



Ameritas Life Insurance Corp.

A STOCK COMPANY  
LINCOLN, NEBRASKA

**GROUP DENTAL INSURANCE POLICY**

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<b>The Policyholder</b>	<b>ONSLow COUNTY SCHOOLS</b>	<b>Policy Number</b>	<b>10-350354</b>
<b>State of Delivery</b>	<b>North Carolina</b>	<b>Plan Effective Date</b>	<b>September 1, 2003</b>
		<b>Plan Change Effective Date</b>	<b>September 1, 2018</b>
<b>Premium Due Date 1st of each month.</b>		<b>Renewal Date</b>	<b>September 1</b>

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

**READ YOUR POLICY CAREFULLY. THIS POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND AMERITAS LIFE INSURANCE CORP.**

**LATE ENTRANTS MAY BE SUBJECT TO A WAITING PERIOD. SEE PAGE 9060.**

**IMPORTANT CANCELLATION INFORMATION. PLEASE READ THE PROVISION ENTITLED "TERMINATION OF THE POLICY" FOUND WITHIN THE GENERAL PROVISIONS ON PAGE 9323.**

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

**AMERITAS LIFE INSURANCE CORP.**

Handwritten signature of Robert John A. Hawks in black ink.

Corporate Secretary

Handwritten signature of William W. Hutz in black ink.

President

## **GRIEVANCE AND APPEAL PROCEDURES**

If all or part of a claim is denied, you may appeal. You may request in writing a review of our benefit decision. This request must be within 180 days after receiving notice of the denial.

You may send us written comments and other items to support your claim. You may request at no charge any non-privileged information that is relevant to your appeal. You may request the names of the experts we may have consulted for advice about Your claim. You may also request, at no charge, any clinical rationale and/or specific clinical guidelines relied upon by them for any benefit determinations related to clinical necessity.

The appeal review will be conducted by someone other than the person who denied the claim. The new reviewer will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. For a dental benefit, denials may be based in whole or in part on a medical judgment. This includes 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.

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 dental 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.

Any request for review concerning this claim should be sent to:

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

**You also have the right to contact the Department of Insurance:**

**North Carolina Department of Insurance  
1201 Mail Service Center  
Raleigh, NC 27699-1201  
800-546-5664 - in North Carolina  
919-807-6750 - outside North Carolina**

Pursuant to NCGS 58-50-61 and 62, services provided by the Managed Care Patient Assistance Program are available through the North Carolina Department of Insurance. To access this program, contact:

Health Insurance Smart NC  
North Carolina Department of Insurance  
1201 Mail Service Center  
Raleigh, NC 27699-1201  
877-885-0231



**NOTICE CONCERNING COVERAGE  
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH  
CAROLINA LIFE AND HEALTH INSURANCE GUARANTY  
ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice.

*However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The North Carolina Life and Health Insurance Guaranty Association  
Post Office Box 10218  
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service Center  
Raleigh, North Carolina 27699-1201

The state law that provides for this safety net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## **COVERAGE**

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

*(please turn to back of page)*

## **EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this association if:

- \* they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- \* the insurer was not authorized to do business in this state;
- \* their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- \* any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- \* any policy of reinsurance (unless an assumption certificate was issued);
- \* interest rate yields that exceed the average rate specified in the law;
- \* dividends;
- \* experience or other credits given in connection with the administration of a policy by a group contractholder;
- \* employers' plans to the extent they are self funded (that is, not insured by an insurance company, even if an insurance company administers them);
- \* unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- \* a policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

NOTICE OF NORTH CAROLINA GENERAL STATUTE  
CONCERNING GROUP INSURANCE PREMIUM

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.





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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Employees Hired 1-15 Of Month
Class 2	Employees Hired 16-31 Of Month
Class 3	Employees Hired 1-15 Of Month
Class 4	Employees Hired 16-31 Of Month

Class Number 1

**DENTAL EMERGENCY**

Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency services are those services required for temporary relief of pain, infection or swelling.

**BENEFITS FOR DENTAL EMERGENCIES**

Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply. In no event will the Covered Person be liable for any more out-of-pocket expenses whether they see a Non-Participating Provider or a Participating Provider for services rendered in connection with a Dental Emergency.

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period	\$1,500
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**ORTHODONTIC EXPENSE BENEFITS**

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

*You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the **ORTHODONTIC EXPENSE BENEFITS** page for details regarding elimination period(s), limitations and exclusions.*

Example

<b>Type 3 Procedure</b>	<b>In-Network Dentist</b>	<b>Out-of-Network Dentist</b>
<b>Coverage:</b>	Plan pays 50%/ You Pay 50%	Plan pays 50%/You pay 50%
<b>Your Dentist's Charge</b>	\$600	\$1,200
<b>Your Plan's Negotiated or Regognized Rate</b>	\$600	\$1,000
<b>Your Plan Pays</b>	\$300	\$500
<b>You Pay</b>	50% co-insurance = \$300	50% co-insurance = \$500
<b>Your Balance Bill (the difference between your plan's payment and Co-insurance, and what the dentist charges)</b>	\$0	\$200
<b>Your Total</b>	\$300	\$700

Class Number 2

**DENTAL EMERGENCY**

Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency services are those services required for temporary relief of pain, infection or swelling.

**BENEFITS FOR DENTAL EMERGENCIES**

Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply. In no event will the Covered Person be liable for any more out-of-pocket expenses whether they see a Non-Participating Provider or a Participating Provider for services rendered in connection with a Dental Emergency.

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,500

**ORTHODONTIC EXPENSE BENEFITS**

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

*You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.*

Example

Type 3 Procedure	In-Network Dentist	Out-of-Network Dentist
<b>Coverage:</b>	Plan pays 50%/ You Pay 50%	Plan pays 50%/You pay 50%
<b>Your Dentist's Charge</b>	\$600	\$1,200
<b>Your Plan's Negotiated or Regognized Rate</b>	\$600	\$1,000
<b>Your Plan Pays</b>	\$300	\$500
<b>You Pay</b>	50% co-insurance = \$300	50% co-insurance = \$500
<b>Your Balance Bill (the difference between your plan's payment and Co-insurance, and what the dentist charges)</b>	\$0	\$200
<b>Your Total</b>	\$300	\$700

Class Number 3

**DENTAL EMERGENCY**

Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency services are those services required for temporary relief of pain, infection or swelling.

**BENEFITS FOR DENTAL EMERGENCIES**

Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply. In no event will the

Covered Person be liable for any more out-of-pocket expenses whether they see a Non-Participating Provider or a Participating Provider for services rendered in connection with a Dental Emergency.

### **DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period	\$1,500
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### **ORTHODONTIC EXPENSE BENEFITS**

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

***You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.***

Example

<b>Type 3 Procedure</b>	<b>In-Network Dentist</b>	<b>Out-of-Network Dentist</b>
<b>Coverage:</b>	Plan pays 50%/ You Pay 50%	Plan pays 50%/You pay 50%
<b>Your Dentist's Charge</b>	\$600	\$1,200
<b>Your Plan's Negotiated or Recognized Rate</b>	\$600	\$1,000
<b>Your Plan Pays</b>	\$300	\$500
<b>You Pay</b>	50% co-insurance = \$300	50% co-insurance = \$500
<b>Your Balance Bill (the difference between your plan's payment and Co-insurance, and what the dentist charges)</b>	\$0	\$200
<b>Your Total</b>	\$300	\$700

Class Number 4

**DENTAL EMERGENCY**

Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency services are those services required for temporary relief of pain, infection or swelling.

**BENEFITS FOR DENTAL EMERGENCIES**

Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply. In no event will the Covered Person be liable for any more out-of-pocket expenses whether they see a Non-Participating Provider or a Participating Provider for services rendered in connection with a Dental Emergency.

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

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.

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%

Type 3 Procedures	50%
Maximum Amount - Each Benefit Period	\$1,500

**ORTHODONTIC EXPENSE BENEFITS**

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

*You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.*

Example

Type 3 Procedure	In-Network Dentist	Out-of-Network Dentist
<b>Coverage:</b>	Plan pays 50%/ You Pay 50%	Plan pays 50%/You pay 50%
<b>Your Dentist's Charge</b>	\$600	\$1,200
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<b>Your Plan Pays</b>	\$300	\$500
<b>You Pay</b>	50% co-insurance = \$300	50% co-insurance = \$500
<b>Your Balance Bill (the difference between your plan's payment and Co-insurance, and what the dentist charges)</b>	\$0	\$200
<b>Your Total</b>	\$300	\$700



**INCREASED MAXIMUM BENEFIT**

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	Unlimited

**BENEFIT THRESHOLD** refers to a maximum amount of benefits paid for dental expenses incurred in the preceding Benefit Period to qualify for an increase in the Carry Over Amount in the subsequent Benefit Period (see below).

A portion of the Carry Over dollars earned for dental services may be used for covered procedures related to Orthodontia benefits, excluding coinsurance and/or deductible, depending upon the Carry Over dollars accumulated by each individual Insured Person. The additional Carry Over dollars will be considered for these services when the Insured Person either exceeds the plan maximum, or the scheduled allowance for a service, as applicable.

Orthodontia Carry Over Amount Per Insured Person – Once Per Lifetime	\$100
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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.

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.

The Carry Over Amount can be accumulated from one Benefit Period to the next Benefit Period 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 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 for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount 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, 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 calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.



**INCREASED MAXIMUM BENEFIT**

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	Unlimited

**BENEFIT THRESHOLD** refers to a maximum amount of benefits paid for dental expenses incurred in the preceding Benefit Period to qualify for an increase in the Carry Over Amount in the subsequent Benefit Period (see below).

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Orthodontia Carry Over Amount Per Insured Person – Once Per Lifetime	\$100
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- 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.

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.

The Carry Over Amount can be accumulated from one Benefit Period to the next Benefit Period 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 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 for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

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### INCREASED MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	Unlimited

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Orthodontia Carry Over Amount Per Insured Person – Once Per Lifetime	\$100
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- 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.

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.

The Carry Over Amount can be accumulated from one Benefit Period to the next Benefit Period 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 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 for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount 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, 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 calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.



### INCREASED MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	Unlimited

**BENEFIT THRESHOLD** refers to a maximum amount of benefits paid for dental expenses incurred in the preceding Benefit Period to qualify for an increase in the Carry Over Amount in the subsequent Benefit Period (see below).

A portion of the Carry Over dollars earned for dental services may be used for covered procedures related to Orthodontia benefits, excluding coinsurance and/or deductible, depending upon the Carry Over dollars accumulated by each individual Insured Person. The additional Carry Over dollars will be considered for these services when the Insured Person either exceeds the plan maximum, or the scheduled allowance for a service, as applicable.

Orthodontia Carry Over Amount Per Insured Person – Once Per Lifetime	\$100
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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.

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.

The Carry Over Amount can be accumulated from one Benefit Period to the next Benefit Period 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 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 for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount 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, 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 calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.





## PREMIUMS

### TABLE OF TENTHLY PREMIUM RATES

#### Classes 01,02

Dental Care Insurance	\$35.62 per Insured Person
	\$36.76 Spouse Only
	\$43.91 Child(ren) Only
	\$80.74 Spouse & Child(ren)

#### Classes 03,04

Dental Care Insurance	\$42.75 per Insured Person
	\$44.11 Spouse Only
	\$52.69 Child(ren) Only
	\$96.89 Spouse & Child(ren)

#### Classes 01,02

Orthodontic Insurance	\$0.61 per Insured Person
	\$0.61 Spouse Only
	\$7.51 Child(ren) Only
	\$8.12 Spouse & Child(ren)

#### Classes 03,04

Orthodontic Insurance	\$0.73 per Insured Person
	\$0.73 Spouse Only
	\$9.01 Child(ren) Only
	\$9.74 Spouse & Child(ren)

## ASSOCIATED GROUPS

ONslow COUNTY SCHOOLS COBRA

**PAYMENT OF PREMIUMS.** The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

**PREMIUM DUE DATE.** The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

**PREMIUM STATEMENTS.** The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

**SIMPLIFIED ACCOUNTING.** The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 12 months before the date we receive evidence that a return is due.

**ADJUSTMENTS IN PREMIUM RATES.** We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 45 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date (of the first contract) shown on the policy cover or more than once in any 12 month period thereafter, based on at least 12 months of experience, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or
2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or
3. We are required by either the federal government or by any state or local government or by any agency thereof to change benefits as a result of regulatory change or pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 45 days in advance of the Premium Due Date for which the rate change

shall be effective. The right to change rates as well as the timing of such changes in the above limited situations shall at all times be subject to applicable state laws and regulations.

**RENEWAL DATE** Renewal Date refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover. The Renewal Date(s) will never be less than 12 months from the Plan Effective Date.



## DEFINITIONS

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

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

**INSURED** refers to a person:

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

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

### Class Number 1

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. 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.

### Class Number 2

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. 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.

### Class Number 3

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. 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.

### Class Number 4

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. 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.

### All Classes

**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 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.

**NON-PARTICIPATING PROVIDERS.** A Non-Participating Provider is any other provider and may also be referred to as an “Out-of-Network Provider”. Members are required to pay the difference between the plan payment and the provider’s actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

#### Class Number 1

**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.

A child enrolled due to a court or an administrative order shall not be considered a late entrant.

#### Class Number 2

**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.

A child enrolled due to a court or an administrative order shall not be considered a late entrant.

#### Class Number 3

**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.

A child enrolled due to a court or an administrative order shall not be considered a late entrant.

#### Class Number 4

**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.

A child enrolled due to a court or an administrative order shall not be considered a late entrant.

#### All Classes

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

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

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



**CONDITIONS FOR INSURANCE COVERAGE**  
*ELIGIBILITY*

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

Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employees hired 1-15 of month working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

**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 becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN, FOSTER AND ADOPTED CHILDREN AND CHILDREN FOR WHICH A PARENT IS REQUIRED BY A COURT OR ADMINISTRATIVE ORDER TO PROVIDE HEALTH BENEFIT PLAN COVERAGE.** A newborn child will be covered from the date of birth. An adopted child, foster child or other child for which a parent is required by a court or administrative order to provide coverage will be covered from the date of placement in the Insured's residence.

Coverage for such child shall consist of coverage for dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities and premature birth, including, but not limited to, necessary care for individuals born with cleft lip or cleft palate.

The Insured may give us written notice within 30 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 30-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 30 days of the child's birth or placement. If no additional premiums are required due to adequate dependent coverage already existing, the 30-day notice period will be waived and no written notice is required.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employees hired 1-15 of month working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on September 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this plan.)

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

In no event, will the waiting period exceed 90 days after a Member's first day of employment.

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

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

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

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.

#### Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employees hired 16-31 of month working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

**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 becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN, FOSTER AND ADOPTED CHILDREN AND CHILDREN FOR WHICH A PARENT IS REQUIRED BY A COURT OR ADMINISTRATIVE ORDER TO PROVIDE HEALTH BENEFIT PLAN COVERAGE.** A newborn child will be covered from the date of birth. An adopted child, foster child or other child for which a parent is required by a court or administrative order to provide coverage will be covered from the date of placement in the Insured's residence.

Coverage for such child shall consist of coverage for dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities and premature birth, including, but not limited to, necessary care for individuals born with cleft lip or cleft palate.

The Insured may give us written notice within 30 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 30-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 30 days of the child's birth or placement. If no additional premiums are required due to adequate dependent coverage already existing, the 30-day notice period will be waived and no written notice is required.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employees hired 16-31 of month working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on September 1. A Member who elects to participate

during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this plan.)

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

In no event, will the waiting period exceed 90 days after a Member's first day of employment.

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

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

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

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.

### Class Number 3

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employees hired 1-15 of month working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN, FOSTER AND ADOPTED CHILDREN AND CHILDREN FOR WHICH A PARENT IS REQUIRED BY A COURT OR ADMINISTRATIVE ORDER TO PROVIDE HEALTH BENEFIT PLAN COVERAGE.** A newborn child will be covered from the date of birth. An adopted child, foster child or other child for which a parent is required by a court or administrative order to provide coverage will be covered from the date of placement in the Insured's residence.

Coverage for such child shall consist of coverage for dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities and premature birth, including, but not limited to, necessary care for individuals born with cleft lip or cleft palate.

The Insured may give us written notice within 30 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 30-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 30 days of the child's birth or placement. If no additional premiums are required due to adequate dependent coverage already existing, the 30-day notice period will be waived and no written notice is required.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employees hired 1-15 of month working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on September 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this plan.)

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment.

In no event, will the waiting period exceed 90 days after a Member's first day of employment.

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

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

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

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

#### Class Number 4

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employees hired 16-31 of month working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she becomes a Member; or
3. the day he or she first has a dependent.

**COVERAGE FOR NEWBORN, FOSTER AND ADOPTED CHILDREN AND CHILDREN FOR WHICH A PARENT IS REQUIRED BY A COURT OR ADMINISTRATIVE ORDER TO PROVIDE HEALTH BENEFIT PLAN COVERAGE.** A newborn child will be covered from the date of birth. An adopted child, foster child or other child for which a parent is required by a court or administrative order to provide coverage will be covered from the date of placement in the Insured's residence.

Coverage for such child shall consist of coverage for dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities and premature birth, including, but not limited to, necessary care for individuals born with cleft lip or cleft palate.

The Insured may give us written notice within 30 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 30-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 30 days of the child's birth or placement. If no additional premiums are required due to adequate dependent coverage already existing, the 30-day notice period will be waived and no written notice is required.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employees hired 16-31 of month working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on September 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this plan.)

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 1 month(s) of continuous active employment. In no event, will the waiting period exceed 90 days after a Member's first day of employment.

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

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

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

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

#### All Classes

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

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

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



## ***TERMINATION DATES***

### Class Number 1

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

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

### **DEPENDENTS.**

#### **We will only terminate coverage:**

when the insured is no longer eligible for coverage through the Exchange  
for non-payment of premiums

when coverage is rescinded in accordance with 45 CFR 147.128

when the qualified dental plan terminates or is decertified when the insured changes from one qualified dental plan to another during an annual open enrollment period or special enrollment period

In the event of termination, We will provide the insured notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

The effective date of the termination will be:

When insured no longer eligible, the last day of the month following the month in which notice of ineligibility is sent to the insured by the Exchange, unless the insured requests an earlier termination date

For nonpayment of premium by insured receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period

For nonpayment of premium for insured NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period

When insured changes from one qualified dental plan to another, the day before the effective date of coverage in the new qualified dental plan

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

Class Number 2

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

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

**DEPENDENTS.**

**We will only terminate coverage:**

when the insured is no longer eligible for coverage through the Exchange  
for non-payment of premiums

when coverage is rescinded in accordance with 45 CFR 147.128

when the qualified dental plan terminates or is decertified when the insured changes from one qualified dental plan to another during an annual open enrollment period or special enrollment period

In the event of termination, We will provide the insured notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

The effective date of the termination will be:

When insured no longer eligible, the last day of the month following the month in which notice of ineligibility is sent to the insured by the Exchange, unless the insured requests an earlier termination date

For nonpayment of premium by insured receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period

For nonpayment of premium for insured NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period

When insured changes from one qualified dental plan to another, the day before the effective date of coverage in the new qualified dental plan

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

### Class Number 3

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

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

### **DEPENDENTS.**

#### **We will only terminate coverage:**

when the insured is no longer eligible for coverage through the Exchange  
for non-payment of premiums

when coverage is rescinded in accordance with 45 CFR 147.128

when the qualified dental plan terminates or is decertified when the insured changes from one qualified dental plan to another during an annual open enrollment period or special enrollment period

In the event of termination, We will provide the insured notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

The effective date of the termination will be:

When insured no longer eligible, the last day of the month following the month in which notice of ineligibility is sent to the insured by the Exchange, unless the insured requests an earlier termination date

For nonpayment of premium by insured receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period

For nonpayment of premium for insured NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period

When insured changes from one qualified dental plan to another, the day before the effective date of coverage in the new qualified dental plan

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

#### Class Number 4

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

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

#### **DEPENDENTS.**

##### **We will only terminate coverage:**

when the insured is no longer eligible for coverage through the Exchange  
for non-payment of premiums

when coverage is rescinded in accordance with 45 CFR 147.128

when the qualified dental plan terminates or is decertified when the insured changes from one qualified dental plan to another during an annual open enrollment period or special enrollment period

In the event of termination, We will provide the insured notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

The effective date of the termination will be:

When insured no longer eligible, the last day of the month following the month in which notice of ineligibility is sent to the insured by the Exchange, unless the insured requests an earlier termination date

For nonpayment of premium by insured receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period

For nonpayment of premium for insured NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period

When insured changes from one qualified dental plan to another, the day before the effective date of coverage in the new qualified dental plan

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

#### All Classes

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

#### **Injury or Sickness** For Certain Dependents

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

## Class 1

### **DENTAL EXPENSE BENEFITS**

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

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

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

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

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

**NOTICE:** Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine plan/insurer or similar term and insured/member/enrollee or similar term payment obligations.

If a service is received out of network, either you or your provider may submit the claim to us:  
800-487-5553

Group Claims  
 PO Box 82520  
 Lincoln, NE 68501  
 group@ameritas.com

Example

<b>Type 3 Procedure</b>	<b><u>In-Network Dentist</u></b>	<b><u>Out-of-Network Dentist</u></b>
<b>Coverage:</b>	<b>Plan pays 50%/You pay 50%</b>	<b>Plan pays 50%/You pay 50%</b>
<b>Your Dentist's Charge</b>	<b>\$600</b>	<b>\$1,200</b>
<b>You Plan's Negotiated or Recognized Rate</b>	<b>\$600</b>	<b>\$1,000</b>
<b>Your Plan Pays</b>	<b>\$300</b>	<b>\$500</b>
<b>You pay</b>	<b>50% co-insurance = \$300</b>	<b>50% co-insurance = \$500</b>
<b>Your balance bill (the difference between your plan's payment and co-insurance, and what the dentist charges)</b>	<b>\$0</b>	<b>\$200</b>
<b>Your Total</b>	<b>\$300</b>	<b>\$700</b>

**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. Our network contract with providers requires them to offer appointments upon request within a reasonable time. For non-emergency appointments, a reasonable amount of time shall not be more than thirty (30) days. Reasonable driving distance varies by the geographic area and specialty type. Network providers are required to furnish or arrange for twenty-four (24) hour per day, seven days per week urgent/emergency care service. Our customer service representatives are prepared to help you find a Participating Provider based on the circumstances. 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](http://www.ameritas.com). For your convenience, our online directories are updated daily.

You may also request a paper directory by calling 800-776-9446.

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for Type 1 and Type 2 procedures.
2. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
8. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

## Class 2

### **DENTAL EXPENSE BENEFITS**

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

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

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

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

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

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine plan/insurer or similar term and insured/member/enrollee or similar term payment obligations.

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800-487-5553

Group Claims

PO Box 82520

Lincoln, NE 68501

group@ameritas.com

Example



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<b>Coverage:</b>	<b>Plan pays 50%/You pay 50%</b>	<b>Plan pays 50%/You pay 50%</b>
<b>Your Dentist's Charge</b>	<b>\$600</b>	<b>\$1,200</b>
<b>You Plan's Negotiated or Recognized Rate</b>	<b>\$600</b>	<b>\$1,000</b>
<b>Your Plan Pays</b>	<b>\$300</b>	<b>\$500</b>
<b>You pay</b>	<b>50% co-insurance = \$300</b>	<b>50% co-insurance = \$500</b>
<b>Your balance bill (the difference between your plan's payment and co-insurance, and what the dentist charges)</b>	<b>\$0</b>	<b>\$200</b>
<b>Your Total</b>	<b>\$300</b>	<b>\$700</b>

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for Type 1 and Type 2 procedures.
2. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
8. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

### Class 3

## **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:

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2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

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

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

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

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NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine plan/insurer or similar term and insured/member/enrollee or similar term payment obligations.

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Example

Type 3 Procedure	<u>In-Network Dentist</u>	<u>Out-of-Network Dentist</u>
Coverage:	Plan pays 50%/You pay 50%	Plan pays 50%/You pay 50%
Your Dentist's Charge	\$600	\$1,200
You Plan's Negotiated or Recognized Rate	\$600	\$1,000

<b>Your Plan Pays</b>	<b>\$300</b>	<b>\$500</b>
<b>You pay</b>	<b>50% co-insurance = \$300</b>	<b>50% co-insurance = \$500</b>
<b>Your balance bill (the difference between your plan's payment and co-insurance, and what the dentist charges)</b>	<b>\$0</b>	<b>\$200</b>
<b>Your Total</b>	<b>\$300</b>	<b>\$700</b>

**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. Our network contract with providers requires them to offer appointments upon request within a reasonable time. For non-emergency appointments, a reasonable amount of time shall not be more than thirty (30) days. Reasonable driving distance varies by the geographic area and specialty type. Network providers are required to furnish or arrange for twenty-four (24) hour per day, seven days per week urgent/emergency care service. Our customer service representatives are prepared to help you find a Participating Provider based on the circumstances. 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](http://www.ameritas.com). For your convenience, our online directories are updated daily.

You may also request a paper directory by calling 800-776-9446.

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for Type 1 and Type 2 procedures.
2. for appliances, restorations, or procedures to:

- a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
  4. to replace lost or stolen appliances.
  5. for any treatment which is for cosmetic purposes.
  6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
  7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
  8. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
  9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
  10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

#### Class 4

### **DENTAL EXPENSE BENEFITS**

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

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

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

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

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

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine plan/insurer or similar term and insured/member/enrollee or similar term payment obligations.

If a service is received out of network, either you or your provider may submit the claim to us:  
800-487-5553  
Group Claims  
PO Box 82520  
Lincoln, NE 68501  
group@ameritas.com

Example

<b>Type 3 Procedure</b>	<b><u>In-Network Dentist</u></b>	<b><u>Out-of-Network Dentist</u></b>
<b>Coverage:</b>	<b>Plan pays 50%/You pay 50%</b>	<b>Plan pays 50%/You pay 50%</b>
<b>Your Dentist's Charge</b>	<b>\$600</b>	<b>\$1,200</b>
<b>You Plan's Negotiated or Recognized Rate</b>	<b>\$600</b>	<b>\$1,000</b>
<b>Your Plan Pays</b>	<b>\$300</b>	<b>\$500</b>
<b>You pay</b>	<b>50% co-insurance = \$300</b>	<b>50% co-insurance = \$500</b>
<b>Your balance bill (the difference between your plan's payment and co-insurance, and what the dentist charges)</b>	<b>\$0</b>	<b>\$200</b>

<b>Your Total</b>	<b>\$300</b>	<b>\$700</b>
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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.

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  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
8. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.



## TABLE OF DENTAL PROCEDURES

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

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

#### Class Number 1

- 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.

#### Class Number 2

- 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.

#### Class Number 3

- 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.

#### Class Number 4

- 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.

#### All Classes

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).

- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

All Classes

**TYPE 1 PROCEDURES**

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

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

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

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

ROUTINE EVALUATION: D0120, D0145

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

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

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

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - 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).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

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

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

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

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 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.

## TYPE 1 PROCEDURES

- 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

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

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

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

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

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

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

### SPACE MAINTAINERS

- D1510 Space maintainer - fixed - unilateral.
  - D1520 Space maintainer - removable - unilateral.
  - D1550 Re-cement or re-bond space maintainer.
  - D1555 Removal of fixed space maintainer.
  - D1575 Distal shoe space maintainer - fixed - unilateral.
- SPACE MAINTAINER: D1510, D1515, D1520, D1525, 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.

### 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**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**

**For Additional Limitations - See Limitations**

### LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

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

### ORAL PATHOLOGY/LABORATORY

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

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

Coverage is limited to 1 examination per biopsy/excision.

### SEALANT

D1351 Sealant - per tooth.

D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.

D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

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

Benefits are considered for persons age 16 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

### AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

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.

## TYPE 2 PROCEDURES

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.
- 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, 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.

### FULL MOUTH DEBRIDEMENT

- 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).

### OTHER PERIODONTAL SERVICES

- 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.

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 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.

## TYPE 2 PROCEDURES

### DENTURE RELINES

- D5730 Reline complete maxillary denture (chairside).
- D5731 Reline complete mandibular denture (chairside).
- D5740 Reline maxillary partial denture (chairside).
- D5741 Reline mandibular partial denture (chairside).
- D5750 Reline complete maxillary denture (laboratory).
- D5751 Reline complete mandibular denture (laboratory).
- D5760 Reline maxillary partial denture (laboratory).
- D5761 Reline mandibular partial denture (laboratory).

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).

## TYPE 2 PROCEDURES

- 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.
- D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
- 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.

### 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. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

### OCCLUSAL ADJUSTMENT



## TYPE 2 PROCEDURES

D9951 Occlusal adjustment - limited.

D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

### MISCELLANEOUS

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

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

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

DESENSITIZATION: D9911

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

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

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

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



### **TYPE 3 PROCEDURES**

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

#### **INLAY RESTORATIONS**

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

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

#### **ONLAY RESTORATIONS**

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

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

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

Frequency is waived for accidental injury.

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

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

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

#### **CROWNS SINGLE RESTORATIONS**

- D2710 Crown - resin-based composite (indirect).
- 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.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

## TYPE 3 PROCEDURES

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

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

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

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

Frequency is waived for accidental injury.

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

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.

### 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

## TYPE 3 PROCEDURES

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).
- D3427 Periradicular surgery without apicoectomy.

### 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.

## TYPE 3 PROCEDURES

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).

### 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 any conventional clasps, rests and teeth).

D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).

D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).

D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).

D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).

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 (maxillary).

D5821 Interim partial denture (mandibular).

D5863 Overdenture - complete maxillary.

## TYPE 3 PROCEDURES

- D5864 Overdenture - partial maxillary.
  - D5865 Overdenture - complete mandibular.
  - D5866 Overdenture - partial mandibular.
  - 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, D6110, D6111, D6114, D6115

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

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

- PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

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

D6010, D6040, D6050, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

### DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

### ADD TOOTH/CLASP TO EXISTING PARTIAL

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

### DENTURE REBASES

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

### TISSUE CONDITIONING

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

### IMPLANTS

- D6010 Surgical placement of implant body: endosteal implant.
- D6040 Surgical placement: eposteal implant.
- D6050 Surgical placement: transosteal implant.
- D6051 Interim abutment.
- D6055 Connecting bar-implant supported or abutment supported.
- D6056 Prefabricated abutment - includes placement.
- D6057 Custom abutment - includes placement.

IMPLANT: D6010, D6040, D6050

## TYPE 3 PROCEDURES

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

D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Benefits for procedures D6051, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6056 and D6057 are limited to 1 of any of these procedures per 5 years.

### 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 porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
- 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 porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
- D6094 Abutment supported crown - (titanium).
- D6194 Abutment supported retainer crown for FPD - (titanium).
- 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.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.
- 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.



### TYPE 3 PROCEDURES

- 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.
- 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.
- 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.
- D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, 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, 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, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

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

### TYPE 3 PROCEDURES

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

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

Frequency is waived for accidental injury.

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

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, 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, D5281, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

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, D6094

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

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, D6194

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

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

## ORTHODONTIC EXPENSE BENEFITS

### Class Number 1

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

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

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

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

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

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

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

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

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

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

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

1. for a Program begun before the Insured became covered under this section.
2. in the first 12 months that a person is insured if the person is a Late Entrant.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. To replace lost, missing or stolen orthodontic appliances.

## Class Number 2

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

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

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

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

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

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

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

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

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

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

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

1. for a Program begun before the Insured became covered under this section.
2. in the first 12 months that a person is insured if the person is a Late Entrant.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. To replace lost, missing or stolen orthodontic appliances.

### Class Number 3

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

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

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

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

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

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

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

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

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

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

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

1. for a Program begun before the Insured became covered under this section.
2. in the first 12 months that a person is insured if the person is a Late Entrant.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. To replace lost, missing or stolen orthodontic appliances.



## Class Number 4

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

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

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

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

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

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

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

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

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

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

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

1. for a Program begun before the Insured became covered under this section.
2. in the first 12 months that a person is insured if the person is a Late Entrant.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. services or supplies for the treatment of an occupational injury or sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. To replace lost, missing or stolen orthodontic appliances.

## COORDINATION OF BENEFITS

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

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:
  - a. Any group insurance policy, but not including school-accident-type coverage, blanket, franchise individual, automobile or homeowner coverage;
  - b. Any group prepayment, group practice or group or individual service plan; or
  - c. A governmental program or coverage required or provided by any law, except Medicaid and any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
2. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
3. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
4. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
  - a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

- b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
  - i. the parents are married;
  - ii. the parents are not separated (whether or not they ever have been married); or
  - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

- c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
  - i. the Plan of the Custodial Parent;
  - ii. the Plan of the spouse of the Custodial Parent;
  - iii. the Plan of the non-Custodial Parent; and then
  - iv. the Plan of the spouse of the non-Custodial Parent.

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

- d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

- 1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

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

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

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



## GENERAL PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this policy is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** (a) After the second anniversary of the date this policy is issued, a misstatement made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

**GRACE PERIOD:** Unless, not less than 45 days before the premium due date, We have delivered to You, or have mailed to Your last address as shown by Our records, a written notice of Our intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of at least 90 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force.

**REINSTATEMENT.** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the Insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the Insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**CLAIM FORMS:** We will provide You the forms needed for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**NOTICE OF CLAIM:** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonable possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at our Home Office or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

**PROOF OF LOSS:** Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss within 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within 180 days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, other than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** At Our own expense We have the right and opportunity to conduct a physical examination of the Insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless You make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for You, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy.

**MISSTATEMENT OF AGE:** If the age of an Insured has been misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age.

**UNPAID PREMIUM:** At the time of payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment.

**CANCELLATION:** We may cancel this policy at any time for reasons previously disclosed by written notice delivered to You, or mailed to Your last address as shown by Our records, stating when the cancellation is effective, which may not be earlier than 45 days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, You may cancel the policy at any time by written notice delivered or mailed to Us, effective on receipt or on a later date specified in the notice. In the event of cancellation, We will promptly return the unearned portion of any premium paid. If You cancel, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the Insured resided when the policy was issued. If We cancel, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which You reside on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

**ILLEGAL OCCUPATION:** We are not liable for any loss to which a contributing cause was an Insured's commission of or attempt to commit a felony or to which a contributing cause was an Insured's being engaged in an illegal occupation

**INTOXICANTS AND NARCOTICS:** We are not liable for any loss sustained or contracted in consequence of an Insured's being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a physician

**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.** An Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of his or her license. We will in no way disturb the provider-patient relationship.



**TERMS AND CONDITIONS.** Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

**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.

**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.



## GENERAL PROVISIONS (CONTINUED)

**CONFORMITY WITH LAW.** Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

**ENTIRE CONTRACT.** The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

**INSURANCE DATA.** The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

- i. necessary to calculate premiums;
- ii. necessary to determine a person's effective date or termination date of insurance;
- iii. necessary to determine the proper coverage level of insurance.

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

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data 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 fails or errors in giving us the necessary data concerning an Insured's termination.

**CERTIFICATES.** We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

**PARTICIPATION REQUIREMENTS.** There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

- a. a certain percentage of all Members qualified for insurance must be insured at all times; and
- b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	20%
Number of Members-	884

**TERMINATION OF THE POLICY.** The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.
2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

**NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40.** No person, employer, principal, agent, trustee or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellations or nonrenewal of group health or life insurance, hospital, medical, or dental services corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of Chapter 58 of the General Statutes and their rights to purchase individual policies under the Federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the General Statutes. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

**CONSIDERATION.** This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

**TERMS AND CONDITIONS.** Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

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

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

**CLAIMS FOR BENEFITS**

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

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

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

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

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

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

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

## APPEAL PROCEDURE

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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

*Application is Hereby Made to*

AMERITAS LIFE INSURANCE CORP.

by: ONSLOW COUNTY SCHOOLS

whose main office address is: 200 BROADHURST RD  
JACKSONVILLE, NC 28540-3551

for Group Policy No. 10-350354

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

ONSLOW COUNTY SCHOOLS

(Full or Corporate Name of Applicant)

Dated at \_\_\_\_\_ By \_\_\_\_\_  
(Signature and Title)

On \_\_\_\_\_, 20\_\_\_\_ Witness \_\_\_\_\_  
(To be signed by Resident Agent where required by law)

**This copy is to remain Attached to the Policy**







