

New York
Notice of Grievance, Utilization Review, and Internal and External Appeal Procedures

Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity determination, as described later in this section. For example, Grievance applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance. You can contact Us to file a Grievance:

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

You may submit an oral Grievance in connection with a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee have up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will review it. We will make a determination and notify You within the following timeframes:

Expedited/Urgent Grievances:

By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided. No preauthorizations are required under your Policy, but You or Your Provider may request a Pre-Treatment Estimate of Benefits.)

In writing, within 15 calendar days of receipt of Your Grievance

Post-Service Grievances:

(A claim for a service or a treatment that has already been provided.)

In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for service.)

In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will review it. We will make a determination and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for Pre-treatment Estimate)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal
All Other Grievances: that are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination.

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

Utilization Review

Utilization Review

We review health services to determine whether the services are or were Medically Necessary ("Medically Necessary"). This process is called Utilization Review (UR). UR includes all review activities, whether they take place prior to the service being performed (Prospective - elective Pre-treatment Estimate of Benefits); when the service is being performed (concurrent); or after the service is performed (retrospective). However, concurrent UR is not typical. If You have any questions about the UR process, please call 877-897-4328 or the number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Providers who are in the same profession and same or similar specialty as the health care Provider who provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us or visit our website as identified on your ID card.

Prospective Pre-Treatment Benefit Review Availability

You may choose to request a review of your benefits prior to receiving treatment.

If We have all the information necessary to make a determination regarding a Pretreatment estimate of benefits, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within fifteen business days of receipt of the request.

If We need additional information, We will request it within 15 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-Treatment Benefit Estimate Reviews. No preauthorizations or pretreatment benefit reviews are required. If you choose to ask for an urgent Pre-treatment benefit review, if We have all the information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective Review of Pretreatment Reviews

We may only reverse a Pre-treatment benefit estimate upon retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Pre-treatment review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Pre-treatment review but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Pre-treatment review; and
- Had We been aware of such information, the benefit for the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Pre-treatment review.

Reconsideration

If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Pre-treatment reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Provider or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

First Level; Standard Appeal

If Your Appeal relates to a Pre-treatment review request, We will make a determination within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeals

Appeals of reviews for benefits related to matters which the Provider considers urgent and requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Second level Appeal

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.** A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made.

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where

appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

I. YOUR RIGHT TO AN EXTERNAL APPEAL

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Policy
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I above.

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external appeal in I above and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only

III. THE EXTERNAL APPEAL PROCESS

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Provider, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Provider certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Provider certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Policy.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We may charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

IV. YOUR RESPONSIBILITIES

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which

You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

COVERED SERVICES/EXCLUSIONS

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with the Notice of Internal and External Appeals Procedures in this subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of pharmacy prescriptions and eye wear. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan (not listed in the Table of Dental Procedures) may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law. Contact Your Participating Provider to confirm discounts or call our Customer Service area at 1-800-659-5556.

If you are travelling outside the United States and require emergency care for a service that would be covered under this Policy, you may contact AXA Assistance USA, Inc. for an appointment with a qualified provider. Such services would be considered as an out-of-network claim.

Pharmacy prescriptions are subject to a discount at Walmart, Sam's Club, and Walmart Neighborhood Pharmacies. Show your prescription ID card at the pharmacy counter, or call us for more information.

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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.

Benefit Class

Class Description

Class 1

All Eligible Employees

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 - Each Benefit Period	\$25

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	\$1,200
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SECTION I

Defined terms will appear capitalized throughout the Certificate or, Policy.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Dental Expense Benefits page of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate or Policy: This Certificate or Policy issued by Ameritas Life Insurance Corp. of New York, including the Schedule of Benefits and any attached riders.

Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate or Policy.

Coinsurance: Coinsurance means more than one party shares in the insurance. Sometimes it can be defined as your share of the costs of covered services. In this policy or certificate, it means Our share of the costs of a Covered Service. This may be calculated as a percent of the Allowed Amount for the service that We are required to pay to a Provider.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Deductibles and/or your share of the Provider's charges after we pay Our portion

Cover, Covered or Covered Services: The services paid for or arranged for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, an Orthodontia Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents:

- a. an Insured's spouse, including those of the same sex, as allowed by state law.
- b. each unmarried child less than 19 years of age, for whom the Insured, the Insured's spouse, including those of the same sex, as allowed by state law, is legally responsible and/or chiefly dependent upon for support and maintenance, to include:
 - i. natural born and step children;
 - ii. adopted children, eligible from the date of placement for adoption;
 - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

- iv. other children who are chiefly dependent upon the Insured, the Insured's spouse, including those of the same sex, as allowed by state law for support and maintenance.
- c. each unmarried child age 19 but less than 24 who is:
 - i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and
 - ii. primarily dependent on the Insured, the Insured's spouse, including those of the same sex, as allowed by state law for support and maintenance.
- d. each unmarried child age 19 or older who:
 - i. is Totally Disabled as defined below; and
 - ii. becomes Totally Disabled while insured as a dependent under b. or c. 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.

Emergency Condition: A medical condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Services: Dental examination and palliative treatment as are required to stabilize the patient.

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an Agreement with Us.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber and Covered Dependents for whom required Premiums have been paid.

Non-Participating Provider: A Provider who doesn't have a direct or indirect contract with Us or another network to provide services to You. You will pay more to see a Non-Participating Provider. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Us.

Participating Provider: A Provider who has a direct or indirect contract with Us or another network to provide services to You. A list of Participating Providers and their locations is available on Our website or upon Your request to Us. The list will be revised from time to time by Us. You will pay higher Cost-Sharing to see a

Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect. A 12-month calendar year.

Premium: The amount that must be paid for Your health insurance coverage.

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.

Schedule of Benefits: The section of this Certificate or Policy that describes the, Deductibles, Coinsurance, Out-of-Pocket Maximums, and other limits on Covered Services.

Service Area: The geographical area in which We provide coverage. Our Service Area consists of the entire state.

Specialist: A Provider, such as a periodontist or endodontist, who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate; Policy is issued.

TOTAL DISABILITY describes that the Insured's Dependent as:

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

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Participating Physician's office or Urgent Care Center.

Us, We, Our: Health Insurer and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate or Policy.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational

You, Your: The Member.

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 full time active employee working at least 35 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.

Retirees are excluded from the Eligible Class for Insurance.

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.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth.

A family policy covering a proposed adoptive parent on whom the child is dependent shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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 full time active employee working at least 35 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.

Retirees are excluded from 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.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, his or her spouse who had been considered a dependent but would be eligible to be a Member as explained above, will automatically be considered a Member with no waiting periods or limitations normally imposed on a late entrant.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is not 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. (Dependents Only) This policy 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 policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election 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. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

Members may change their election option only during an 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, qualification will occur on the first of the month falling on or first following the eligibility period of 90 calendar day(s) of continuous active employment.

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 90 calendar day(s) of continuous active employment.

This eligibility period will never be longer than twelve months.

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. See "Definitions."

EXTENSION OF BENEFITS. A 30-day extension of benefits will be provided for covered services if the course of treatment for such covered services began before the date of termination.

Any extension of benefits provided under the above provision will be considered in accordance with the policy provisions in effect at the time the individual's coverage terminates.

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.

Injury or Sickness **For Certain Dependents**

Coverage will continue for a Dependent student (see Definition of Dependent on 9060) for a covered Dependent student who takes a leave of absence from school due to an injury or illness for a period of twelve months from the last day of attendance in school, provided, however, that nothing in this provision shall require coverage of a dependent student beyond the age at which coverage would otherwise terminate.

Termination of Employment or Membership
Insureds and Dependents

1. Eligibility

Whenever any individual becomes ineligible for continued participation in this plan as a result of termination of employment or membership in the class or classes eligible for coverage under the policy, such employee or member shall be entitled without evidence of insurability upon application to continue benefits under this policy for himself or herself and his or her eligible dependents, subject to the group policy's terms and conditions and the conditions listed below.

This provision is not applicable where a continuation benefit is available to the employee or member pursuant to Chapter 18 of the Employment Retirement Income Security Act, 29 U.S.C. s 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. s300bb-1 et seq.

Continuation shall not be available for: (A) any person who is covered, becomes covered or could be covered under Title XVIII of the United States Social Security Act (Medicare) as amended or superseded; or (B) an employee, member or dependent by any other insured or uninsured arrangement which provides similar coverages for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent.

Please contact the person who handles the policyholders insurance matters to see if these provisions are available to you.

2. Extension Period

The extension period is:

- a. 18 months after the date the employee's or member's benefits under the policy would otherwise have terminated because of termination of employment or membership; or
- b. The end of the period for which premium payments were made, if the employee or member fails to make timely payment of a required premium payment; or
- c. In the case of an eligible dependent of an employee or member, the date thirty-six months after the date such person's benefits under the policy would otherwise have terminated by reason of:
 - i. the death of the employee or member;
 - ii. the divorce or legal separation of the employee or member from his or her spouse;
 - iii. the employee or member becoming entitled to benefits under Title XVIII of the United States Social Security Act (Medicare); or
 - iv. a dependent child ceasing to be a dependent child as defined under the terms of the policy; or
- d. 29 months in the case of an individual who is determined, under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date such individual becomes ineligible for continued participation in this plan; or
- e. The date on which the group policy is terminated or, in the case of an employee, the date his

employer terminates participation under the group policy. However, if this clause applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

- i. The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with this paragraph had a termination described in this paragraph had not occurred, and
- ii. The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy, and
- iii. The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.

3. Requesting Coverage

An employer or member who wishes continuation of coverage must request such continuation in writing, along with the required first premium payment, to the policyholder or employer within the sixty day period following the later of:

- a. The date of such termination; or
- b. The date the employee is sent notice by first class mail of the right to continuation by either his employer or the group policyholder; or
- c. In the case of eligibility for continuation as a result of disability as defined under Title II or XVI of the Social Security Act (see 2.d. above), an employee or member must give notice to the employer or policyholder within sixty days of the days of the determination under these Acts.

4. Premiums

An employee or member electing continuation must pay the group policyholder or his employer, but not more than frequently than on a monthly basis in advance, the amount of the required premium payment, which will not exceed 102% of the group rate for the benefits being continued under the group policy on the due date of each payment.

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 Maximum Covered Expense as covered under your plan.

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.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

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 prosthetic crown, appliance, or fixed partial denture. 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 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.

unless such appliance, restoration or procedure is considered medically necessary.

3. 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.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes except that treatment for cosmetic purposes shall not include any services incidental to or following surgery resulting from trauma, infection or other diseases of the involved part, and treatment necessary due to congenital disease or anomaly.
6. 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.)
7. 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).
8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law.
9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

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 prosthetic crown, appliance, or fixed partial denture 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.
- B/R means By Report.
- 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 - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$19.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$14.00
D0150 Comprehensive oral evaluation - new or established patient.	\$29.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$29.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none"> Coverage is limited to 1 of each of these procedures per 1 provider. In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 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	
<ul style="list-style-type: none"> Coverage is limited to 2 of any of these procedures per 1 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 - complete series of radiographic images.	\$60.00
D0330 Panoramic radiographic image.	\$49.00
COMPLETE SERIES/PANORAMIC: D0210, D0330	
<ul style="list-style-type: none"> Coverage is limited to 1 of any of these procedures per 3 year(s). 	
OTHER XRAYs	
D0220 Intraoral - periapical first radiographic image.	\$11.00
D0230 Intraoral - periapical each additional radiographic image.	\$9.00
D0240 Intraoral - occlusal radiographic image.	\$15.00
D0250 Extraoral - first radiographic image.	\$20.00
D0260 Extraoral - each additional radiographic image.	\$15.00
PERIAPICAL: D0220, D0230	
<ul style="list-style-type: none"> 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.	\$9.00
D0272 Bitewings - two radiographic images.	\$17.00
D0273 Bitewings - three radiographic images.	\$20.00
D0274 Bitewings - four radiographic images.	\$26.00
D0277 Vertical bitewings - 7 to 8 radiographic images.	\$40.00
BITEWINGS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none"> Coverage is limited to 2 of any of these procedures per 1 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	
<ul style="list-style-type: none"> Coverage is limited to 1 of any of these procedures per 3 year(s). 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.	\$40.00
D1120 Prophylaxis - child.	\$28.00

TYPE 1 PROCEDURES

Maximum Covered
Expense

D1206	Topical application of fluoride varnish.	\$15.00
D1208	Topical application of fluoride-excluding varnish.	\$15.00
D9931	Cleaning and inspection of a removable appliance.	\$40.00

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120, D9931

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- 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.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	\$141.00
D1515	Space maintainer - fixed - bilateral.	\$231.00
D1520	Space maintainer - removable - unilateral.	\$221.00
D1525	Space maintainer - removable - bilateral.	\$270.00
D1550	Re-cement or re-bond space maintainer.	\$29.00
D1555	Removal of fixed space maintainer.	\$40.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	\$213.00
D8220	Fixed appliance therapy.	\$213.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$18.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$18.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> 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.	\$21.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$42.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$42.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> Coverage is limited to 1 of any of these procedures per 12 month(s). Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$13.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$14.00
D1353 Sealant repair - per tooth.	\$13.00
SEALANT: D1351, D1352, D1353	
<ul style="list-style-type: none"> Coverage is limited to 1 of any of these procedures per 3 year(s). Benefits are considered for persons age 16 and under. Benefits are considered on permanent molars only. Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$30.00
D2150 Amalgam - two surfaces, primary or permanent.	\$38.00
D2160 Amalgam - three surfaces, primary or permanent.	\$46.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$55.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> 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.	\$37.00
D2331 Resin-based composite - two surfaces, anterior.	\$46.00
D2332 Resin-based composite - three surfaces, anterior.	\$58.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$64.00
D2391 Resin-based composite - one surface, posterior.	\$40.00
D2392 Resin-based composite - two surfaces, posterior.	\$51.00
D2393 Resin-based composite - three surfaces, posterior.	\$64.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$70.00
D2410 Gold foil - one surface.	\$30.00
D2420 Gold foil - two surfaces.	\$38.00
D2430 Gold foil - three surfaces.	\$46.00
D2990 Resin infiltration of incipient smooth surface lesions.	\$37.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$78.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	\$72.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$65.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$69.00
D2932	Prefabricated resin crown.	\$78.00
D2933	Prefabricated stainless steel crown with resin window.	\$78.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$78.00

STAINLESS STEEL CROWN: D2390, 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.	\$24.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	\$12.00
D2920	Re-cement or re-bond crown.	\$24.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	\$58.00
D6092	Re-cement or re-bond implant/abutment supported crown.	\$24.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	\$24.00
D6930	Re-cement or re-bond fixed partial denture.	\$33.00

SEDATIVE FILLING

D2940	Protective restoration.	\$22.00
D2941	Interim therapeutic restoration - primary dentition.	\$17.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$41.00
D3221	Pulpal debridement, primary and permanent teeth.	\$41.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$61.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$54.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$47.00
D3333	Internal root repair of perforation defects.	\$67.00
D3351	Apexification/recalcification - initial visit (apical closure/calccific repair of perforations, root resorption, etc.).	\$67.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calccific repair of perforations, root resorption, pulp space disinfection, etc.).	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calccific repair of perforations, root resorption, etc.).	\$132.00
D3357	Pulpal regeneration - completion of treatment.	\$132.00
D3430	Retrograde filling - per root.	\$52.00
D3450	Root amputation - per root.	\$124.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$105.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$185.00
D3320	Endodontic therapy, bicuspid tooth.	\$218.00
D3330	Endodontic therapy, molar.	\$286.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$109.00

TYPE 2 PROCEDURES

Maximum Covered
Expense

D3346	Retreatment of previous root canal therapy - anterior.	\$231.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$266.00
D3348	Retreatment of previous root canal therapy - molar.	\$330.00

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.	\$67.00
D3356	Pulpal regeneration - interim medication replacement.	\$45.00
D3410	Apicoectomy - anterior.	\$191.00
D3421	Apicoectomy - bicuspid (first root).	\$220.00
D3425	Apicoectomy - molar (first root).	\$238.00
D3426	Apicoectomy (each additional root).	\$85.00
D3427	Periradicular surgery without apicoectomy.	\$172.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$121.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$61.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$166.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$83.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$304.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$152.00
D4263	Bone replacement graft - first site in quadrant.	\$99.00
D4264	Bone replacement graft - each additional site in quadrant.	\$75.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$50.00
D4270	Pedicle soft tissue graft procedure.	\$224.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$276.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$133.00
D4275	Soft tissue allograft.	\$237.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$276.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft.	\$238.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site.	\$95.00

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.

TYPE 2 PROCEDURES

Maximum Covered
Expense

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

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$62.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$31.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$46.00

CHEMOTHERAPEUTIC 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 comprehensive evaluation and diagnosis.	\$37.00
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FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$38.00
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PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$38.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$32.00
D5610	Repair resin denture base.	\$38.00
D5620	Repair cast framework.	\$45.00
D5630	Repair or replace broken clasp.	\$47.00
D5640	Replace broken teeth - per tooth.	\$34.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$70.00
D5731	Reline complete mandibular denture (chairside).	\$70.00
D5740	Reline maxillary partial denture (chairside).	\$63.00
D5741	Reline mandibular partial denture (chairside).	\$63.00
D5750	Reline complete maxillary denture (laboratory).	\$104.00
D5751	Reline complete mandibular denture (laboratory).	\$102.00
D5760	Reline maxillary partial denture (laboratory).	\$104.00
D5761	Reline mandibular partial denture (laboratory).	\$105.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$34.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$34.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	\$65.00
D7220	Removal of impacted tooth - soft tissue.	\$81.00
D7230	Removal of impacted tooth - partially bony.	\$107.00
D7240	Removal of impacted tooth - completely bony.	\$125.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	\$143.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$67.00
D7251 Coronectomy-intentional partial tooth removal.	\$125.00
OTHER ORAL SURGERY	
D7260 Oroantral fistula closure.	\$158.00
D7261 Primary closure of a sinus perforation.	\$158.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$96.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$96.00
D7280 Surgical access of an unerupted tooth.	\$148.00
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.	\$107.00
D7283 Placement of device to facilitate eruption of impacted tooth.	\$45.00
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$56.00
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$28.00
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$71.00
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$36.00
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).	\$102.00
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$254.00
D7410 Excision of benign lesion up to 1.25 cm.	\$101.00
D7411 Excision of benign lesion greater than 1.25 cm.	\$130.00
D7412 Excision of benign lesion, complicated.	\$143.00
D7413 Excision of malignant lesion up to 1.25 cm.	\$137.00
D7414 Excision of malignant lesion greater than 1.25 cm.	\$100.00
D7415 Excision of malignant lesion, complicated.	\$110.00
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$137.00
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$100.00
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$101.00
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$130.00
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$101.00
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$130.00
D7465 Destruction of lesion(s) by physical or chemical method, by report.	\$31.00
D7471 Removal of lateral exostosis (maxilla or mandible).	\$90.00
D7472 Removal of torus palatinus.	\$90.00
D7473 Removal of torus mandibularis.	\$90.00
D7485 Surgical reduction of osseous tuberosity.	\$147.00
D7490 Radical resection of maxilla or mandible.	\$137.00
D7510 Incision and drainage of abscess - intraoral soft tissue.	\$45.00
D7520 Incision and drainage of abscess - extraoral soft tissue.	\$52.00
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$42.00
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.	\$114.00
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$114.00
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$150.00
D7910 Suture of recent small wounds up to 5 cm.	\$20.00
D7911 Complicated suture - up to 5 cm.	\$23.00
D7912 Complicated suture - greater than 5 cm.	\$33.00
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$109.00
D7963 Frenuloplasty.	\$136.00
D7970 Excision of hyperplastic tissue - per arch.	\$84.00
D7972 Surgical reduction of fibrous tuberosity.	\$133.00
D7980 Sialolithotomy.	\$125.00
D7983 Closure of salivary fistula.	\$40.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

TYPE 2 PROCEDURES

Maximum Covered
Expense

D7285	Incisional biopsy of oral tissue - hard (bone, tooth).	\$136.00
D7286	Incisional biopsy of oral tissue - soft.	\$73.00
D7287	Exfoliative cytological sample collection.	\$37.00
D7288	Brush biopsy - transepithelial sample collection.	\$37.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$25.00
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PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	\$96.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	\$32.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes.	\$64.00
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes.	\$16.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$26.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$18.00
D9440	Office visit - after regularly scheduled hours.	\$31.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$19.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 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.	\$24.00
D9952	Occlusal adjustment - complete.	\$121.00

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.	\$21.00
D2951	Pin retention - per tooth, in addition to restoration.	\$12.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$37.00

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 - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
INLAY RESTORATIONS	
D2510 Inlay - metallic - one surface.	\$191.00
D2520 Inlay - metallic - two surfaces.	\$227.00
D2530 Inlay - metallic - three or more surfaces.	\$244.00
D2610 Inlay - porcelain/ceramic - one surface.	\$210.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$229.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$250.00
D2650 Inlay - resin-based composite - one surface.	\$218.00
D2651 Inlay - resin-based composite - two surfaces.	\$215.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$223.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> 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.	\$247.00
D2543 Onlay - metallic - three surfaces.	\$276.00
D2544 Onlay - metallic - four or more surfaces.	\$287.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$247.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$277.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$285.00
D2662 Onlay - resin-based composite - two surfaces.	\$232.00
D2663 Onlay - resin-based composite - three surfaces.	\$239.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$254.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> 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, 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, D6780, D6781, D6782, D6783, 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, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$108.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$268.00
D2720 Crown - resin with high noble metal.	\$276.00
D2721 Crown - resin with predominantly base metal.	\$210.00
D2722 Crown - resin with noble metal.	\$258.00
D2740 Crown - porcelain/ceramic substrate.	\$298.00
D2750 Crown - porcelain fused to high noble metal.	\$289.00
D2751 Crown - porcelain fused to predominantly base metal.	\$248.00
D2752 Crown - porcelain fused to noble metal.	\$266.00
D2780 Crown - 3/4 cast high noble metal.	\$275.00
D2781 Crown - 3/4 cast predominantly base metal.	\$239.00
D2782 Crown - 3/4 cast noble metal.	\$250.00

TYPE 3 PROCEDURES

Maximum Covered
Expense

D2783	Crown - 3/4 porcelain/ceramic.	\$298.00
D2790	Crown - full cast high noble metal.	\$275.00
D2791	Crown - full cast predominantly base metal.	\$239.00
D2792	Crown - full cast noble metal.	\$250.00
D2794	Crown - titanium.	\$275.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, 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, D6780, D6781, D6782, D6783, 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, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	\$60.00
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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.	\$95.00
D2954	Prefabricated post and core in addition to crown.	\$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	\$48.00
D2981	Inlay repair necessitated by restorative material failure.	\$38.00
D2982	Onlay repair necessitated by restorative material failure.	\$38.00
D2983	Veneer repair necessitated by restorative material failure.	\$38.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	\$54.00
D9120	Fixed partial denture sectioning.	\$54.00

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	\$171.00
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PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	\$308.00
D5120	Complete denture - mandibular.	\$299.00
D5130	Immediate denture - maxillary.	\$334.00
D5140	Immediate denture - mandibular.	\$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$257.00
D5810	Interim complete denture (maxillary).	\$136.00
D5811	Interim complete denture (mandibular).	\$143.00

TYPE 3 PROCEDURES

Maximum Covered
Expense

D5820	Interim partial denture (maxillary).	\$120.00
D5821	Interim partial denture (mandibular).	\$126.00
D5863	Overdenture - complete maxillary.	\$308.00
D5864	Overdenture - partial maxillary.	\$357.00
D5865	Overdenture - complete mandibular.	\$308.00
D5866	Overdenture - partial mandibular.	\$357.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary.	\$308.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular.	\$308.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary.	\$357.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular.	\$357.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary.	\$308.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular.	\$308.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	\$357.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	\$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, 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.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, 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.	\$17.00
D5411	Adjust complete denture - mandibular.	\$16.00
D5421	Adjust partial denture - maxillary.	\$18.00
D5422	Adjust partial denture - mandibular.	\$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	\$40.00
D5660	Add clasp to existing partial denture.	\$46.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	\$112.00
D5711	Rebase complete mandibular denture.	\$119.00
D5720	Rebase maxillary partial denture.	\$107.00
D5721	Rebase mandibular partial denture.	\$113.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	\$31.00
D5851	Tissue conditioning, mandibular.	\$34.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	\$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	\$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	\$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	\$257.00
D6062	Abutment supported cast metal crown (high noble metal).	\$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	\$280.00
D6064	Abutment supported cast metal crown (noble metal).	\$304.00
D6065	Implant supported porcelain/ceramic crown.	\$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$280.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$280.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$257.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$280.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$280.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$257.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$280.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$280.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$304.00
D6075 Implant supported retainer for ceramic FPD.	\$257.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$280.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$280.00
D6094 Abutment supported crown - (titanium).	\$280.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$280.00
D6205 Pontic - indirect resin based composite.	\$231.00
D6210 Pontic - cast high noble metal.	\$280.00
D6211 Pontic - cast predominantly base metal.	\$280.00
D6212 Pontic - cast noble metal.	\$304.00
D6214 Pontic - titanium.	\$280.00
D6240 Pontic - porcelain fused to high noble metal.	\$280.00
D6241 Pontic - porcelain fused to predominantly base metal.	\$280.00
D6242 Pontic - porcelain fused to noble metal.	\$257.00
D6245 Pontic - porcelain/ceramic.	\$257.00
D6250 Pontic - resin with high noble metal.	\$280.00
D6251 Pontic - resin with predominantly base metal.	\$257.00
D6252 Pontic - resin with noble metal.	\$304.00
D6545 Retainer - cast metal for resin bonded fixed prosthesis.	\$93.00
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$93.00
D6549 Resin retainer - for resin bonded fixed prosthesis.	\$93.00
D6600 Inlay - porcelain/ceramic, two surfaces.	\$229.00
D6601 Inlay - porcelain/ceramic, three or more surfaces.	\$251.00
D6602 Inlay - cast high noble metal, two surfaces.	\$206.00
D6603 Inlay - cast high noble metal, three or more surfaces.	\$226.00
D6604 Inlay - cast predominantly base metal, two surfaces.	\$178.00
D6605 Inlay - cast predominantly base metal, three or more surfaces.	\$195.00
D6606 Inlay - cast noble metal, two surfaces.	\$187.00
D6607 Inlay - cast noble metal, three or more surfaces.	\$206.00
D6608 Onlay - porcelain/ceramic, two surfaces.	\$247.00
D6609 Onlay - porcelain/ceramic, three or more surfaces.	\$272.00
D6610 Onlay - cast high noble metal, two surfaces.	\$226.00
D6611 Onlay - cast high noble metal, three or more surfaces.	\$249.00
D6612 Onlay - cast predominantly base metal, two surfaces.	\$195.00
D6613 Onlay - cast predominantly base metal, three or more surfaces.	\$215.00
D6614 Onlay - cast noble metal, two surfaces.	\$206.00
D6615 Onlay - cast noble metal, three or more surfaces.	\$226.00
D6624 Inlay - titanium.	\$226.00
D6634 Onlay - titanium.	\$249.00
D6710 Crown - indirect resin based composite.	\$231.00
D6720 Crown - resin with high noble metal.	\$280.00
D6721 Crown - resin with predominantly base metal.	\$145.00
D6722 Crown - resin with noble metal.	\$234.00
D6740 Crown - porcelain/ceramic.	\$257.00
D6750 Crown - porcelain fused to high noble metal.	\$304.00
D6751 Crown - porcelain fused to predominantly base metal.	\$280.00
D6752 Crown - porcelain fused to noble metal.	\$257.00
D6780 Crown - 3/4 cast high noble metal.	\$304.00
D6781 Crown - 3/4 cast predominantly base metal.	\$280.00
D6782 Crown - 3/4 cast noble metal.	\$257.00
D6783 Crown - 3/4 porcelain/ceramic.	\$257.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6790 Crown - full cast high noble metal.	\$280.00
D6791 Crown - full cast predominantly base metal.	\$280.00
D6792 Crown - full cast noble metal.	\$257.00
D6794 Crown - titanium.	\$280.00
D6940 Stress breaker.	\$78.00
FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794	
<ul style="list-style-type: none"> • 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, 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. • Benefits will not be considered if procedure D2390, 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	
<ul style="list-style-type: none"> • 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, 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, D6780, D6781, D6782, D6783, 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. • Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634	
<ul style="list-style-type: none"> • 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, 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, D6780, D6781, D6782, D6783, 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. • Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, 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. 	

TYPE 3 PROCEDURES

Maximum Covered
Expense

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, 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.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverages under more than one Plan. "Plan" is defined below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expenses.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims that have been submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" means the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental treatment:
 - a. Any group insurance and group remittance subscriber contracts.
 - b. Uninsured arrangements of group coverage.
 - c. Group coverage through HMO's and other prepayment, group practice and individual practice plans.
 - d. Blanket coverages except as stated in paragraph (2b) below.
 - e. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.
 - f. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
2. "Plan" does **not** include the following:
 - a. Individual or family benefits provided through insurance contracts, direct payment subscriber contracts, coverage through HMO's or other prepayment arrangements, group practice and individual practice plans.
 - b. Blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.
3. "Allowable Expense" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had claim been made for them.
4. "Claim Determination Period" is the Benefit Period, over which allowable expenses are compared with total benefits payable in the absence of Coordination of Benefits, to determine:

- a. whether over insurance exists; and
- b. how much each plan will pay or provide.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
 - a. The benefits of a Plan which covers a person as an employee, member or subscriber are determined before those of a Plan which covers the person as a dependent.
 - b. When a Plan and another Plan cover the same child as a dependent of different persons, called parents, the benefits of the Plan of the parent whose birthday (month and day in a calendar year) falls earlier in a year are determined before those of a plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the Plan that covered either of the parents longer is primary.
 - c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
 - the Plan of the parent with custody of the child;
 - the Plan of the spouse of the parent with custody of the child;
 - the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree establish a parent's responsibility for the child's dental treatment and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

- d. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- e. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and
2. Obtain from any other insurance company, organization or person any information with respect to your

coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments which should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION XIII General Provisions

Agreements between Us and Participating Providers. Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider

1. **Assignment.** You cannot assign any benefits or monies due under this Certificate or Policy to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Policy or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.
2. **Changes in This Certificate or; Policy.** We may unilaterally change this Certificate; or Policy upon renewal, if We give the Group Policyholder 45 days' prior written notice.
3. **Choice of Law.** This Certificate or Policy shall be governed by the laws of the State of New York.
4. **Clerical Error.** Clerical error, whether by the Group Policyholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
5. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate or Policy may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.
6. **Enrollment ERISA.** The Group Policyholder will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all group members covered under this Certificate or Policy, and any other information required to confirm their eligibility for coverage. The Group Policyholder will provide Us with this information upon request.

The Group Policyholder may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The "plan administrator" is the Group Policyholder, or a third party appointed by the Group Policyholder. We are not the ERISA plan administrator.
7. **Entire Agreement.** This Certificate or Policy, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.
8. **Furnishing Information and Audit.** The Group Policyholder and all persons covered under this Certificate or Policy will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Provider; or to make decisions regarding the Medical Necessity of Your care. The Group Policyholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the Group Policyholder's New York office.
9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate or Policy. To be entitled

to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

10. **Incontestability.** No statement made by You will be the basis for voiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

No statement by You in an application for coverage under this Policy shall void the Policy or be used in any legal proceeding unless the application is or an exact copy is attached to this Policy.

11. **Independent Contractors.** Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

12. **Material Accessibility.** We will give the Group Policyholder, and the Group Policyholder will give You, identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate or Policy. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Certificate or Policy will be mailed to Your address as it appears on our records or to the address of the Group Policyholder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Ameritas Life Insurance Corp. of New York, 1350 Broadway, Suite 2201, New York, NY, 10018.

15. **Premium Payment.** The initial premium is payable one month in advance by You to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.

16. **Premium Refund.** We will give any refund of Premiums, if due, to the Group Policyholder.

17. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months

after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

18. **Renewal Date.** The renewal date for the Certificate or Policy is January 1, the anniversary of the effective date of the Group Policy each Year. This Certificate or Policy will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group Policyholder as permitted by the Certificate or Policy, or by You upon 30 days' prior written notice to the Group Policyholder.
19. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Certificate or Policy. An Example of the use of the standards are To determine whether payment will be made under the Alternative Benefit provision. Those standards will not be contrary to the descriptions in this Certificate or Policy. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate or Policy.
20. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.
21. **Severability.** The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate or Policy.
22. **Significant Change in Circumstances.** If We are unable to arrange for Covered Services as provided under this Certificate or Policy as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.
23. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness, or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate or Policy. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages

or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

24. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate or Policy. You must start any lawsuit against Us under this Certificate or Policy within 2 years from the date the claim was required to be filed.
25. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact us at 877-233-3797 to access these services.
26. **Venue for Legal Action.** If a dispute arises under this Certificate or Policy, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.
27. **Waiver.** The waiver by any party of any breach of any provision of the Certificate or Policy will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
28. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate or Policy in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.
29. **Who Receives Payment under This Certificate.** Payments under this Certificate or Policy for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.
30. **Workers' Compensation Not Affected.** The coverage provided under this Certificate or Policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
31. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate or Policy, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate or Policy, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
 - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
 - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and

- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate or Policy, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. 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 the new Notice effective for all personal health information maintained by us.

Ameritas Privacy Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

YOUR RIGHTS YOU HAVE THE RIGHT TO:

Get a copy of your claims records

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days

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. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect payment for your care.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask 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.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can 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.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends.**
At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation.**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways— usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Address workers’ compensation, law enforcement, and other government requests – We can share health information about you:

- For workers’ compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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 here 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 if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

