Ameritas

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL, EYE AND HEARING DIAGNOSIS / AID INSURANCE CERTIFICATE

The Policyholder **BANKERS LIFE NEBRASKA PREFERRED TRUSTS**
CHOICE ADMINISTRATORS

Employer Unit

Insured Person

Certificate Effective Date
Refer to Exceptions on 9070.

Plan 4000

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

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

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

The laws of the state in which the group policy was delivered govern the group policy and this certificate.

Corporate Secretary

President

CALIFORNIA - IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, including your ability to access dental services in a timely manner, please contact your agent or feel free to contact us at the following:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1-877-897-4328 (Toll-Free)

APPEAL PROCEDURE

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

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

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

We will review your claim promptly after we receive your request. If additional information is needed we will only request what is reasonably necessary to handle the claim. A written decision based on the facts as known by us will be provided within fifteen (15) calendar days after receipt of your request.

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

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

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

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

CALIFORNIA
CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA)

NOTICE: These provisions are only applicable to certain plans as defined under the Act. Not all employers or groups are subject to this law. For further details to determine if this continuation coverage is available, please contact the person who handles the Policyholder's insurance matters.

The California Continuation Benefits Replacement Act (Cal-COBRA) signed into law effective January 1, 1998 requires that any **employer** meeting the definition under the Act allow a **qualified beneficiary** to continue group health coverage, including dental and vision care coverages after it would otherwise end, as a result of a **qualifying event**. Continuation coverage will be provided under the plan with the same terms and conditions that apply to similarly situated individuals.

A. DEFINITIONS

EMPLOYER means any employer that:

1. meets the definition of "small employer" as set forth in California;

2. employed 2-19 eligible employees on at least 50 percent of its working days during the preceding calendar year or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter; and

3. is not subject to Section 4980B of the United States Internal Revenue Code (Federal COBRA) or Chapter 18 of the Employee Retirement Income Security Act.

QUALIFIED BENEFICIARY means any individual who, on the day before the qualifying event, is an insured under a group benefit plan. An individual will not be considered to be a qualified beneficiary if:

1. The individual is entitled or becomes entitled to Medicare benefits. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

2. The individual is covered or becomes covered under another group benefit plan which does not impose any exclusion or limitation with respect to any preexisting condition.

3. The individual is covered, becomes covered or is eligible to coverage under Federal COBRA, Chapter 18 of the Employee Retirement Income Security Act, or Chapter 6A of the Public Health Service Act.

4. The qualified beneficiary fails to meet the notification requirements as stated within the Enrollment provision below.

5. The qualified beneficiary fails to submit the correct premium amount for continuation of coverage, or fails to satisfy other terms and conditions of the plan contract.

QUALIFYING EVENT means any of the following events that, but for the election of continuation of coverage under this provision, would result in a loss of coverage for the qualified beneficiary under the group benefit plan:

1. The death of the covered employee.

2. The termination of employment or reduction of hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

3. The divorce or legal separation of the covered employee from the covered employee's spouse.

4. The loss of dependent status by a dependent enrolled in the group benefit plan.

5. With respect to a covered dependent only, the covered employee's entitlement of benefits under Medicare (Title XVIII of the United States Social Security Act).

B. ENROLLMENT

NOTICE REQUIREMENTS. The qualified beneficiary must request the continuation of coverage in writing and deliver such notice, by first-class mail, or other reliable means of delivery, to the health services plan (or to the employer if the employer has contracted with the insurer to perform the administrative services under Cal-COBRA) within the 60-day period following the later of:

1. the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event;

2. the date the enrollee was sent notice of the ability to continue coverage.

PREMIUM PAYMENTS. The first premium payment must be delivered by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail, or private courier company to the health services plan (or the employer if the employer has contracted with the plan to perform the administrative services under Cal-COBRA) in accordance with the following terms and conditions:

1. the first premium must be delivered within 45 days of the date of the qualified beneficiary provided written notice to the health services plan; and

2. the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due.

Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage.

MONTHLY COST. The premium will be due monthly and will not be more than 110% of the applicable rate charged for a similarly situated individual under the group benefit plan.

C. CONTINUATION PERIOD

Continuation coverage shall terminate for those qualified beneficiaries at the first to occur of the following:

1. For those who are eligible for continuation coverage as a result of a termination of employment or reduction in work hours, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

2. For those who are eligible for continuation coverage as a result of: (a) the death of an employee, (b) a loss of dependent status, (c) divorce or legal separation, or (d) the employee's eligibility for Medicare (for dependent coverage), the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

3. For those qualified beneficiaries who are eligible for continuation coverage and are determined to be disabled by the Social Security Administration at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event. The qualified beneficiary must notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage based on this criteria.

4. For those who fail to make premium payments, at the end of the period for which premium payments were made.

5. In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage as a result of termination of employment or reduction of hours, as defined within paragraph (2) of "Qualifying Event", but who has another qualifying event as described in paragraphs (1), (3), (4) or (5) of "Qualifying Event", within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide the administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

6. The employer, or any successor employer ceases to provide any group benefit plan to his or her employees. See Additional Provisions below.

7. The qualified beneficiary moves out of the insurer's service area or the qualified beneficiary commits fraud or deception in the use of the insurer's services.

An individual who becomes a qualified beneficiary shall continue to receive coverage until continuation coverage is terminated at the qualified beneficiary's election or the period of time provided for continuation coverage as defined in Section C. Continuation Period, whichever comes first, even if the employer that sponsored the group benefit plan subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

D. ADDITIONAL PROVISIONS

CHANGE IN GROUP BENEFIT PLANS. If the continuation coverage would terminate prior to the end of the period the qualified beneficiary would have remained covered as a result of a termination of an agreement between the group benefit plan and the employer, and a new group benefit plan is available for active employees, then the qualified beneficiary may continue coverage based on the following terms and conditions:

1. the coverage will continue for the balance of the period that the qualified beneficiary would have remained covered under the prior plan;

2. notice must be provided to the new group benefit plan within 30 days after receiving notice of the termination of the prior plan;

3. any requirements for enrollment in, and payment to, the new group benefit plan must be met.

Coverage will terminate if the qualified beneficiary fails to comply with paragraphs (2) or (3) above.

NEWBORN OR ADOPTED CHILDREN. Any child who is born to or is placed for adoption with a former employee who is a qualified beneficiary during the period of continuation coverage, shall be considered a qualified beneficiary and entitled to receive coverage benefits as well for the remainder of

the period that the former employee is covered under the plan. Notice must be provided within 30 days of the child's birth or placement of adoption.

For purposes of this section:

"COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and as amended.

"Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

Thank you for choosing Ameritas Group for your dental care coverage. As a member, you always have complete freedom of choice in choosing your dental provider; however, by choosing a PPO network provider, you may reduce your out-of-pocket expenses due to the discounted fees on covered dental procedures.

Please read the following information so you will know from whom or what group of providers dental care may be obtained.

For the most current and complete provider listing and information, please visit the ***Plan Member*** section of our website, **www.ameritas.com** and click on the ***Find a Provider*** tab. Additional information available online includes driving directions to the provider's office and how to nominate a dentist or specialist for our network.

If you do not have access to the Internet and are in need of dental participating provider information, contact our provider relations department at 1-800-755-8844.

For questions regarding your dental benefit coverage, contact our customer relations department at 1-800-487-5553 Monday-Thursday, 7:00am - midnight and Friday, 7:00am - 6:30 pm Central Time.

When scheduling your appointment, please verify the provider is an active network participant.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم **877-233-3797**. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ **877-233-3797** համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 **877-233-3797** 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis **877-233-3797**. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または **877-233-3797** までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ **877-233-3797** ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: **877-233-3797** 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویند مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره **877-233-3797** تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ **877-233-3797** 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или **877-233-3797**. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al **877-233-3797**. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa **877-233-3797**. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc **877-233-3797**. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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AMENDMENT RIDER

If your group qualified for takeover benefits the following would be applicable:

To be attached to and made a part of your Certificate of Insurance.

Issued to Choice Administrators.

It is hereby agreed that this certificate is amended as follows:

1) The paragraph in the section entitled Deductible Amount on the 9040, SCHEDULE OF BENEFITS is added:

Dental expenses incurred by an individual on or after January 1, of the first year of the Plan Effective Date, but before the Plan Effective Date, will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to the Plan Effective Date; and

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

2) Limitation #3 in the section entitled LIMITATIONS on the 9219, DENTAL EXPENSE BENEFITS is deleted and the following is substituted:

3. a. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth, unless the insured person is covered on the Plan Effective Date. For those Insureds covered on the Plan Effective Date, see b.

b. Limitation a. will be waived for those Insureds whose coverage was effective on the Plan Effective Date and

i. the person has the tooth extracted while insured under the prior contract: and

ii. has a prosthetic crown, appliance, or fixed partial denture installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a six-month period; and

iii. the prosthetic crown, appliance, or fixed partial denture noted above must be an initial placement.

3) The following paragraph is hereby added to the section entitled ORTHODONTIC EXPENSE BENEFITS (if Applicable) on the 9040, SCHEDULE OF BENEFITS:

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on the Plan Effective Date, and

b. on the Plan Effective Date is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Rider is effective the Plan Effective Date.

Ameritas Life Insurance Corp.

William W Lester
President

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

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-487-5553 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

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:

When a Participating Provider is used:	
Type 1 Procedures	$0
Combined Type 2, Type 3 and Type 4 Procedures - Each Benefit Period	$25
When a Non-Participating Provider is used:	
Combined Type 1, Type 2, and Type 3 Procedures - Each Benefit Period	$75
Maximum Deductible per Benefit Period	$75

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required.

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	100%	80%
Type 2 Procedures:		
Step 1	80%	80%
Step 2	90%	80%
Step 3	100%	80%

Step 1 applies during the first Benefit Period the person becomes insured.

If the person visits a dentist during each Benefit Period and submits a claim, Step 2 will apply during the second Benefit Period, and Step 3 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist and submit a claim, Step 1 will apply during the following Benefit Period. If any person that has dropped back visits a dentist during subsequent Benefit Periods and submits a claim, the next highest Step will apply during the next Benefit Period.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will apply for the balance of that Benefit Period and the person must advance to Steps 2 and 3.

Type 3 Procedures	50%	50%
Type 4 Procedures	80%	N/A

When a Non-Participating Provider is used:	
Maximum Amount - Each Benefit Period	$1,100*
When a Participating Provider is used:	
Maximum Amount - Each Benefit Period	$1,300*

Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

Benefits for Dental Emergencies: If you are in need of emergency dental services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

EYE CARE EXPENSE BENEFITS

Deductible Amount:	$0
Maximum Amount - Each Benefit Period	$100*

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

HEARING DIAGNOSIS / AID BENEFITS

Deductible Amount:	$0
Coinsurance Percentage:	
Exams	100%***
Hearing Aids	50%
Hearing Aid Maintenance	100%***

***refer to 9290 SCHEDULE OF HEARING DIAGNOSIS / AID BENEFITS regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):	
1st 12 month Period	$100
2nd 12 month Period	$300
3rd 12 month Period or thereafter	$400

The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing diagnosis / aid benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured’s initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

COMBINED EXPENSE BENEFITS

*Combined Dental and Eye Care Maximum - Each Benefit Period	$1,300

The maximums listed with the (*) above are subject to the maximum amount listed here.

INCREASED DENTAL MAXIMUM BENEFIT

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

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

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

a) The insured person has submitted a claim for dental expenses incurred during the preceding Benefit Period, and

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding Benefit Period were expenses resulting from services rendered by a Participating Provider, and

c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount or PPO Bonus for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

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

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

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-96000-9999 issued to CALIFORNIA CHOICE and each Certificate of Insurance issued under such policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable for Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$175 per eye	$175 per eye	$350 per eye	$350 per eye

Exclusions and Limitations

No benefit will be payable for any HCPCS Level II codes not listed in the definition of Covered Procedures.

No benefit will be payable for any Insured under the age of 18.

No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.

Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800:	Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.
S0810:	Photorefractive Keratectomy (PRK)

Benefit Period. 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. During the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of the same year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on January 1, 2020

Ameritas Life Insurance Corp.

William W Lester
President

DEFINITIONS

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

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

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

UN-REGISTERED DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another. This partnership has not been registered with the California Secretary of State as prescribed under Section 297 of the California Family Code or any other state or local jurisdiction.

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

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered Domestic Partner.

b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse or the Insured's Registered Domestic Partner or the Insured's Un-Registered Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Injury or Sickness for Certain Dependents
Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or

the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

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

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

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

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

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

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

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

EMPLOYER UNIT means any business organization which has elected to participate in the BANKERS LIFE NEBRASKA PREFERRED TRUSTS.

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, Employees must work the minimum number of hours required to be considered eligible for benefits as determined by the Employer Unit.

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

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

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

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

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

If employment is the basis for membership, Employees must work a minimum number of hours required to be considered eligible for Dependent Insurance as determined by the Employer Unit.

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

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Employer Unit has the option of offering the dependents of the deceased employee continued coverage. If elected by the Employer Unit 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.

PARTICIPATION REQUIREMENTS. The following requirement(s) must be met in order for coverage to be placed in force, and to remain in force for each Employer Unit:

Employer Unit must have elected a medical plan administered by Choice Administrators, Inc.

Percentage of Members in an Employer Unit	60%
Minimum Number of insured employees required of each Employer Unit for the insurance to remain in force for that Employer Unit	2

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

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

ELIGIBILITY PERIOD. For Members eligible on the date the Employer Unit was accepted into the Trust, coverage is effective immediately.

For persons who become Members after the date the Employer Unit was accepted into the Trust, the Eligibility Period will be determined by the Employer Unit. The Eligibility Period is selected by the Employer Unit, subject to the condition that the same Eligibility Period be applied to all Members within the same Employer Unit. New Members should check with their Employer Unit to determine which Eligibility Period was selected.

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:

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 Unit on a full time basis at one of the Employer Unit's business establishments or at some location to which the Employer Unit'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.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on 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 any other payment arrangement as required by the Employer Unit;
3. the date coverage for the Insured's Employer Unit is terminated;
4. the date the policy is terminated; or
5. the date the number of Insureds falls below any participation requirements shown above.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on 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 any other payment arrangement as required by the Employer Unit;
4. the date all Dependent Insurance under the policy is terminated;
5. the date all Dependent Insurance is cancelled for a specific Employer Unit; or
6. the date this policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

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

In addition to the provision below, please review the provisions of the California Continuation Benefits Replacement Act (Cal-COBRA) included within this document.

Labor Dispute
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

DENTAL EXPENSE BENEFITS

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

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

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

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

You and your dependents have the freedom to select any dentist of your choice nationwide. Out-of-pocket expenses may be lower if services are provided by a Participating Provider.

ACCESS TO PARTICIPATING PROVIDERS. If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need

of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

Provider Directories can be accessed by visiting our website www.ameritas.com.

For your convenience, our online directories are updated daily.

TIMELY ACCESS TO CARE.
Urgent appointments will be offered within seventy-two (72) hours of the time of request for appointment, when consistent with the Covered Person's individual needs and as required by professionally recognized standards of practice.

Non-urgent appointments will be offered within thirty-six (36) business days of the request for appointment. Preventive appointments will be offered within forty (40) business days of the request for appointment.

When it is necessary for a Dentist or a Covered Person to reschedule an appointment, Dentists will promptly reschedule in a manner that is appropriate for the Covered Person's health care needs, and ensures continuity of care consistent with good professional practice.

LANGUAGE INTERPRETER SERVICES. Language interpreter services are available at no cost to you, including at time of appointment by contacting us toll-free at 1-877-233-3797.

DENTAL EMERGENCY. Emergency health care services means health care services rendered for any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, (3) Serious dysfunction of any bodily organ or part.

URGENT CARE. Urgent care means a condition that requires prompt attention where the insured faces an imminent and serious threat to his or her health. This includes but is not limited to, the potential loss of life, limb, or other major bodily function, or when the normal timeframe for the decision making process would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function.

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. for Type 3 Procedures in the first 12 months the person is covered under this contract. This period of time may be reduced for time covered under a prior Choice Plan.

2. for Type 4 Procedures in the first 12 months the person is covered under this contract. This period of time may be reduced for time covered under a prior Choice Plan.

3. 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.

4. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

5. 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.

6. 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.

7. to replace lost or stolen appliances.

8. for any treatment which is for cosmetic purposes.

9. 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.)

10. 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).

11. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

12. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

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

The attached is a list of dental procedures for which benefits are payable under this section. **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.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as 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.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

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

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.
In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.
D0120, D0145, also contribute(s) to this limitation.
If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.
D0150, D0180, also contribute(s) to this limitation.
An additional D0120 may be allowed if service is received during pregnancy.
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.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

BITEWINGS

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

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 2 of any of these procedures per benefit period.
D0277, also contribute(s) to this limitation.
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

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.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

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

PROPHYLAXIS: D1110, D1120

TYPE 1 PROCEDURES

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

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

An additional D1110 may be allowed if service is received during pregnancy.

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

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

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

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

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

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY

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

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

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

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

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

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

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

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

TYPE 2 PROCEDURES

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

- D2390 Resin-based composite crown, anterior.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

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

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

RECEMENT

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

SEDATIVE FILLING

- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

DENTURE REPAIR

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

DENTURE REBASES

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

DENTURE RELINES

- D5730 Reline complete maxillary denture (direct).
- D5731 Reline complete mandibular denture (direct).
- D5740 Reline maxillary partial denture (direct).

TYPE 2 PROCEDURES

D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
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 - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

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

OTHER ORAL SURGERY
D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.

TYPE 2 PROCEDURES

D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

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

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 2 PROCEDURES

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

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

SPACE MAINTAINERS

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

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

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

INLAY RESTORATIONS

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

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

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

ONLAY RESTORATIONS

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

POST AND CORE

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

FIXED CROWN AND PARTIAL DENTURE REPAIR

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

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

TYPE 3 PROCEDURES

ENDODONTICS MISCELLANEOUS

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

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

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

Benefits are considered on permanent teeth only.

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

SURGICAL ENDODONTICS

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

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.

TYPE 3 PROCEDURES

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
Each quadrant is limited to 2 of any of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING
D4249 Clinical crown lengthening - hard tissue.

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

ANTIMICROBIAL AGENTS: D4381
Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT
D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

TYPE 3 PROCEDURES

Coverage is limited to 1 of any of these procedures per 5 year(s).
An additional D4355 may be allowed if service is received during pregnancy.

PERIODONTAL MAINTENANCE

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

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.
D1110, D1120, also contribute(s) to this limitation.
An additional D4910 may be allowed if service is received during pregnancy.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.

TYPE 3 PROCEDURES

D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

TISSUE CONDITIONING

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

PROSTHODONTICS - FIXED

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

TYPE 3 PROCEDURES

D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

TYPE 3 PROCEDURES

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

TYPE 1 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

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

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.
In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.
D0120, D0145, also contribute(s) to this limitation.
If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.
D0150, D0180, also contribute(s) to this limitation.
An additional D0120 may be allowed if service is received during pregnancy.
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.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

BITEWINGS

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

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 2 of any of these procedures per benefit period.
D0277, also contribute(s) to this limitation.
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

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.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

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

PROPHYLAXIS: D1110, D1120

TYPE 1 PROCEDURES

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

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

An additional D1110 may be allowed if service is received during pregnancy.

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

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

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

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

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

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY

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

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

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

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

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

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

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

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

- D2390 Resin-based composite crown, anterior.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

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

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

RECEMENT

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

SEDATIVE FILLING

- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.

PERIODONTAL MAINTENANCE

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

PERIODONTAL MAINTENANCE: D4346, D4910

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

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

An additional D4910 may be allowed if service is received during pregnancy.

Benefits are not available if performed on the same date as any other periodontal service.

Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.

Procedure D4346 is limited to persons age 14 and over.

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

DENTURE REPAIR

- D5511 Repair broken complete denture base, mandibular.
- D5512 Repair broken complete denture base, maxillary.
- D5520 Replace missing or broken teeth - complete denture (each tooth).
- D5611 Repair resin partial denture base, mandibular.
- D5612 Repair resin partial denture base, maxillary.
- D5621 Repair cast partial framework, mandibular.
- D5622 Repair cast partial framework, maxillary.

TYPE 2 PROCEDURES

D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
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 - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

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

OTHER ORAL SURGERY
D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.

TYPE 2 PROCEDURES

D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

TYPE 2 PROCEDURES

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

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

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

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

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

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

TYPE 3 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

SPACE MAINTAINERS

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

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

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

INLAY RESTORATIONS

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

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

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

ONLAY RESTORATIONS

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

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

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

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

Frequency is waived for accidental injury.

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

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

TYPE 3 PROCEDURES

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).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

POST AND CORE

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

FIXED CROWN AND PARTIAL DENTURE REPAIR

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

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

TYPE 3 PROCEDURES

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

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

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

Frequency is waived for accidental injury.

TYPE 3 PROCEDURES

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

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

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

Frequency is waived for accidental injury.

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

TISSUE CONDITIONING

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

PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported crown - porcelain fused to high noble alloys.
- D6067 Implant supported crown - high noble alloys.
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
- D6077 Implant supported retainer for metal FPD - high noble alloy.
- D6082 Implant supported crown-porcelain fused to predominantly base alloys.
- D6083 Implant supported crown-porcelain fused to noble alloys.
- D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
- D6086 Implant supported crown-predominantly base alloys.
- D6087 Implant supported crown-noble alloys.
- D6088 Implant supported crown-titanium and titanium alloys.
- D6094 Abutment supported crown - titanium and titanium alloys.
- D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
- D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
- D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
- D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
- D6121 Implant supported retainer for metal FPD-predominantly base alloys.
- D6122 Implant supported retainer for metal FPD-noble alloys.
- D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
- D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
- D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.

TYPE 3 PROCEDURES

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

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).
D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

Benefits will not be considered if procedure D2390, 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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

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

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

Frequency is waived for accidental injury.

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

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

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

TYPE 3 PROCEDURES

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

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

Frequency is waived for accidental injury.

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

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

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

TYPE 4 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.

D3221 Pulpal debridement, primary and permanent teeth.

D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).

D3333 Internal root repair of perforation defects.

D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).

D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).

D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).

D3357 Pulpal regeneration - completion of treatment.

D3430 Retrograde filling - per root.

D3450 Root amputation - per root.

D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.

D3320 Endodontic therapy, premolar tooth (excluding final restorations).

D3330 Endodontic therapy, molar tooth (excluding final restorations).

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.

D3346 Retreatment of previous root canal therapy - anterior.

D3347 Retreatment of previous root canal therapy - premolar.

D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

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

Benefits are considered on permanent teeth only.

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

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.

D3356 Pulpal regeneration - interim medication replacement.

D3410 Apicoectomy - anterior.

D3421 Apicoectomy - premolar (first root).

D3425 Apicoectomy - molar (first root).

D3426 Apicoectomy (each additional root).

D3471 Surgical repair of root resorption - anterior.

D3472 Surgical repair of root resorption - premolar.

D3473 Surgical repair of root resorption - molar.

D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.

D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.

D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

TYPE 4 PROCEDURES

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4263 Bone replacement graft - retained natural tooth - first site in quadrant.

D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.

D4265 Biologic materials to aid in soft and osseous tissue regeneration.

D4270 Pedicle soft tissue graft procedure.

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.

D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.

D4276 Combined connective tissue and double pedicle graft, per tooth.

D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.

D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

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

Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

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

Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

Coverage is limited to treatment of periodontal disease.

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

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

Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.

D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

ANTIMICROBIAL AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

TYPE 4 PROCEDURES

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

FULL MOUTH DEBRIDEMENT: D4355

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

An additional D4355 may be allowed if service is received during pregnancy.

EYE CARE INSURANCE

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

COVERED EXPENSES. Covered Expenses include the charge for the covered procedure furnished up to the maximum amount.

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Eye Care Services, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. Such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or frames or lenses ordered before the Insured was covered under this section.
2. subject to Extension of Benefits, any examination performed or frame or lens ordered after the Insured's coverage under this section ceases.
3. sub-normal vision aids; orthoptic or vision training or any associated testing.
4. non-prescription lenses.
5. replacement or repair of lost or broken lenses or frames except at normal intervals.
6. any eye examination or corrective eyewear required by an employer as a condition of employment.
7. medical or surgical treatment of the eyes.
8. any service or supply not shown on the Schedule of Eye Care Services.
9. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Maximum Amount -- Each Benefit Period	$100*

The Maximum Amount is the most the plan will provide for all services subject to any plan frequencies, limitations, and/or deductible.

Vision Examination

May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.

Materials

Frame

Lenses

- Single Vision
- Bifocal
- Trifocal
- No line bifocal or progressive power
- Lenticular
- Contact Lenses

HEARING DIAGNOSIS / AID BENEFITS

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

a. the actual charge for services or supplies furnished; or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Diagnosis / Aid Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means an allowed charge covered under the plan. Covered Expenses are subject to Deductibles, Coinsurance levels and any frequency or other maximums. These are described in the Schedule of Benefits (9040 CA Ed. 03-08). The plan will apply a deductible, as needed, before calculating a plan payment. The plan payment will then be calculated by multiplying the Coinsurance Percentage (for example 100%, or 50%) times the amount in the Maximum Covered Expense column in the Schedule of Hearing Diagnosis/Aid Services. The resulting amount is the Covered Expense. The Covered Expense may not exceed the Maximum Amount as shown in the Schedule of Benefits.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the date the Hearing Aid Purchase Agreement is signed. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.

2. any examination performed or supply furnished after the Insured's coverage under this section ceases.

3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
   a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and

b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
c. at least 3 years has passed since placement of the previous hearing aid.

5. surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.

6. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.

7. any procedure not shown in the Schedule of Hearing Diagnosis / Aid Services.

8. charges for services not provided by a licensed provider or other licensed professional legally authorized to administer covered services within the scope of that license.

9. because of war or any act of war, declared or not.

10. removal of foreign bodies or ear wax from the ear or any part of the ear.

11. hearing assistance devices not listed in the Schedule of Hearing Diagnosis / Aid Services.

SCHEDULE OF HEARING DIAGNOSIS / AID SERVICES

The following is a complete list of hearing diagnosis / aid services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to $75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed or recommended by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to $40 per Benefit Period

COORDINATION OF BENEFITS

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

INCONTESTABILITY. We cannot contest the validity of the policy after one year from the date of issue except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for one year while the Insured is alive. Any of the Insured's statements that we contest must be in a written application signed by the Insured.

TERMINATION OF EMPLOYER UNIT PARTICIPATION UNDER THE POLICY. In addition to the Policy termination rights contained elsewhere, we may terminate a particular Employer Unit's participation under the policy for any one or more of the following reasons:

a. failure to make required premium payments;

b. the number of Insureds falls below any participation requirements shown in the Conditions for Insurance Coverage.

c. the failure of the Employer Unit to satisfy the conditions for participation in the BANKERS LIFE NEBRASKA PREFERRED TRUSTS or the policy.

INSURANCE DATA. The Policyholder and the Employer Unit, including each Insured, will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to the following:

i. data necessary for us to calculate premiums;

ii. data necessary for us to determine a person's effective date or termination date of insurance;

We shall reserve the right to inspect any of the Policyholder or Employer Unit's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder and/or the Employer Unit.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder or the Employer Unit fails or errs in giving us the date necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder and/or Employer Unit fails or errs in giving us the necessary data concerning an Insured's termination.

NOTICE REQUIREMENTS. If an Insured's coverage under this policy is terminated, premiums are increased, benefits are reduced or eliminated or eligibility for such coverage is restricted in any way, then such action will not be effective unless written notice of the action is delivered by mail to the last known address of the appropriate insurance producer and the administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the Employer Unit and the certificate holder at least 30 days prior to the effective date of the action.

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. **Eligibility and Benefits Provided Under the Group Policy**

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

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

B. **Qualified Medical Child Support Order ("QMCSO")**

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

C. Termination Of The Group Policy

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

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

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

D. Claims For Benefits

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

E. Continuation of Coverage Provisions (COBRA)

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

i. Definitions For This Section

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

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

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

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

   1. The date on which Insurance would otherwise end; and

   2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

   1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

   2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

   3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

   a. The date of the disability determination;

   b. The date of the Qualifying Event; or

   c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

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

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

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

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental, Eye and Hearing Diagnosis / Aid policy and (b) not subject to any preexisting condition limitation in that policy.

F. Your Rights under ERISA

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

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

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

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

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

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

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

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

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

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

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Dental, Lasik Vision Correction, Eye and Hearing care Claims:
Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

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

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

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

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

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

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

APPEAL PROCEDURE

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:
Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Your Information. Your Rights. Our Responsibilities.

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

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

how we use or disclose information

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

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

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

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

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

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

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

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

our responsibilities

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

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.
- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

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

This revised notice is effective 9/30/17.

"California*Choice* Program"

EXPLANATORY SUPPLEMENT TO

CERTIFICATE OF INSURANCE

Your Employer has chosen to offer health coverage to you and your fellow Employees through the California*Choice* Program. This California*Choice* Explanatory Supplement explains and complements the Certificate of Insurance used by Ameritas Life Insurance Corporation ("CARRIER") in the California*Choice* Program. This California*Choice* Explanatory Supplement explains certain details specific to the California*Choice* Program.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a mechanism that makes available to employers with 100 or fewer Full-Time and Full-Time Equivalent (FTE) employees a variety of substantially similar medical and specialized health care products ("California*Choice* Program Products") that are offered by the health care service plans and insurance carriers participating in the California*Choice* Program. Such Products include medical, dental, vision, and chiropractic/acupuncture care benefit plans. You, as an Employee, have the opportunity to select to receive your health benefits from one or more of these health plans or carriers through the California*Choice* Program. This gives you the sort of choice of health care coverage that previously has been enjoyed by only a few.

The California*Choice* Program is administered by California*Choice* Benefit Administrators.

You have selected CARRIER as the insurance carrier from which you wish to receive your employer-sponsored California*Choice* dental benefits, and you and your eligible Dependents have chosen to become "Insureds" of CARRIER and "Enrollees" in the California*Choice* Program.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in CARRIER are listed below.

1. <u>Participation Requirements</u>

   Your Employer must have medical coverage through though California*Choice* in order to elect to offer dental coverage to its employees. (This medical coverage requirement, as well as the medical coverage eligibility requirement in Section 2 immediately below, shall cease to be in effect in the event that your Employer loses its medical coverage because of the operation of the Partial Payment Protocol described below in Section 7.)

   One hundred percent (100%) of your fellow employees eligible for medical coverage through the California*Choice* Program are eligible to receive their dental coverage through the California*Choice* Program if your employer has selected these optional benefits.

Employer Sponsored Dental (Employer contributes at least 50% of lowest cost premium plan available to Employee)

At least, seventy percent (70%) of your fellow Employees will receive their coverage from one of the health plans or carriers participating in the California*Choice* Program. If there are only two Employees, both must participate in the Program.

2. Eligibility Requirements

a. Employee Eligibility

An Eligible Employee is one who lives or works in CARRIER's Service Area, who is permanently and actively employed for compensation an average of 30 hours per week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.

- Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, if they are actively engaged on a full-time basis in the small employer's business and included as employees under an insurance policy or health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary or substitute basis.

- Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:

  - They otherwise meet the definition of an Eligible Employee except for the number of hours worked

  - The employer offers the employees health coverage under a health benefit plan

  - All similarly situated employees are offered coverage under the health benefit plan

The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in CARRIER through the California*Choice* Program, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial

enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (v) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (iv) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child"

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit administrators request it. .

California*Choice* Benefit Administrators will provide you a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless you provides written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or CARRIER will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or CARRIER may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or CARRIER may request initial proof of incapacity/dependency and then yearly, and the Employee must provide the requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage hereunder at a time other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th of the month of marriage, Premiums are charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a stamped copy of the Marriage Certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage hereunder at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date

occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation will be required).

(iii) New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage hereunder at a time other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days following the date of the Enrollee's marriage to or establishment of a registered domestic partnership with the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the Marriage Certificate to, or State-stamped copy of the Declaration of Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or establishment of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or establishment of the domestic partnership. If the marriage or establishment of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage hereunder, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Have filed a Declaration of Domestic Partnership with the Secretary of State
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage hereunder at a time other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled

as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Declaration of Domestic Partnership within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request and Declaration to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed established when both partners file the properly executed Declaration of Domestic Partnership is filed with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

(a) Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent;

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption, placement for adoption of a child or arrival of status of eligible dependent child, coverage effective on the effective date of such event;

- to add Employee and spouse or domestic partner after marriage or establishment of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/establishment of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage/establishment of the domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/establishment of domestic partnership, coverage is effective on the 1st of the month following date of receipt:

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or establishment of domestic partnership occurs before the 16th day of the month, coverage effective as of the date of marriage or establishment of domestic partnership; if marriage or establishment of domestic partnership occurs on or after the 16th date of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the CARRIER Certificate of Insurance for further information regarding rights to request enrollment at a later time.

(b) Late Enrollment

Late enrollees (as defined in California Insurance Code section 10753(l) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to Insurance Code section 10753(l) and as further articulated in CARRIER's Certificate of Insurance, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California Insurance Code Section 10965.3(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (a) of Insurance Code Section 10133.56 and that the provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United (I) States military returning from active duty or a member of the California National Guard returning from active duty service; and
- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in CARRIER by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other coverage or within 60 days of another triggering event listed immediately above, pursuant to Insurance Code Section 10753(l) and as articulated further in CARRIER's Certificate of Insurance. Coverage with CARRIER through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

The waiting period for coverage hereunder, which shall be applicable for all Employees, is the same as for medical coverage.

5. Benefits

The benefits you have chosen to receive from CARRIER are described in the CARRIER Certificate of Insurance to which this California*Choice* Explanatory Supplement is attached. CARRIER will make all benefit and coverage dispute determinations, although these determinations are subject to CARRIER's grievance procedures. You may not change your benefit level within CARRIER other than during your Group's open enrollment period unless you experience a triggering event listed in section 3.a above.

a. Cal-COBRA and COBRA

CARRIER has agreed to provide coverage for you if you are CalCOBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your Employer. Please examine your options carefully before declining this coverage.

b. Copayments

As noted in the CARRIER Certificate of Insurance, certain covered services and benefits are subject to copayments which you will be required to make.

c. Plan Materials

CARRIER will provide you with an identification card and its provider directory, along with the CARRIER Certificate of Insurance. California*Choice* Benefit Administrators provides this California*Choice* Explanatory Supplement. (In lieu of hard copies, CARRIER and California*Choice* Benefit Administrators may notify you of where to obtain electronic copies of the Certificate of Insurance and the California*Choice* Certificate Explanatory Supplement.)

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by CaliforniaChoice Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: "Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your CARRIER and with the California Department of Insurance if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage." Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due, CARRIER (or California*Choice* Benefit Administrators on behalf of CARRIER) will mail your Employer a "Notice of Start of Grace Period" stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive

day, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to CARRIER, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer's responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the California Department of Insurance if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace Period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of CARRIER will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, CARRIER (or California*Choice* Benefit Administrators on behalf of CARRIER) will cancel your Employer's CARRIER Group Policy (the "Group Policy") and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer. It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace Period is dated and lasts at least 30 consecutive days. If the affected premium(s) is/are not paid by the last day of the Grace Period, GROUP's coverage under this Policy will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contract(s) terminated on the last day of March).

CARRIER (or California*Choice* Benefit Administrators on behalf of CARRIER) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the Group Policy has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the California Insurance Commissioner if your Employer believes coverage has been improperly cancelled, and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* Benefit Administrators telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Group Policy; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, with an explanation of the Member's options to purchase continuation coverage (including

coverage effective as of the termination date so the Member can avoid a break in coverage). Such explanation of the Member's option will include (a) the deadline by which the Member must elect to purchase such continuation coverage, (which will be 63 days after the date CARRIER mails the Member the Notice Confirming Cancellation of Coverage); (b) how to obtain the forms necessary to purchase continuation coverage; and (c) referral to CARRIER's website and the Department of Insurance's website for additional information relating to rates and regarding the Member's rights to continuation coverage.

For more information on conversion coverage and your rights to HIPAA coverage, please see CARRIER's Certificate of Insurance.

7. Partial payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the California*Choice* Explanatory Supplement to the Group Service Agreement that is part of your Employer's contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g.*, dental) have the same

membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in CARRIER through to the California*Choice* Program upon the anniversary date of its Group Policy with CARRIER, your Employer must have a minimum of two (2) Eligible Employees (or such number as may come to be used in controlling statutes or regulations to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This California*Choice* Explanatory Supplement merely explains the particular features of your coverage from CARRIER because of CARRIER's participation in the California*Choice* Program. You should refer to the CARRIER Certificate of Insurance to which this is merely an Explanatory Supplement, for all other details regarding your coverage in and receipt of health care services from CARRIER.