This is Your
INSURANCE CERTIFICATE
Issued by
Ameritas Life Insurance Corp. of New York
1350 Broadway, Suite 2201
New York NY  10018

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Policy between Ameritas Life Insurance Corp. of New York (hereinafter referred to as “We”, “Us”, or “Our”) and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers. You should always consider receiving dental care services first through the in-network benefits portion of this Certificate.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. Some Covered services, such as Orthodontics are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Certificate for more information.

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

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

The insurance evidenced by this Certificate provides Dental and Eye Care insurance ONLY.

William W Lester, President
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SECTION I

Definitions

Defined terms will appear capitalized throughout the Certificate.

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

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

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

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

Certificate: This Certificate issued by Ameritas Life Insurance Corp. of New York, including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Policy.

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

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when you receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

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

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

Dependents: The Subscriber’s Spouse and Children.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma.

Exclusions: Services that We do not pay for or Cover.

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

General Dentist: A dentist licensed under Title 8 of the New York State Education Law (or comparable state law, if applicable) who is not a Specialist.
Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a policyholder.

Hospital: A short term, acute, general Hospital, which:
- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Late Entrant: Any Dependent whose Effective Date of insurance is more than 31 days form the date the Dependent becomes eligible for insurance or who has elected to become insured again after having been terminated.

Maximum Amount: The maximum amount payable for each covered person per Plan Year. The Maximum Amount is shown on the Schedule of Benefits.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

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

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, “Member” also means the Member’s designee.

Non-Participating Provider: A Provider who doesn’t have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.
Policy: The policy entered into between Ameritas Life Insurance Corp. of New York and the Group and any riders attached to the Policy.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.ameritas.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D.-Medical Doctor or D.O.-Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require preauthorization in the Schedule of Benefits section of this certificate.

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

Primary Care Dentist (“PCD”): A participating dentist who directly provides or coordinates a range of dental services for You.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider’s services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Certificate.

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

Service Area: The geographical area, in which We provide coverage. Our Service Area consists of all counties within New York State.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Us, We, Our: Ameritas Life Insurance Corp. of New York and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.
SECTION II
How Your Coverage Works

A. Your Coverage under this Certificate.
Your employer (referred to as the “Group”) has purchased a Group dental and eye care insurance Policy from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and/or their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:
- Medically Necessary;
- Provided by a Participating Provider for in network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.
To find out if a Provider is a Participating Provider, and for details about licensure and training:
- Check Your Provider directory, available at Your request.
- Call 800-659-5556, the number on Your ID card; or.
Participating and Non-Participating Providers are available nationwide.

D. The Role of Primary Care Dentists.
This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist (“PCD”).

E. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. When making appointments with Participating Providers, call the office to make sure he or she is in the network.

To see a Provider, call his or her office and tell the Provider that You are an Ameritas Life Insurance Corp. of New York plan Member, and explain the reason for Your visit. Have Your ID card available. The Provider’s office may ask You for Your Group or Member ID number. When You go to the Provider’s office, bring Your ID card with You.

We Cover the services of Non-Participating Providers. However, some services are only Covered when you go to a Participating Provider. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject To Preauthorization.
Our Preauthorization is not required before You receive certain Covered Services.

H. Pre-Determination/Pre-Treatment Estimates.
We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision.
through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal appeal and external appeal.

I. Medical Management.
The benefits available to You under this Certificate may be subject to pre-service, concurrent, and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

J. Medical Necessity.
We Cover certain benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, “service”) is Medically Necessary e.g. periodontal surgery. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Providers;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

K. Important Telephone Numbers and Addresses.

- CLAIMS
  P.O. Box 82595
  Lincoln NE  68501-2595
  Fax: 402-467-7336
  group@ameritas.com
  (Submit claim forms to this address.)
• COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  P.O. Box 82657
  Lincoln NE  68501-2657
  877-897-4328

• CUSTOMER SERVICE
  800-659-5556
  Customer Service Representatives are available Monday - Thursday 7 am to Midnight and Friday 7 am to 6:30 pm Central Time.

• OUR WEBSITE
  www.ameritas.com
SECTION III
Access to Care and Transitional Care

A. When Your Provider Leaves the Network
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider’s contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered services for up to 90 days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, Authorization, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider’s ability to practice, continued treatment with that Provider is not available.

B. New Members In a Course of Treatment
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive network level Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for You to continue to receive Covered services for up to 60 days the Non-Participating Provider must agree to accept as payment Our fees for such services. The provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Service as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.
SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Cost-Sharing amounts incurred with Participating Providers and Non-Participating Providers accumulate to the Deductible.

You have a combined In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services applies towards Your In-Network Deductible. Cost-Sharing for in-network services applies toward Your Out-of-Network Deductible. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.
There are no Copayments for Covered Services under this Certificate.

C. Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.

D. Out-of-Pocket Limit.
This Certificate does not have an Out-of-Pocket Limit.

E. In and Out-of-Network Annual Maximum.
This Certificate has an in and out-of-network annual maximum for non-orthodontic benefits described in the Schedule of Benefits section of this Certificate. Once You have met the in and out-of-network annual maximum for non-orthodontic Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for the remainder of that Plan Year. If you have other than individual coverage, the individual in and out-of-network annual maximum applies to each person covered under this Certificate. Once a person within a family meets the individual in and out-of-network annual maximum, no more benefits will be payable for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family in and out-of-network annual maximum in the Schedule of Benefits section of this Certificate, no more benefits will be payable for the family for the remainder of that Plan Year.

F. Lifetime Maximum for In and Out-of-Network Cosmetic Orthodontics.
This Certificate has a lifetime maximum for in and out-of-network cosmetic orthodontic benefits. Once You have met the lifetime maximum for in and out-of-network cosmetic orthodontics in the Schedule of Benefits section of this Certificate, no more benefits for those services will be payable for the remainder of Your lifetime. If you have other than individual coverage, the individual lifetime maximum for in and out-of-network cosmetic orthodontics applies to each person covered under this Certificate. Once a person within a family meets the individual lifetime maximum for cosmetic orthodontics, no benefits for cosmetic orthodontia will be payable for that person.

G. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider’s actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider’s actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

H. Allowed Amount.
“Allowed Amount” means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the maximum allowable charge (MAC) amount we have negotiated with the Participating Provider, the amount approved by us, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. For Providers, the allowed amount will be the lesser of:

   The Provider's Charge
   The Maximum Procedure Allowance (MPA) which is an allowance derived from submitted provider charges.
   The Maximum Covered Expense which is a scheduled dollar amount per procedure.

The Non-Participating Provider’s actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider’s charge. Contact Us at 800-659-5556, the number on Your ID card, or visit Our website at www.ameritas.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.
SECTION V
Who Is Covered

A. Who is Covered Under this Certificate.
You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending upon the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered (including same sex Spouse, as allowed by state law).
3. **Individual and Child/Children.** If You selected individual and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.
If You selected individual and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the year in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child’s Physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.
Coverage under this Certificate will begin as of the Effective Date shown on the cover page of the Policy.

If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the next renewal to add Your Spouse.
If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant’s birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to individual and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.
You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group dental plan due to:
1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions towards the group dental plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other group dental plan.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:
1. You or Your Spouse or Child loses eligibility for Medicaid or a state child dental plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

F. Domestic Partner Coverage.
This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership. a. The affidavit must be notarized and must contain the following:
   · The partners are both 18 years of age or older and are mentally competent to consent to contract;
The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
The partners have been living together on a continuous basis prior to the date of the application;
Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and

b. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
   • A joint bank account;
   • A joint credit card or charge card;
   • Joint obligation on a loan;
   • Status as an authorized signatory on the partner’s bank account, credit card or charge card;
   • Joint ownership of holdings or investments;
   • Joint ownership of residence;
   • Joint ownership of real estate other than residence;
   • Listing of both partners as tenants on the lease of the shared residence;
   • Shared rental payments of residence (need not be shared 50/50);
   • Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   • A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
   • Shared household budget for purposes of receiving government benefits;
   • Status of one (1) as representative payee for the other’s government benefits;
   • Joint ownership of major items of personal property (e.g., appliances, furniture);
   • Joint ownership of a motor vehicle;
   • Joint responsibility for child care (e.g., school documents, guardianship);
   • Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
   • Execution of wills naming each other as executor and/or beneficiary;
   • Designation as beneficiary under the other’s life insurance policy;
   • Designation as beneficiary under the other’s retirement benefits account;
   • Mutual grant of durable power of attorney;
   • Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   • Affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
   • Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.
SECTION VI

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect, except as described in the Orthodontic Expense Benefits section of this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

D. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

E. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

F. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

G. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

H. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

I. Medically Necessary.
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.

J. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

K. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

L. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

M. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

N. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

O. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

P. Services with No Charge.
We do not Cover services for which no charge is normally made.

Q. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

R. Workers’ Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law.
SECTION VII

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 800-659-5556; the number on your ID card or visiting Our website at www.ameritas.com.

Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or to the address on Your ID card. You may also submit a claim to Us electronically by using the instructions in the How Your Coverage Works section of this Certificate or the instructions on Your ID card or by visiting Our website www.ameritas.com.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 120 days; after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-service Claim Determinations.
1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.
If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.
A post-service claim is a request for a benefit for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.
SECTION VIII
New York
Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at 877-897-4328 or the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of benefits for urgent care. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You in writing within the following timeframes:

Expeditied/Urgent Grievances: By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:
(A request for a service or treatment that has not yet been provided.)
In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:
(A claim for a service or treatment that has already been provided.)
In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances:
(That are not in relation to a claim or request for a service or treatment.)
45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 877-897-4328 or the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:
Expedited/Urgent Grievances: The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal.
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of Your Appeal.
(A claim for a service or treatment that has already been provided.)

All Other Grievances: 30 calendar days of receipt of Your Appeal.
(That are not in relation to a claim or request for a service or treatment.)

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

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
www.communityhealthadvocates.org
SECTION IX

Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 877-897-4328 or the number on your ID card. The toll-free number is available at least 40 hours a week with an after hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 877-897-4328 or visit Our website at www.ameritas.com

B. Preauthorization Reviews
We do not require Preauthorization Reviews under this Policy. If we do in the future:

1. Non-Urgent Preauthorization Reviews. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

C. Concurrent Reviews.

1. Non-Urgent Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.
2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

**D. Retrospective Reviews.**

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

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

**E. Retrospective Review of Preauthorized Services.**

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

**F. Reconsideration.**

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization benefit estimates the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

**G. Utilization Review Internal Appeals.**

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment
will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. If only a portion of the additional information is received, We will request the missing information, in writing, within five business days of receipt of the partial information. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal.

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

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

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Appeal Assistance.

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

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: 1-888-614-5400, or email cha@cssny.org

www.communityhealthadvocates.org
A. **Your Right to an External Appeal.**

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

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

B. **Your Right to Appeal A Determination that A Service Is Not Medically Necessary.**

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. **Your Right to Appeal A Determination that A Service is Experimental or Investigational.**

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation. Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.
D. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

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

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

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments provided in the clinical trial.

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

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

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

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.
SECTION XI
Coordination of Benefits

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.
1. “Allowable expense” is the necessary, reasonable, and customary item of expense for dental and eye care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. “Plan” is other group dental coverage with which We will coordinate benefits. The term “plan” includes:
   • Group dental and eye care benefits and blanket or group remittance dental and eye care benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   • Dental and eye care benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
   • Dental and eye care benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. “Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. “Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.
The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:
1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court
decree between the parents that establishes financial responsibility for the child’s dental care expenses:
   • The plan of the parent who has custody will be primary;
   • If the parent with custody has remarried, and the child is also covered as a child under the
     step-parent’s plan, the plan of the parent with custody will pay first, the step-parent's plan will pay
     second, and the plan of the parent without custody will pay third; and
   • If a court decree between the parents says which parent is responsible for the child’s dental and
     eye care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the
     decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not
   laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another
   plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the
   plan that covers such person as an active employee or spouse or child of an active employee will be
   primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be
   primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving
   services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and
this plan during a claim determination period will not exceed Our maximum available benefit for each Covered
Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each
claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that
have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or
receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You
must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our
payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and
You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be
always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules
described above in the following manner:
1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as
   the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will
calculate the amount We should pay on the assumption that the non-complying plan and this Certificate
provide identical benefits. When the information is received, We will make any necessary adjustments.
SECTION XII

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the year in which the Child turns 26 years of age. For a Child who is a student at an accredited institution of learning, until the end of the year in which the Child turns 26 years of age.

6. For all other Dependents, the date in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us; requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us; to the Subscriber. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to one year; Your enrollment under the Certificate.

9. The date that the Subscriber's Policy is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 30 days prior written notice.

10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.
See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.
SECTION XIII

Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Certificate, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.
SECTION XIV
Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying Events.
Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber’s employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber’s class;
   - Divorce or legal separation from the Subscriber;
   - Death of the Subscriber; or
   - The covered employee becoming entitled to Medicare.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber’s employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber’s class;
   - Loss of covered Child status under the plan rules;
   - Death of the Subscriber; or
   - The covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:
1. The date 18 months after the Subscriber’s coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Member is determined to be disabled under the United States Social Security Act.
2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber’s eligibility for Medicare, or the failure to qualify under the definition of “Children”;
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.
Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act (“USERRA”), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:
1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
2. If You or Your Dependent’s coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.
SECTION XV
General Provisions

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

2. Assignment.
You cannot assign any benefits or monies due under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. Changes in This Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group 30 days’ prior written notice.

This Certificate shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

The Group will provide Us with the enrollment form or information including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Policy with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

8. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.
9. **Fraud and Abusive Billing.**
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. **Furnishing Information and Audit.**
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

11. **Identification Cards.**
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

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

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

14. **Material Accessibility.**
We will give the Group, and the Group will give You; ID cards, Certificates riders and other necessary materials.

15. **More Information about Your Dental Plan.**
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Group. You agree to provide your Group and Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to:
Ameritas Life Insurance Corp. of New York
P.O. Box 82595
Lincoln NE  68501-2595

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

On occasion a payment will be made to You when You are not Covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

19. Renewal Date.
The renewal date for the Certificate is the anniversary of the effective date of the Group Policy of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Certificate, or by the Group upon 30 days’ prior written notice to Us.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

21. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. Section 125 Plans.
This Certificate is provided as part of Your Group’s Section 125 plan. Each Member has the option under the Section 125 plan of participating or not participating in this Certificate. If a Member does not elect to participate when initially eligible, the Member may elect to participate during a subsequent election period. An election period will be held each year and those electing to participate in this Certificate at that time will have their insurance become effective on January 1.

23. Severability.
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

24. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to
arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

25. **Third Party Beneficiaries.**
No third party beneficiaries are intended to be created by this Certificate and nothing in the Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate’s provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

26. **Time to Sue.**
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.

27. **Translation Services.**
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 800-659-5556, the number on Your ID card, to access these services.

28. **Waiver.**
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

29. **Who May Change this Certificate.**
This Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

30. **Who Receives Payment under this Certificate.**
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You, the Subscriber or the Provider unless an assignment has been made.

31. **Workers’ Compensation Not Affected.**
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers’ compensation insurance or law.

32. **Your Dental Records and Reports.**
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
• Permit copying of Your dental records by Us.

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

<table>
<thead>
<tr>
<th>Benefit Class</th>
<th>Class Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 2</td>
<td>Employees Electing Plan B</td>
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</tbody>
</table>

### DENTAL EXPENSE BENEFITS

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

**Deductible Amount:**

- Type 1 Procedures: $0
- Combined Type 2 and Type 3 Procedures - Each Plan Year: $100

**Member Coinsurance Percentage:**

- Type 1 Procedures: 0%
- Type 2 Procedures: 0% of Schedule
- Type 3 Procedures: 0% of Schedule

**Maximum Amount - Each Plan Year:** $1,000

### ORTHODONTIC EXPENSE BENEFITS

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

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

### EYE CARE EXPENSE BENEFITS

- Deductible Amount: $0
- Maximum Amount - Each Plan Year: $150

*Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.*
TABLE OF DENTAL PROCEDURES

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

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

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

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

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

ROUTINE EVALUATION: D0120, D0145
- Coverage is limited to 2 of any of these procedures per Plan Year.
- 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.

PROPHYLAXIS (CLEANING) AND FLUORIDE
D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208
- Coverage is limited to 1 of any of these procedures per Plan Year.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120
- Coverage is limited to 2 of any of these procedures per Plan Year.
- D4346, D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935
- Coverage is limited to 2 of any of these procedures per Plan Year.
- Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SPACE MAINTAINERS
D1510 Space maintainer - fixed - unilateral.
D1516 Space maintainer - fixed - bilateral, maxillary.
D1517 Space maintainer - fixed - bilateral, mandibular.
D1520 Space maintainer - removable - unilateral.
D1526 Space maintainer - removable - bilateral, maxillary.
D1527 Space maintainer - removable - bilateral, mandibular.
D1550 Re-cement or re-bond space maintainer.
D1555 Removal of fixed space maintainer.
D1575 Distal shoe space maintainer - fixed - unilateral.

SPACE MAINTAINER: D1510, D1520, D1575
- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.
TYPE 1 PROCEDURES

APPLIANCE THERAPY
   D8210  Removable appliance therapy.
   D8220  Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220
   - Coverage is limited to the correction of thumb-sucking.
## TYPE 2 PROCEDURES

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS** - Maximum Covered Expense

**PAYMENT BASIS - PARTICIPATING PROVIDERS** - Maximum Allowable Charge

*For Additional Limitations - See Limitations*

### LIMITED ORAL EVALUATION

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused.</td>
<td>$25.00</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit).</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

**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.

### COMPLETE SERIES OR PANORAMIC

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images.</td>
<td>$51.00</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image.</td>
<td>$41.00</td>
</tr>
</tbody>
</table>

**Complete Series/Panoramic: D0210, D0330**

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

### OTHER XRAYS

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image.</td>
<td>$9.00</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image.</td>
<td>$7.00</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image.</td>
<td>$13.00</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.</td>
<td>$16.00</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image.</td>
<td>$16.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image.</td>
<td>$8.00</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images.</td>
<td>$14.00</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three radiographic images.</td>
<td>$17.00</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four radiographic images.</td>
<td>$22.00</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 radiographic images.</td>
<td>$34.00</td>
</tr>
</tbody>
</table>

**Bitewings: D0270, D0272, D0273, D0274**

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

**Vertical Bitewings: D0277**

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

### ORAL PATHOLOGY/LABORATORY

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0472</td>
<td>Accession of tissue, gross examination, preparation and transmission of written report.</td>
<td>$30.00</td>
</tr>
<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and transmission of written report.</td>
<td>$59.00</td>
</tr>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.</td>
<td>$59.00</td>
</tr>
</tbody>
</table>

**Oral Pathology Laboratory: D0472, D0473, D0474**

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

### SEALANT

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351</td>
<td>Sealant - per tooth.</td>
<td>$19.00</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in a moderate to high caries risk patient-permanent.</td>
<td>$19.00</td>
</tr>
</tbody>
</table>
### TYPE 2 PROCEDURES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1353</td>
<td>Sealant repair - per tooth.</td>
<td>$19.00</td>
</tr>
<tr>
<td>SEALANT: D1351, D1352, D1353</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Coverage is limited to 1 of any of these procedures per 3 year(s).</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Benefits are considered for persons age 16 and under.</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Benefits are considered on permanent molars only.</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Coverage is allowed on the occlusal surface only.</td>
<td></td>
</tr>
<tr>
<td><strong>AMALGAM RESTORATIONS (FILLINGS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent.</td>
<td>$43.00</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent.</td>
<td>$66.00</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent.</td>
<td>$79.00</td>
</tr>
<tr>
<td>AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Coverage is limited to 1 of any of these procedures per 6 month(s).</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.</td>
<td></td>
</tr>
<tr>
<td><strong>RESIN RESTORATIONS (FILLINGS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior.</td>
<td>$52.00</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior.</td>
<td>$66.00</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior.</td>
<td>$82.00</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces or involving incisal angle (anterior).</td>
<td>$91.00</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite - one surface, posterior.</td>
<td>$57.00</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior.</td>
<td>$72.00</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior.</td>
<td>$91.00</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior.</td>
<td>$100.00</td>
</tr>
<tr>
<td>D2410</td>
<td>Gold foil - one surface.</td>
<td>$43.00</td>
</tr>
<tr>
<td>D2420</td>
<td>Gold foil - two surfaces.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D2430</td>
<td>Gold foil - three surfaces.</td>
<td>$66.00</td>
</tr>
<tr>
<td>D2990</td>
<td>Resin infiltration of incipient smooth surface lesions.</td>
<td>$52.00</td>
</tr>
<tr>
<td>COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Coverage is limited to 1 of any of these procedures per 6 month(s).</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Porcelain and resin benefits are considered for anterior and bicuspid teeth only.</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.</td>
<td></td>
</tr>
<tr>
<td>GOLD FOIL RESTORATIONS: D2410, D2420, D2430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Gold foils are considered at an alternate benefit of an amalgam/composite restoration.</td>
<td></td>
</tr>
<tr>
<td><strong>STAINLESS STEEL CROWN (PREFABRICATED CROWN)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior.</td>
<td>$111.00</td>
</tr>
<tr>
<td>D2929</td>
<td>Prefabricated porcelain/ceramic crown - primary tooth.</td>
<td>$102.00</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth.</td>
<td>$93.00</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth.</td>
<td>$99.00</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown.</td>
<td>$111.00</td>
</tr>
<tr>
<td>D2933</td>
<td>Prefabricated stainless steel crown with resin window.</td>
<td>$111.00</td>
</tr>
<tr>
<td>D2934</td>
<td>Prefabricated esthetic coated stainless steel crown - primary tooth.</td>
<td>$111.00</td>
</tr>
<tr>
<td>STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Replacement is limited to 1 of any of these procedures per 12 month(s).</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Porcelain and resin benefits are considered for anterior and bicuspid teeth only.</td>
<td></td>
</tr>
<tr>
<td><strong>RECEMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.</td>
<td>$34.00</td>
</tr>
<tr>
<td>D2915</td>
<td>Re-cement or re-bond indirectly fabricated or prefabricated post and core.</td>
<td>$17.00</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown.</td>
<td>$34.00</td>
</tr>
<tr>
<td>D2921</td>
<td>Reattachment of tooth fragment, incisal edge or cusp.</td>
<td>$82.00</td>
</tr>
<tr>
<td>D6092</td>
<td>Re-cement or re-bond implant/abutment supported crown.</td>
<td>$34.00</td>
</tr>
</tbody>
</table>
**TYPE 2 PROCEDURES**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6093</td>
<td>Re-cement or re-bond implant/abutment supported fixed partial denture.</td>
<td>$34.00</td>
</tr>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture.</td>
<td>$47.00</td>
</tr>
</tbody>
</table>

**SEDATIVE FILLING**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2940</td>
<td>Protective restoration.</td>
<td>$32.00</td>
</tr>
<tr>
<td>D2941</td>
<td>Interim therapeutic restoration - primary dentition.</td>
<td>$24.00</td>
</tr>
</tbody>
</table>

**FULL MOUTH DEBRIDEMENT**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.</td>
<td>$53.00</td>
</tr>
</tbody>
</table>

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

**OTHER PERIODONTAL SERVICES**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.</td>
<td>$37.00</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance.</td>
<td>$54.00</td>
</tr>
</tbody>
</table>

**PERIODONTAL MAINTENANCE: D4346, D4910**

- Coverage is limited to 2 of any of these procedures per Plan Year.
- 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**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth).</td>
<td>$45.00</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary.</td>
<td>$54.00</td>
</tr>
<tr>
<td>D5621</td>
<td>Repair cast partial framework, mandibular.</td>
<td>$64.00</td>
</tr>
<tr>
<td>D5622</td>
<td>Repair cast partial framework, maxillary.</td>
<td>$64.00</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken retentive/clasping materials per tooth.</td>
<td>$67.00</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth.</td>
<td>$48.00</td>
</tr>
</tbody>
</table>

**DENTURE RELINES**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside).</td>
<td>$100.00</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside).</td>
<td>$100.00</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside).</td>
<td>$90.00</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside).</td>
<td>$90.00</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory).</td>
<td>$149.00</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory).</td>
<td>$146.00</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory).</td>
<td>$149.00</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory).</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - primary tooth.</td>
<td>$48.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal).</td>
<td>$48.00</td>
</tr>
</tbody>
</table>

**BIOPSY OF ORAL TISSUE**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue - hard (bone, tooth).</td>
<td>$194.00</td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue - soft.</td>
<td>$105.00</td>
</tr>
<tr>
<td>D7287</td>
<td>Exfoliative cytological sample collection.</td>
<td>$52.00</td>
</tr>
<tr>
<td>D7288</td>
<td>Brush biopsy - transepithelial sample collection.</td>
<td>$52.00</td>
</tr>
</tbody>
</table>

**PALLIATIVE**
TYPE 2 PROCEDURES

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.  $37.00
D9430  Office visit for observation (during regularly scheduled hours) - no other services performed.  $25.00
D9440  Office visit - after regularly scheduled hours.  $44.00
D9930  Treatment of complications (post-surgical) - unusual circumstances, by report.  $27.00
       CONSULTATION: D9310  
          • Coverage is limited to 1 of any of these procedures per provider.
       OFFICE VISIT: D9430, D9440  
          • Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL GUARD

D9944  Occlusal guard - hard appliance, full arch.  B/R
D9945  Occlusal guard - soft appliance, full arch.  B/R
D9946  Occlusal guard - hard appliance, partial arch.  B/R

MISCELLANEOUS

D0486  Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.  $30.00
D2951  Pin retention - per tooth, in addition to restoration.  $16.00
D9911  Application of desensitizing resin for cervical and/or root surfaces, per tooth.  $52.00
       DESENSITIZATION: D9911  
          • Coverage is limited to 1 of any of these procedures per 6 month(s).
          • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
          • Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
          • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.
INLAY RESTORATIONS

D2510 Inlay - metallic - one surface. $153.00
D2520 Inlay - metallic - two surfaces. $182.00
D2530 Inlay - metallic - three or more surfaces. $195.00
D2610 Inlay - porcelain/ceramic - one surface. $168.00
D2620 Inlay - porcelain/ceramic - two surfaces. $183.00
D2630 Inlay - porcelain/ceramic - three or more surfaces. $200.00
D2650 Inlay - resin-based composite - one surface. $175.00
D2651 Inlay - resin-based composite - two surfaces. $172.00
D2652 Inlay - resin-based composite - three or more surfaces. $178.00

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces. $198.00
D2543 Onlay - metallic - three surfaces. $221.00
D2544 Onlay - metallic - four or more surfaces. $230.00
D2642 Onlay - porcelain/ceramic - two surfaces. $198.00
D2643 Onlay - porcelain/ceramic - three surfaces. $221.00
D2644 Onlay - porcelain/ceramic - four or more surfaces. $228.00
D2662 Onlay - resin-based composite - two surfaces. $185.00
D2663 Onlay - resin-based composite - three surfaces. $191.00
D2664 Onlay - resin-based composite - four or more surfaces. $203.00

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect). $86.00
D2712 Crown - 3/4 resin-based composite (indirect). $214.00
D2720 Crown - resin with high noble metal. $221.00
D2721 Crown - resin with predominantly base metal. $168.00
## TYPE 3 PROCEDURES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2722</td>
<td>Crown - resin with noble metal.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic.</td>
<td>$238.00</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal.</td>
<td>$231.00</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal.</td>
<td>$198.00</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal.</td>
<td>$213.00</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - 3/4 cast high noble metal.</td>
<td>$220.00</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown - 3/4 cast predominantly base metal.</td>
<td>$191.00</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown - 3/4 cast noble metal.</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - 3/4 porcelain/ceramic.</td>
<td>$238.00</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high noble metal.</td>
<td>$220.00</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown - full cast predominantly base metal.</td>
<td>$191.00</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown - full cast noble metal.</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2794</td>
<td>Crown - titanium.</td>
<td>$220.00</td>
</tr>
</tbody>
</table>

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

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

**CORE BUILD-UP**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required.</td>
<td>$48.00</td>
</tr>
</tbody>
</table>

CORE BUILDUP: D2950

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

**POST AND CORE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2952</td>
<td>Post and core in addition to crown, indirectly fabricated.</td>
<td>$76.00</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown.</td>
<td>$64.00</td>
</tr>
</tbody>
</table>

**FIXED CROWN AND PARTIAL DENTURE REPAIR**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure.</td>
<td>$39.00</td>
</tr>
<tr>
<td>D2981</td>
<td>Inlay repair necessitated by restorative material failure.</td>
<td>$31.00</td>
</tr>
<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure.</td>
<td>$31.00</td>
</tr>
<tr>
<td>D2983</td>
<td>Veneer repair necessitated by restorative material failure.</td>
<td>$31.00</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair necessitated by restorative material failure.</td>
<td>$43.00</td>
</tr>
<tr>
<td>D9120</td>
<td>Fixed partial denture sectioning.</td>
<td>$43.00</td>
</tr>
</tbody>
</table>

**ENDODONTICS MISCELLANEOUS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.</td>
<td>$30.00</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth.</td>
<td>$30.00</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.</td>
<td>$46.00</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).</td>
<td>$40.00</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).</td>
<td>$35.00</td>
</tr>
<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects.</td>
<td>$50.00</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).</td>
<td>$50.00</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).</td>
<td>$34.00</td>
</tr>
</tbody>
</table>
## TYPE 3 PROCEDURES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3353</td>
<td>Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).</td>
<td>$98.00</td>
</tr>
<tr>
<td>D3357</td>
<td>Pulpal regeneration - completion of treatment.</td>
<td>$98.00</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling - per root.</td>
<td>$39.00</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation - per root.</td>
<td>$92.00</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection (including any root removal), not including root canal therapy.</td>
<td>$78.00</td>
</tr>
</tbody>
</table>

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

- Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth.</td>
<td>$138.00</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, premolar tooth (excluding final restorations).</td>
<td>$163.00</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar tooth (excluding final restorations).</td>
<td>$213.00</td>
</tr>
<tr>
<td>D3332</td>
<td>Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.</td>
<td>$81.00</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior.</td>
<td>$172.00</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - premolar.</td>
<td>$198.00</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar.</td>
<td>$246.00</td>
</tr>
</tbody>
</table>

**ROOT CANALS: D3310, D3320, D3330, D3332**

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

### RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

### SURGICAL ENDODONTICS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3355</td>
<td>Pulpal regeneration - initial visit.</td>
<td>$50.00</td>
</tr>
<tr>
<td>D3356</td>
<td>Pulpal regeneration - interim medication replacement.</td>
<td>$34.00</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy - anterior.</td>
<td>$142.00</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy - premolar (first root).</td>
<td>$164.00</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy - molar (first root).</td>
<td>$178.00</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy (each additional root).</td>
<td>$64.00</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy.</td>
<td>$128.00</td>
</tr>
</tbody>
</table>

### SURGICAL PERIODONTICS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$90.00</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$45.00</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$124.00</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$62.00</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$227.00</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.</td>
<td>$114.00</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone replacement graft - retained natural tooth - first site in quadrant.</td>
<td>$74.00</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone replacement graft - retained natural tooth - each additional site in quadrant.</td>
<td>$56.00</td>
</tr>
<tr>
<td>D4265</td>
<td>Biologic materials to aid in soft and osseous tissue regeneration.</td>
<td>$37.00</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure.</td>
<td>$167.00</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D4274</td>
<td>Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).</td>
<td>$99.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Maximum Covered Expense</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>D4275</td>
<td>Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.</td>
<td>$177.00</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined connective tissue and double pedicle graft, per tooth.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D4277</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.</td>
<td>$178.00</td>
</tr>
<tr>
<td>D4278</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
<td>$71.00</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D4285</td>
<td>Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
<td>$80.00</td>
</tr>
</tbody>
</table>

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

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

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

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

**CROWN LENGTHENING**
- D4249 Clinical crown lengthening - hard tissue. $136.00

**NON-SURGICAL PERIODONTICS**
- D4341 Periodontal scaling and root planing - four or more teeth per quadrant. $46.00
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant. $23.00
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report. $34.00

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

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

**PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)**
- D5110 Complete denture - maxillary. $246.00
- D5120 Complete denture - mandibular. $239.00
- D5130 Immediate denture - maxillary. $267.00
- D5140 Immediate denture - mandibular. $258.00
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). $177.00
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). $205.00
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth). $286.00
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth). $286.00
- D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth). $177.00
- D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth). $205.00
- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth). $286.00
## TYPE 3 PROCEDURES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).</td>
<td>$286.00</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary partial denture - flexible base (including any clasps, rests and teeth).</td>
<td>$177.00</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular partial denture - flexible base (including any clasps, rests and teeth).</td>
<td>$205.00</td>
</tr>
<tr>
<td>D5282</td>
<td>Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary.</td>
<td>B/R</td>
</tr>
<tr>
<td>D5283</td>
<td>Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular.</td>
<td>B/R</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary).</td>
<td>$177.00</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular).</td>
<td>$205.00</td>
</tr>
<tr>
<td>D5672</td>
<td>B/R</td>
<td></td>
</tr>
<tr>
<td>D5286</td>
<td>D5283</td>
<td></td>
</tr>
<tr>
<td>D5284</td>
<td>D5285</td>
<td></td>
</tr>
<tr>
<td>D5810</td>
<td>Interim complete denture (maxillary).</td>
<td>$109.00</td>
</tr>
<tr>
<td>D5811</td>
<td>Interim complete denture (mandibular).</td>
<td>$115.00</td>
</tr>
<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary).</td>
<td>$96.00</td>
</tr>
<tr>
<td>D5821</td>
<td>Interim partial denture (mandibular).</td>
<td>$101.00</td>
</tr>
<tr>
<td>D5863</td>
<td>Overdenture - complete maxillary.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D5864</td>
<td>Overdenture - partial maxillary.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D5865</td>
<td>Overdenture - complete mandibular.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D5866</td>
<td>Overdenture - partial mandibular.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D5876</td>
<td>Add metal substructure to acrylic full denture (per arch).</td>
<td>B/R</td>
</tr>
<tr>
<td>D6110</td>
<td>Implant/abutment supported removable denture for edentulous arch - maxillary.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D6111</td>
<td>Implant/abutment supported removable denture for edentulous arch - mandibular.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D6112</td>
<td>Implant/abutment supported removable denture for partially edentulous arch - maxillary.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D6113</td>
<td>Implant/abutment supported removable denture for partially edentulous arch - mandibular.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D6114</td>
<td>Implant/abutment supported fixed denture for edentulous arch - maxillary.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D6115</td>
<td>Implant/abutment supported fixed denture for edentulous arch - mandibular.</td>
<td>$246.00</td>
</tr>
<tr>
<td>D6116</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - maxillary.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D6117</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - mandibular.</td>
<td>$286.00</td>
</tr>
<tr>
<td>D6118</td>
<td>Implant/abutment supported interim fixed denture for edentulous arch - mandibular.</td>
<td>$115.00</td>
</tr>
<tr>
<td>D6119</td>
<td>Implant/abutment supported interim fixed denture for edentulous arch - maxillary.</td>
<td>$109.00</td>
</tr>
</tbody>
</table>

### COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

### PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

### DENTURE ADJUSTMENTS
- D5410 Adjust complete denture - maxillary. $14.00
- D5411 Adjust complete denture - mandibular. $13.00
- D5421 Adjust partial denture - maxillary. $15.00
- D5422 Adjust partial denture - mandibular. $14.00

**DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422**
- Coverage is limited to dates of service more than 6 months after placement date.

### ADD TOOTH/CLASP TO EXISTING PARTIAL
- D5650 Add tooth to existing partial denture. $32.00
- D5660 Add clasp to existing partial denture-per tooth. $37.00

### DENTURE REBASES
- D5710 Rebase complete maxillary denture. $90.00
- D5711 Rebase complete mandibular denture. $95.00
- D5720 Rebase maxillary partial denture. $86.00

### COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

### PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

### DENTURE ADJUSTMENTS
- D5410 Adjust complete denture - maxillary. $14.00
- D5411 Adjust complete denture - mandibular. $13.00
- D5421 Adjust partial denture - maxillary. $15.00
- D5422 Adjust partial denture - mandibular. $14.00

**DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422**
- Coverage is limited to dates of service more than 6 months after placement date.

### ADD TOOTH/CLASP TO EXISTING PARTIAL
- D5650 Add tooth to existing partial denture. $32.00
- D5660 Add clasp to existing partial denture-per tooth. $37.00

### DENTURE REBASES
- D5710 Rebase complete maxillary denture. $90.00
- D5711 Rebase complete mandibular denture. $95.00
- D5720 Rebase maxillary partial denture. $86.00
## TYPE 3 PROCEDURES

**D5721**  Rebase mandibular partial denture.  
Maximum Covered Expense $90.00

**TISSUE CONDITIONING**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary.</td>
<td>$25.00</td>
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<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular.</td>
<td>$27.00</td>
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**PROSTHODONTICS - FIXED**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
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<tbody>
<tr>
<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6059</td>
<td>Abutment supported porcelain fused to metal crown (high noble metal).</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6060</td>
<td>Abutment supported porcelain fused to metal crown (predominantly base metal).</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6061</td>
<td>Abutment supported porcelain fused to metal crown (noble metal).</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6062</td>
<td>Abutment supported cast metal crown (high noble metal).</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6063</td>
<td>Abutment supported cast metal crown (predominantly base metal).</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6064</td>
<td>Abutment supported cast metal crown (noble metal).</td>
<td>$243.00</td>
</tr>
<tr>
<td>D6065</td>
<td>Implant supported porcelain/ceramic crown.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6066</td>
<td>Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).</td>
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</tr>
<tr>
<td>D6067</td>
<td>Implant supported metal crown (titanium, titanium alloy, high noble metal).</td>
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</tr>
<tr>
<td>D6068</td>
<td>Abutment supported retainer for porcelain/ceramic FPD.</td>
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<tr>
<td>D6069</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (high noble metal).</td>
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<tr>
<td>D6070</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).</td>
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<tr>
<td>D6071</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (noble metal).</td>
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<td>D6072</td>
<td>Abutment supported retainer for cast metal FPD (high noble metal).</td>
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<tr>
<td>D6073</td>
<td>Abutment supported retainer for cast metal FPD (predominantly base metal).</td>
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<tr>
<td>D6074</td>
<td>Abutment supported retainer for cast metal FPD (noble metal).</td>
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<tr>
<td>D6075</td>
<td>Implant supported retainer for ceramic FPD.</td>
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<tr>
<td>D6076</td>
<td>Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).</td>
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<tr>
<td>D6077</td>
<td>Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).</td>
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<tr>
<td>D6094</td>
<td>Abutment supported crown - (titanium).</td>
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<tr>
<td>D6194</td>
<td>Abutment supported retainer crown for FPD - (titanium).</td>
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<tr>
<td>D6205</td>
<td>Pontic - indirect resin based composite.</td>
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</tr>
<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic - cast predominantly base metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic - cast noble metal.</td>
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<tr>
<td>D6214</td>
<td>Pontic - titanium.</td>
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<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal.</td>
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<tr>
<td>D6241</td>
<td>Pontic - porcelain fused to predominantly base metal.</td>
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<tr>
<td>D6242</td>
<td>Pontic - porcelain fused to noble metal.</td>
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<tr>
<td>D6245</td>
<td>Pontic - porcelain/ceramic.</td>
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<tr>
<td>D6250</td>
<td>Pontic - resin with high noble metal.</td>
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<tr>
<td>D6251</td>
<td>Pontic - resin with predominantly base metal.</td>
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<tr>
<td>D6252</td>
<td>Pontic - resin with noble metal.</td>
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<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis.</td>
<td>$75.00</td>
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<tr>
<td>D6548</td>
<td>Retainer - porcelain/ceramic for resin bonded fixed prosthesis.</td>
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</tr>
<tr>
<td>D6549</td>
<td>Resin retainer - for resin bonded fixed prosthesis.</td>
<td>$75.00</td>
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<tr>
<td>D6600</td>
<td>Retainer inlay - porcelain/ceramic, two surfaces.</td>
<td>$183.00</td>
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<tr>
<td>D6601</td>
<td>Retainer inlay - porcelain/ceramic, three or more surfaces.</td>
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</tr>
<tr>
<td>D6602</td>
<td>Retainer inlay - cast high noble metal, two surfaces.</td>
<td>$164.00</td>
</tr>
<tr>
<td>D6603</td>
<td>Retainer inlay - cast high noble metal, three or more surfaces.</td>
<td>$181.00</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer inlay - cast predominantly base metal, two surfaces.</td>
<td>$142.00</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces.</td>
<td>$156.00</td>
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<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces.</td>
<td>$150.00</td>
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<tr>
<td>D6607</td>
<td>Retainer inlay - cast noble metal, three or more surfaces.</td>
<td>$164.00</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer onlay - porcelain/ceramic, two surfaces.</td>
<td>$198.00</td>
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<tr>
<td>D6609</td>
<td>Retainer onlay - porcelain/ceramic, three or more surfaces.</td>
<td>$218.00</td>
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<tr>
<td>D6610</td>
<td>Retainer onlay - cast high noble metal, two surfaces.</td>
<td>$181.00</td>
</tr>
<tr>
<td>D6611</td>
<td>Retainer onlay - cast high noble metal, three or more surfaces.</td>
<td>$199.00</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer onlay - cast predominantly base metal, two surfaces.</td>
<td>$156.00</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer onlay - cast predominantly base metal, three or more surfaces.</td>
<td>$172.00</td>
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## TYPE 3 PROCEDURES

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6614</td>
<td>Retainer onlay - cast noble metal, two surfaces.</td>
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</tr>
<tr>
<td>D6615</td>
<td>Retainer onlay - cast noble metal, three or more surfaces.</td>
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</tr>
<tr>
<td>D6624</td>
<td>Retainer inlay - titanium.</td>
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</tr>
<tr>
<td>D6634</td>
<td>Retainer onlay - titanium.</td>
<td>$199.00</td>
</tr>
<tr>
<td>D6710</td>
<td>Retainer crown - indirect resin based composite.</td>
<td>$185.00</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown - resin with high noble metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown - resin with predominantly base metal.</td>
<td>$116.00</td>
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<tr>
<td>D6722</td>
<td>Retainer crown - resin with noble metal.</td>
<td>$187.00</td>
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<tr>
<td>D6740</td>
<td>Retainer crown - porcelain/ceramic.</td>
<td>$206.00</td>
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<tr>
<td>D6750</td>
<td>Retainer crown - porcelain fused to high noble metal.</td>
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</tr>
<tr>
<td>D6751</td>
<td>Retainer crown - porcelain fused to predominantly base metal.</td>
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</tr>
<tr>
<td>D6752</td>
<td>Retainer crown - porcelain fused to noble metal.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - 3/4 cast high noble metal.</td>
<td>$243.00</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer crown - 3/4 cast predominantly base metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - 3/4 cast noble metal.</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6783</td>
<td>Retainer crown - 3/4 porcelain/ceramic.</td>
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</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown - full cast predominantly base metal.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown - full cast noble metal.</td>
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</tr>
<tr>
<td>D6794</td>
<td>Retainer crown - titanium.</td>
<td>$224.00</td>
</tr>
<tr>
<td>D6940</td>
<td>Stress breaker.</td>
<td>$62.00</td>
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</table>

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
TYPE 3 PROCEDURES

- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.
- Replacement is limited to 1 of any of these procedures per 5 year(s).
  - D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

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

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

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

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

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

SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. $48.00
D7220 Removal of impacted tooth - soft tissue. $60.00
D7230 Removal of impacted tooth - partially bony. $80.00
D7240 Removal of impacted tooth - completely bony. $93.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications. $107.00
D7250 Removal of residual tooth roots (cutting procedure). $50.00
D7251 Coronectomy-intentional partial tooth removal. $93.00

OTHER ORAL SURGERY

D7260 Oroantral fistula closure. $118.00
D7261 Primary closure of a sinus perforation. $118.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. $71.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization). $71.00
D7280 Exposure of an unerupted tooth. $111.00
D7282 Mobilization of erupted or malpositioned tooth to aid eruption. $80.00
D7283 Placement of device to facilitate eruption of impacted tooth. $33.00
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. $41.00
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant. $21.00
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. $53.00
D7321 Alveopasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant. $27.00
D7340 Vestibuloplasty - ridge extension (secondary epithelialization). $76.00
### TYPE 3 PROCEDURES

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7350</td>
<td>Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).</td>
<td>$190.00</td>
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<tr>
<td>D7410</td>
<td>Excision of benign lesion up to 1.25 cm.</td>
<td>$76.00</td>
</tr>
<tr>
<td>D7411</td>
<td>Excision of benign lesion greater than 1.25 cm.</td>
<td>$97.00</td>
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<tr>
<td>D7412</td>
<td>Excision of benign lesion, complicated.</td>
<td>$107.00</td>
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<tr>
<td>D7413</td>
<td>Excision of malignant lesion up to 1.25 cm.</td>
<td>$102.00</td>
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<tr>
<td>D7414</td>
<td>Excision of malignant lesion greater than 1.25 cm.</td>
<td>$75.00</td>
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<tr>
<td>D7415</td>
<td>Excision of malignant lesion, complicated.</td>
<td>$82.00</td>
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<tr>
<td>D7440</td>
<td>Excision of malignant tumor - lesion diameter up to 1.25 cm.</td>
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</tr>
<tr>
<td>D7441</td>
<td>Excision of malignant tumor - lesion diameter greater than 1.25 cm.</td>
<td>$75.00</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.</td>
<td>$76.00</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.</td>
<td>$97.00</td>
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<tr>
<td>D7460</td>
<td>Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.</td>
<td>$76.00</td>
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<tr>
<td>D7461</td>
<td>Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.</td>
<td>$97.00</td>
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<tr>
<td>D7465</td>
<td>Destruction of lesion(s) by physical or chemical method, by report.</td>
<td>$23.00</td>
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<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible).</td>
<td>$67.00</td>
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<tr>
<td>D7472</td>
<td>Removal of torus palatinus.</td>
<td>$67.00</td>
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<tr>
<td>D7473</td>
<td>Removal of torus mandibularis.</td>
<td>$67.00</td>
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<tr>
<td>D7485</td>
<td>Reduction of osseous tuberosity.</td>
<td>$110.00</td>
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<tr>
<td>D7490</td>
<td>Radical resection of maxilla or mandible.</td>
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<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue.</td>
<td>$34.00</td>
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<tr>
<td>D7520</td>
<td>Incision and drainage of abscess - extraoral soft tissue.</td>
<td>$39.00</td>
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<tr>
<td>D7530</td>
<td>Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.</td>
<td>$31.00</td>
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<tr>
<td>D7540</td>
<td>Removal of reaction producing foreign bodies, musculoskeletal system.</td>
<td>$85.00</td>
</tr>
<tr>
<td>D7550</td>
<td>Partial ostectomy/sequestrectomy for removal of non-vital bone.</td>
<td>$85.00</td>
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<tr>
<td>D7560</td>
<td>Maxillary sinusotomy for removal of tooth fragment or foreign body.</td>
<td>$112.00</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm.</td>
<td>$15.00</td>
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<tr>
<td>D7911</td>
<td>Complicated suture - up to 5 cm.</td>
<td>$17.00</td>
</tr>
<tr>
<td>D7912</td>
<td>Complicated suture - greater than 5 cm.</td>
<td>$24.00</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenuloplasty-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.</td>
<td>$81.00</td>
</tr>
<tr>
<td>D7963</td>
<td>Frenuloplasty.</td>
<td>$101.00</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue - per arch.</td>
<td>$62.00</td>
</tr>
<tr>
<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity.</td>
<td>$99.00</td>
</tr>
<tr>
<td>D7979</td>
<td>Non-surgical sialolithotomy.</td>
<td>$47.00</td>
</tr>
<tr>
<td>D7980</td>
<td>Surgical sialolithotomy.</td>
<td>$93.00</td>
</tr>
<tr>
<td>D7983</td>
<td>Closure of salivary fistula.</td>
<td>$30.00</td>
</tr>
</tbody>
</table>

**REMOVAL OF BONE TISSUE: D7471, D7472, D7473**
- Coverage is limited to 5 of any of these procedures per lifetime.

### ANESTHESIA-GENERAL/IV

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9219</td>
<td>Evaluation for moderate sedation, deep sedation or general anesthesia.</td>
<td>$14.00</td>
</tr>
<tr>
<td>D9222</td>
<td>Deep sedation/general anesthesia - first 15 minutes.</td>
<td>$29.00</td>
</tr>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia - each subsequent 15 minute increment.</td>
<td>$29.00</td>
</tr>
<tr>
<td>D9239</td>
<td>Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.</td>
<td>$24.00</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.</td>
<td>$24.00</td>
</tr>
</tbody>
</table>

**GENERAL ANESTHESIA: D9222, D9223, D9239, D9243**
- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### OCCLUSAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9951</td>
<td>Occlusal adjustment - limited.</td>
<td>$18.00</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment - complete.</td>
<td>$90.00</td>
</tr>
</tbody>
</table>

**OCCLUSAL ADJUSTMENT: D9951, D9952**
- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.
ORTHODONTIC EXPENSE BENEFITS

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

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

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

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

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

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

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

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

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

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

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

EXTENSION OF BENEFITS. Benefits will be payable for a period of 30 days following termination of coverage under this section for any covered expenses incurred during that 30-day period. Eligible covered...
expenses would be those services appropriate to the course of treatment and that would have normally occurred during that 30-day period had coverage not terminated.

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

1. for a Program begun on or after the Insured's 17th birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen’s compensation or similar law.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. To replace lost, missing or stolen orthodontic appliances.
EYE CARE INSURANCE

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

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

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

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

Plan Year 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 plan year means the period from his or her effective date through December 31 of that year.

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

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

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

1. vision examinations.
2. frames or lenses ordered before the Insured was covered under this section.
3. subject to Extension of Benefits, frame or lens ordered after the Insured’s coverage under this section ceases.
4. sub-normal vision aids; orthoptic or vision training or any associated testing.
5. non-prescription lenses.
6. replacement or repair of lost or broken lenses or frames except at normal intervals.
7. any corrective eyewear required by an employer as a condition of employment.
8. medical or surgical treatment of the eyes.
9. any service or supply not shown on the Schedule of Eye Care Services.
10. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

<table>
<thead>
<tr>
<th>MATERIALS</th>
<th>SERVICE</th>
<th>Maximum Amount - Each Plan Year</th>
<th>MAXIMUM COVERED EXPENSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame</td>
<td>Frame</td>
<td></td>
<td>$150</td>
</tr>
</tbody>
</table>

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

**Materials**

Frame

Lenses

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

N-I Disclosure NY Rev. 02-17
Increased Dental Maximum Benefit Rider 9042 NY Rev. 07-14
THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

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

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

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

If you have received an identification card describing the Eye-Med Network Discount, you are eligible for the discounts listed below at no additional cost to you or your group. You may present your ID card to the EyeMed provider for these discounts and may contact EyeMed at the toll-free number listed on the ID card or via their website for discount information.

When an EyeMed network provider is utilized, the member receives the following discounts (unlimited):

Eye Exam
- $5 off routine eye exam
- $10 off contact lens eye exam

Standard Plastic Lenses Member Cost
- $50 for Single Vision
- $70 for Bifocal
- $105 for Trifocal

Frames
- 35% off retail price when a complete pair of glasses is purchased.
- 20% off retail price when glasses components are purchased separately.

Lens Options Member Cost
- $65 for Standard Progressive (plus standard plastic lens cost)
- $40 for Standard Polycarbonate
- $15 for Tint (solid or gradient)
- $15 for Scratch-Resistant Coating or Ultraviolet Coating
- $45 for Anti-Reflective Coating
- 20% discount for Premium Progressive
- 20% discount for Other Add-ons

Contact Lenses
- 15% off retail price (conventional contacts only)
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
Laser Vision Correction

- 15% off retail price —or—
- 5% off promotional price
- Available only at U.S. Laser Network participating locations for LASIK and PRK laser eye surgery.
INCREASED DENTAL MAXIMUM BENEFIT

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

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

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

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

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

The Carry Over Amount can be accumulated from one Benefit Period to the next Benefit Period 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 for that Benefit Period; or

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

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

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.
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 1-800-659-5556.

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. of New York. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. of New York 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. of New York believes the Policyholder has failed to perform its obligations relating to the Group Policy.

   After the first policy year, Ameritas Life Insurance Corp. of New York 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. of New York 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 and Eye Care 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