of notice of a request for expedited external review, we will complete a preliminary review of the request to determine whether the request meets the eligibility requirements for external review. We will then immediately issue a notice of initial

determination informing the commissioner, and you, or your authorized representative of our eligibility determination including a statement informing you or your authorized representative of the right to appeal that determination to the commissioner.

**NOTICE OF PROTECTION PROVIDED BY
IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - \$300,000 in death benefits
 - \$100,000 in net cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans (see definition below)
 - \$300,000 in disability income protection insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values
- Annuities
 - \$250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1300
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service S&P Global Ratings.

The Association is subject to supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

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**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Eligible Employee Electing Dental

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Once per Lifetime	\$50

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	\$1,000
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ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	\$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	\$1,000

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

After the first Benefit Period following the effective date of this provision, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits will be increased by the Carry Over Amount if:

- a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and
- b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

After the first Benefit Period following the coverage effective date, the Carry Over Amount will be increased by the PPO Bonus if:

- a) The insured person has submitted a claim for dental expenses incurred during the preceding Benefit Period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding Benefit Period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount and the PPO Bonus.

The Carry Over Amount and the PPO Bonus can be accumulated from one Benefit Period to the next Benefit Period up to the Maximum Carry Over amount unless:

- a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount or PPO Bonus for that Benefit Period; or
- b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

The Carry Over Amount and the PPO Bonus, if applicable, accrued prior to June 1, 2022 will apply to the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits if proof is furnished to us that such Carry Over Amount was incurred under the Policyholder's dental insurance policy in force immediately prior to June 1, 2022 except as noted below. Any qualified Carry Over Amount under a prior policy will apply toward the total Maximum Carry Over Amount under this policy. In no event will the Carry Over Amount under a prior policy plus any accumulated Carry Over Amount, if applicable, under this policy exceed the Maximum Carry Over Amount. Any future Carry Over Amounts accumulated or forfeited in subsequent Benefit Periods will be calculated as outlined above. Please note that if the first Benefit Period is for a period of less than 12 months the Carry Over Amount will be accumulated in the second Benefit Period without a

claim having to be filed but the Carry Over Amount in all subsequent Benefit Periods may be forfeited as per the rules in b. above.

Eligibility for the Carry Over Amount and the PPO Bonus will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount and/or the PPO Bonus, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount or PPO Bonus calculations. The request for review must be within 24 months from the date the Carry Over Amount or the PPO Bonus was established.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

- a. an Insured's spouse.
- b. each unmarried child through the end of the year in which they turn 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

- a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or
- b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing dental working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing dental working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This program of coverage is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Annual Election Period. The first Annual Election Period will be in May 2022 and those who elect to

participate in this program at that time will have their insurance become effective on June 1, 2022. Each Annual election Period thereafter will be in December for a January 1 effective date.

A Member may change their election option only during an Annual Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 60 calendar day(s) of continuous active employment.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.
3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan, if services are provided by a Participating Provider, who is a general dentist.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

- D0210 Intraoral - comprehensive series of radiographic images.
- D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

- D0220 Intraoral - periapical first radiographic image.
- D0230 Intraoral - periapical each additional radiographic image.
- D0240 Intraoral - occlusal radiographic image.
- D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
- D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

- D0270 Bitewing - single radiographic image.
- D0272 Bitewings - two radiographic images.
- D0273 Bitewings - three radiographic images.
- D0274 Bitewings - four radiographic images.
- D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per benefit period.

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.

TYPE 1 PROCEDURES

- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per benefit period.

Benefits are considered for persons age 15 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per benefit period.

D4346, D4910, also contribute(s) to this limitation.

An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per benefit period.

Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANTS AND CARIES MEDICAMENTS

- D1351 Sealant - per tooth.
- D1353 Sealant repair - per tooth.
- D1354 Application of caries arresting medicament-per tooth.
- D1355 Caries preventive medicament application - per tooth.

SEALANT: D1351, D1353

Coverage is limited to 1 of any of these procedures per 3 year(s).

D1354, D1355, also contribute(s) to this limitation.

Benefits are considered for persons age 13 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
- D1556 Removal of fixed unilateral space maintainer-per quadrant.
- D1557 Removal of fixed bilateral space maintainer-maxillary.
- D1558 Removal of fixed bilateral space maintainer-mandibular.
- D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 13 and under.

Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

PERIODONTAL MAINTENANCE

- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
- D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.

D1110, D1120, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2928 Prefabricated porcelain/ceramic crown - permanent tooth.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

D2930 Prefabricated stainless steel crown - primary tooth.

TYPE 2 PROCEDURES

- D2931 Prefabricated stainless steel crown - permanent tooth.
 - D2932 Prefabricated resin crown.
 - D2933 Prefabricated stainless steel crown with resin window.
 - D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.
- STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934
- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

- D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
- D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
- D2920 Re-cement or re-bond crown.
- D2921 Reattachment of tooth fragment, incisal edge or cusp.
- D6092 Re-cement or re-bond implant/abutment supported crown.
- D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
- D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

- D2940 Placement of interim direct restoration.
- D2991 Application of hydroxyapatite regeneration medicament - per tooth.

DENTURE RELINES

- D5730 Reline complete maxillary denture (direct).
 - D5731 Reline complete mandibular denture (direct).
 - D5740 Reline maxillary partial denture (direct).
 - D5741 Reline mandibular partial denture (direct).
 - D5750 Reline complete maxillary denture (indirect).
 - D5751 Reline complete mandibular denture (indirect).
 - D5760 Reline maxillary partial denture (indirect).
 - D5761 Reline mandibular partial denture (indirect).
 - D5765 Soft liner for complete or partial removable denture-indirect.
- DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765
- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

- D7111 Extraction, coronal remnants - primary tooth.
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

- D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
- D7220 Removal of impacted tooth - soft tissue.
- D7230 Removal of impacted tooth - partially bony.
- D7240 Removal of impacted tooth - completely bony.
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
- D7250 Removal of residual tooth roots (cutting procedure).
- D7251 Coronectomy - intentional partial tooth removal, impacted teeth only.
- D7252 Partial extraction for immediate implant placement.

OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Exposure of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

TYPE 2 PROCEDURES

- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7509 Marsupialization of odontogenic cyst.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7961 Buccal/labial frenectomy (frenulectomy).
- D7962 Lingual frenectomy (frenulectomy).
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7979 Non-surgical sialolithotomy.
- D7980 Surgical sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

- D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
- D7286 Incisional biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

- D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.

TYPE 2 PROCEDURES

- D9222 Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof.
- D9223 Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof.
- D9239 Administration of moderate sedation - intravenous first 15 minute increment, or any portion thereof.
- D9243 Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9224, D9225, D9239, D9243, D9246 or D9247) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

- D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
- D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
- D9440 Office visit - after regularly scheduled hours.
- D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

- D9951 Occlusal adjustment - limited.
- D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

- D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
- D2951 Pin retention - per tooth, in addition to restoration.
- D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS

- D2510 Inlay - metallic - one surface.
- D2520 Inlay - metallic - two surfaces.
- D2530 Inlay - metallic - three or more surfaces.
- D2610 Inlay - porcelain/ceramic - one surface.
- D2620 Inlay - porcelain/ceramic - two surfaces.
- D2630 Inlay - porcelain/ceramic - three or more surfaces.
- D2650 Inlay - resin-based composite - one surface.
- D2651 Inlay - resin-based composite - two surfaces.
- D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

- D2542 Onlay - metallic - two surfaces.
- D2543 Onlay - metallic - three surfaces.
- D2544 Onlay - metallic - four or more surfaces.
- D2642 Onlay - porcelain/ceramic - two surfaces.
- D2643 Onlay - porcelain/ceramic - three surfaces.
- D2644 Onlay - porcelain/ceramic - four or more surfaces.
- D2662 Onlay - resin-based composite - two surfaces.
- D2663 Onlay - resin-based composite - three surfaces.
- D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2753 Crown-porcelain fused to titanium and titanium alloys.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

TYPE 3 PROCEDURES

- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.
- D2792 Crown - full cast noble metal.
- D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

CORE BUILD-UP

- D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

- D2952 Post and core in addition to crown, indirectly fabricated.
- D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

- D2980 Crown repair necessitated by restorative material failure.
- D2981 Inlay repair necessitated by restorative material failure.
- D2982 Onlay repair necessitated by restorative material failure.
- D2983 Veneer repair necessitated by restorative material failure.
- D6980 Fixed partial denture repair necessitated by restorative material failure.
- D9120 Fixed partial denture sectioning.

ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.
- D3921 Decoronation or submergence of an erupted tooth.

TYPE 3 PROCEDURES

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, premolar tooth (excluding final restorations).
- D3330 Endodontic therapy, molar tooth (excluding final restorations).
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - premolar.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

SURGICAL PERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
- D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and pedicle graft, per tooth.

TYPE 3 PROCEDURES

- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

Each quadrant is limited to 2 of any of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

- D4249 Clinical crown lengthening - hard tissue.

NON-SURGICAL PERIODONTICS

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

ANTIMICROBIAL AGENTS: D4381

Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

- D5110 Complete denture - maxillary.
- D5120 Complete denture - mandibular.
- D5130 Immediate denture - maxillary.
- D5140 Immediate denture - mandibular.
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

TYPE 3 PROCEDURES

- D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
- D5228 Immediate mandibular partial denture-flexible base(including any clasps, rests and teeth).
- D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
- D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
- D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
- D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
- D5863 Overdenture - complete maxillary - natural tooth borne.
- D5864 Overdenture - partial maxillary - natural tooth borne.
- D5865 Overdenture - complete mandibular - natural tooth borne.
- D5866 Overdenture - partial mandibular - natural tooth borne.
- D5876 Add metal substructure to acrylic complete denture - per arch.
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
- D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
- D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

- D5410 Adjust complete denture - maxillary.
- D5411 Adjust complete denture - mandibular.
- D5421 Adjust partial denture - maxillary.
- D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

TYPE 3 PROCEDURES

- D5511 Repair broken complete denture base, mandibular.
- D5512 Repair broken complete denture base, maxillary.
- D5520 Replace missing or broken teeth - complete denture - per tooth.
- D5611 Repair resin partial denture base, mandibular.
- D5612 Repair resin partial denture base, maxillary.
- D5621 Repair cast partial framework, mandibular.
- D5622 Repair cast partial framework, maxillary.
- D5630 Repair or replace broken retentive/clasping materials per tooth.
- D5640 Replace missing or broken teeth - partial denture - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL

- D5650 Add tooth to existing partial denture - per tooth.
- D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.
- D5725 Rebase hybrid prosthesis.

TISSUE CONDITIONING

- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported crown - porcelain fused to high noble alloys.
- D6067 Implant supported crown - high noble alloys.
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
- D6077 Implant supported retainer for metal FPD - high noble alloy.
- D6082 Implant supported crown-porcelain fused to predominantly base alloys.
- D6083 Implant supported crown-porcelain fused to noble alloys.
- D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
- D6086 Implant supported crown-predominantly base alloys.
- D6087 Implant supported crown-noble alloys.
- D6088 Implant supported crown-titanium and titanium alloys.
- D6094 Abutment supported crown - titanium and titanium alloys.
- D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
- D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
- D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
- D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
- D6121 Implant supported retainer for metal FPD-predominantly base alloys.
- D6122 Implant supported retainer for metal FPD-noble alloys.
- D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
- D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.

TYPE 3 PROCEDURES

- D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
 - D6205 Pontic - indirect resin based composite.
 - D6210 Pontic - cast high noble metal.
 - D6211 Pontic - cast predominantly base metal.
 - D6212 Pontic - cast noble metal.
 - D6214 Pontic - titanium and titanium alloys.
 - D6240 Pontic - porcelain fused to high noble metal.
 - D6241 Pontic - porcelain fused to predominantly base metal.
 - D6242 Pontic - porcelain fused to noble metal.
 - D6243 Pontic-porcelain fused to titanium and titanium alloys.
 - D6245 Pontic - porcelain/ceramic.
 - D6250 Pontic - resin with high noble metal.
 - D6251 Pontic - resin with predominantly base metal.
 - D6252 Pontic - resin with noble metal.
 - D6545 Retainer - cast metal for resin bonded fixed prosthesis.
 - D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
 - D6549 Resin retainer - for resin bonded fixed prosthesis.
 - D6600 Retainer inlay - porcelain/ceramic, two surfaces.
 - D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
 - D6602 Retainer inlay - cast high noble metal, two surfaces.
 - D6603 Retainer inlay - cast high noble metal, three or more surfaces.
 - D6604 Retainer inlay - cast predominantly base metal, two surfaces.
 - D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
 - D6606 Retainer inlay - cast noble metal, two surfaces.
 - D6607 Retainer inlay - cast noble metal, three or more surfaces.
 - D6608 Retainer onlay - porcelain/ceramic, two surfaces.
 - D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
 - D6610 Retainer onlay - cast high noble metal, two surfaces.
 - D6611 Retainer onlay - cast high noble metal, three or more surfaces.
 - D6612 Retainer onlay - cast predominantly base metal, two surfaces.
 - D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
 - D6614 Retainer onlay - cast noble metal, two surfaces.
 - D6615 Retainer onlay - cast noble metal, three or more surfaces.
 - D6624 Retainer inlay - titanium.
 - D6634 Retainer onlay - titanium.
 - D6710 Retainer crown - indirect resin based composite.
 - D6720 Retainer crown - resin with high noble metal.
 - D6721 Retainer crown - resin with predominantly base metal.
 - D6722 Retainer crown - resin with noble metal.
 - D6740 Retainer crown - porcelain/ceramic.
 - D6750 Retainer crown - porcelain fused to high noble metal.
 - D6751 Retainer crown - porcelain fused to predominantly base metal.
 - D6752 Retainer crown - porcelain fused to noble metal.
 - D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
 - D6780 Retainer crown - 3/4 cast high noble metal.
 - D6781 Retainer crown - 3/4 cast predominantly base metal.
 - D6782 Retainer crown - 3/4 cast noble metal.
 - D6783 Retainer crown - 3/4 porcelain/ceramic.
 - D6784 Retainer crown 3/4-titanium and titanium alloys.
 - D6790 Retainer crown - full cast high noble metal.
 - D6791 Retainer crown - full cast predominantly base metal.
 - D6792 Retainer crown - full cast noble metal.
 - D6794 Retainer crown - titanium and titanium alloys.
 - D6940 Stress breaker.
- FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

TYPE 3 PROCEDURES

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

TYPE 3 PROCEDURES

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

- a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program on or after the Insured's 19th birthday.
2. for a Program begun before the Insured became covered under this section.
3. in the first 12 months that a person is insured if the person is a Late Entrant.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
- (2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan: Dental Insurance

Name, Address of Plan Sponsor: EDWARDS CHEVROLET-CADILLAC, INC.
DBA EDWARDS AUTO GROUP
927 32ND AVE
COUNCIL BLFS, IA 51501

Plan Sponsor Tax Id Number: 42-0646357

Plan Number: 501

Type of Plan: Group Insurance Plan

Name, Address, Phone Number
of Plan Administrator: RON FORTENBURY
EDWARDS CHEVROLET-CADILLAC, INC.
DBA EDWARDS AUTO GROUP
927 32ND AVE
COUNCIL BLFS, IA 51501
712-336-2541

Name, Address of Registered Agent
for Service of Legal Process: Plan Sponsor

If Legal Process Involves Claims
For Benefits Under The Group
Policy, Additional Notification of
Legal Process Must Be Sent To: Ameritas Life Insurance Corp.
P.O. Box 82595
Lincoln, NE 68501

Sources of Contributions: Employer/Member

Funding Method: Ameritas Life Insurance Corp.--Fully Insured

Plan Fiscal Year End: May 31

Type of Administration:
General Administration Plan Sponsor
Contract & Claim Administration Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-800-487-5553.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
 1. The date on which Insurance would otherwise end; and
 2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
 1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
 2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
 3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
 - a. The date of the disability determination;

- b. The date of the Qualifying Event; or
 - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
 5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
 6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA

continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and

copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

FAMILY AND MEDICAL LEAVE as Federally Mandated Family and Medical Leave

If You become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) Your coverage may be continued on the

same basis as if You were an Actively at Work employee for up to 12 weeks during the 12 month period, as defined by Us, for any of the following reasons:

- a) to care for Your child after the birth or placement of a child with You for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
- b) to care for Your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition;
- c) for Your own serious health condition: or
- d) because of a “qualifying exigency” arising out of a spouse, son, daughter, or parent on covered active duty (or has been notified of an impending call to order to covered active duty) in the Armed Forces.

In the event You or Your spouse is both covered as employees of Ours, the continued coverage may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin of a “covered service member” is entitled to up to 26 weeks of leave during a single 12 month period to care for the service member with a serious injury or illness.

Conditions

1. If, on the day Your coverage is to begin, You are already on an FMLA leave of absence You will be considered Actively at Work. Coverage for You and any eligible dependents will begin in accordance with the terms of the Plan. However, if Your leave of absence is due to Your own or any eligible dependent’s serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
 - a) You have worked for Us for at least one year;
 - b) You have worked at least 1,250 hours over the previous 12 months;
 - c) We employ at least 50 employees within 75 miles from Your worksite; and
 - d) You continue to pay any required premium for Yourself and any eligible dependents in a manner determined by Us.
3. In the event You choose not to pay any required premium during Your leave, Your coverage will not be continued during the leave. You will be able to reinstate Your coverage on the day You return to work, subject to any changes that may have occurred in the Plan during the time You were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
4. You and Your dependents are subject to all conditions and limitations of the Plan during Your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
5. If requested by Ameritas You or We must submit proof acceptable to them that Your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day Your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
 - a) the day You return to work;
 - b) the day You notify Us that You are not returning to work;
 - c) the day Your coverage would otherwise end under the Plan; or

- d) the day coverage has been continued for 12 weeks.

Definitions

Prior Group Plan means the group plan providing similar benefits (whether insured or self insured including HMO's and other prepayment plans provided by Us) in effect immediately prior to the effective date of this Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Serious Health Condition is defined as stated in the FMLA.

Us is defined as the employer.

Important Notice

Contact Us for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS as Federally Mandated

Definitions

Health Coverage means hospital, surgical, medical, dental, vision, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of open enrollments or plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Continuation of Group Health Coverage

1. For You and Your Eligible Dependents: If Health Coverage ends because of Your service in the Uniformed Services, You may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
 - a) the end of the period during which You are eligible to apply for reemployment in accordance with USERRA; or
 - b) 24 consecutive months after coverage ended.

2. To continue coverage, You or Your dependent must pay the required premium, (including Your former employer's share and any retroactive premium), unless Your service in the Uniformed Service is for fewer than 31 days, in which event You must pay Your share, if any, of the premium. The Plan Administrator will inform You or Your dependent of procedures to pay premiums.
3. End of Continuation. A Covered Person's continued Health Coverage will end at midnight on the earliest of:
 - a) the day Your former employer ceases to provide any group health plan to any employee;
 - b) the day premium is due and unpaid;
 - c) the day a Covered Person again becomes covered under the plan;
 - d) the day Health Coverage has been continued for the period of time provided in part 1.(a) or (b) above (or any longer period provided in the Plan); or
 - e) the day the plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the "When Dependents Coverage Ends" provision of the Plan.

4. Other Continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your Plan Administrator, then the premium You are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the Uniformed Services)

Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then existing health coverage provided by Us.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by Us or Your former employer, will apply.

Special Enrollment

An eligible person who has not previously enrolled for coverage may be able to enroll during a special enrollment period.

A special enrollment period of 31 days is allowed for:

- Enrollment of eligible persons due to marriage, birth, adoption or placement for adoption
- Enrollment of eligible persons not previously covered under this plan due to having had other group health plan or health insurance coverage at the time it was previously offered, and who have lost that coverage because of any of the following:
- Exhaustion of COBRA continuation coverage.

The other coverage was not COBRA coverage, and it was terminated due to a loss of eligibility, including loss due to death, divorce, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person. A loss of eligibility includes that due to moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area, or exhausting the lifetime limit on all benefits.

The other coverage was not COBRA coverage and the employer ceased to make a contribution for the coverage.

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health Plan coverage under Medicaid or SCHIP.

**CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:
Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.

- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

THIS NOTICE OF PRIVACY PRACTICES (“NOTICE”) DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary, and to make a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at www.ameritas.com and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

how we use or disclose information

We must use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

We have the right to use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers’ Compensation** as authorized by, or to the extent necessary to comply with, state workers’ compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice, and give you a copy of it.
- We will not use or share your information other than as described in this Notice, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing at the contact information below if you change your mind.

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

- **Submitting a Written Request.** If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at privacy@ameritas.com, or call 1-800-487-5553
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.