



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

**CERTIFICATE
PREFERRED PROVIDER GROUP DENTAL INSURANCE**

The Policyholder **DALTON PUBLIC SCHOOLS**

Policy Number **10-31181** **Insured Person**

Plan Effective Date **January 1, 2008** **Certificate Effective Date**
Refer to Exceptions

Plan Change Effective Date **January 1, 2018**

Class Number **2**

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder. Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate. The group policy may be amended or cancelled without the consent of the insured person. The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

IMPORTANT NOTICE

Dental benefits include a Preferred Provider Option. An Insured person has the freedom of choice to receive treatment from any Provider. Reimbursement for all services, including treatment for dental emergencies, to a Non-Preferred Provider will be equal to or greater than reimbursement to a Preferred Provider. The Insured should verify with their provider if they are a Preferred Provider. The Insured may be responsible for additional charges if services are provided by a Non-Preferred Provider.

President

**GEORGIA
IMPORTANT INFORMATION TO INSURED**

We are here to serve you . . .

You have the right to receive appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, you should first contact us at the address shown below.

If you have a grievance or complaint regarding:

- (a) the availability, delivery, or quality of dental plan services;
- (b) benefits or claims payment, handling, or reimbursement for dental services

You may document your concerns in writing and forward your written documentation to the following:

Name:	Quality Control
Address:	P.O. Box 82657 Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

Please also refer to your Explanation of Benefits and your certificate of coverage for appeals rights related to claims.

If after a careful review of your appeal, we determine that the benefit should have been denied, we will send you a written notice of that decision. You will also receive a notice of your right to appeal the decision to the Georgia Insurance Department.

If we agree that a benefit is available, we will issue a new predetermination of benefits or pay the claim in question.

You always have the right to contact the Department of Insurance:

**Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334**

**Telephone: 404-656-2070
Toll Free: 800-656-2298
Between 8:00 AM and 6:00 PM**

Non-Insurance Products/Services

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

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

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

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

Name of Provision	Page Number
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Increased Maximum Benefit	9042
Definitions	
Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Elimination Period	
Contribution Requirement	
Effective Date	
Termination Date	
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods, Missing Tooth Clause, Cosmetic Clause	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
ERISA Information and Notice of Your Rights	ERISA Notice

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

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

Benefit Class

Class Description

Class 2

Employees Electing The Low Plan

DENTAL EXPENSE BENEFITS

When you select a Preferred Provider, a contracted fee is charged for covered services, which is intended to provide Insureds, reduced out of pocket costs. The reimbursement to a Non-Preferred Provider will be at least equal to or greater than the reimbursement to a Preferred Provider.

Deductible Amount:

Type 1 Procedures - Each Visit	\$5
Type 2 Procedures - Each Benefit Period	\$50

If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period ; and
 - ii. these expenses are applied towards the Deductible Amount for that Benefit Period,
- such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period .

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%

Maximum Amount - Each Benefit Period	\$750
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INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$125
PPO Bonus – Each Benefit Period	\$50
Benefit Threshold Per Insured Person – Each Benefit Period	\$250
Maximum Carry Over Amount	\$500

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

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

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

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

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

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

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

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

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

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.

MEMBER refers to an employee of the eligible class(es) as defined by the Policyholder.

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.

FULL-TIME STUDENT. A full-time student means that the child remains a dependent of the Insured or the Insured's spouse, has been enrolled for five calendar months or more as a full-time student at a post secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury.

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.

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.

PREFERRED AND NON-PREFERRED PROVIDERS. A Preferred Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Preferred 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 Preferred Provider's contracted fees for covered services. A Non-Preferred 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 Preferred Provider.

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employees electing the low plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth.

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

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

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employees electing the low plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

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

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

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 30 calendar day(s) of continuous active employment.

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

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

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

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

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

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

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

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

TERMINATION DATES

INSUREDS. The Insured may terminate coverage upon written notice to the Policyholder. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

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

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

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider. The Insured should verify with their provider if they are a Preferred Provider. The Insured may be responsible for additional charges if services are provided by a Non-Preferred 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.

In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Preferred Providers.

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 Preferred Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan, if services are provided by a Preferred Provider, who is a general dentist.

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

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

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the

Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

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

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

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

1. for 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.
2. for any procedure begun after the insured person's insurance under this contract terminates.
3. to replace lost or stolen appliances.
4. for any treatment which is for cosmetic purposes.
5. 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.)
6. 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).
7. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
8. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
9. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

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

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

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Ø 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.
- Ø 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.
- Ø 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).
- Ø 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.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON-PREFERRED PROVIDERS - Usual and Customary
PAYMENT BASIS - PREFERRED 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 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- 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 1 of any of these procedures per 6 month(s).
- 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 5 year(s).

OTHER XRAYS

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

PERIAPICAL: D0220, D0230

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

BITEWINGS

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

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 5 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

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

TYPE 1 PROCEDURES

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

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

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

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- Not allowed when done on the same date as periodontal services.

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.

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-PREFERRED PROVIDERS - Usual and Customary

PAYMENT BASIS - PREFERRED PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY

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

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

TYPE 2 PROCEDURES

- 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.

ENDODONTICS MISCELLANEOUS

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

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.

TYPE 2 PROCEDURES

- 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.

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.

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable comprehensive 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.

OTHER PERIODONTAL SERVICES: D4346, D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- 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 clasp-per tooth.
- D5640 Replace broken teeth - per tooth.

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).

TYPE 2 PROCEDURES

OTHER ORAL SURGERY

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

BIOPSY OF ORAL TISSUE

- D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
- D7286 Incisional biopsy of oral tissue - soft.

TYPE 2 PROCEDURES

- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

- D9110 Palliative (emergency) treatment of dental pain - minor procedure.
PALLIATIVE TREATMENT: D9110
 - Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

PROFESSIONAL CONSULT/VISIT/SERVICES

- D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
- D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
- D9440 Office visit - after regularly scheduled hours.
- D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.
CONSULTATION: D9310
 - Coverage is limited to 1 of any of these procedures per 1 provider.
- OFFICE VISIT: D9430, D9440
 - Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

- D9951 Occlusal adjustment - limited.
- 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.

COORDINATION OF BENEFITS

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

GENERAL PROVISIONS

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

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

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 10 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

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

TIME OF PAYMENT. We will pay all benefits within 15 working days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 15 working days of receipt, we will notify you within that 15-day period providing you with a list of information necessary for us to pay the claim. Upon receipt of the additional information, we will have an additional 15 working days within which to process the claim and either make payment or notify the claimant of the denial. We will pay interest at the rate of eighteen percent per year on benefits for valid claims not paid within the time periods noted above until the claim is settled.

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.

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

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

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. Eligibility and Benefits Provided Under the Group Policy

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

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

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

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

C. Termination Of The Group Policy

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

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

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

D. Claims For Benefits

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

E. Continuation of Coverage Provisions (COBRA)

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

i. Definitions For This Section

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

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

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

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
 - a. The date of the disability determination;
 - b. The date of the Qualifying Event; or
 - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

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

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

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

4. COBRA Continuation For Certain Bankruptcy Proceedings

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

v. Premium Requirements

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

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

F. Your Rights under ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Rights

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

20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

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

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

CLAIMS FOR BENEFITS

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

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

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

YOUR RIGHTS

YOU HAVE THE RIGHT TO:

Get a copy of your claims records

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

Correct your claims records

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

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit the information we share

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

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

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

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

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

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

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

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

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

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

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Run our organization

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

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

Pay for your health services

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

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

Administer your health plan

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

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

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

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

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

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

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

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

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

OUR RESPONSIBILITIES

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

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

This Revised Notice is effective 9/23/13.

