



**Ameritas Life Insurance Corp.**

A STOCK COMPANY  
5900 "O" Street  
Lincoln, Nebraska 68510

**GROUP DENTAL INSURANCE POLICY**

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<b>The Policyholder</b>	<b>CITY OF SALEM VIRGINIA</b>	<b>Policy Number</b>	<b>10-17629</b>
<b>State of Delivery</b>	<b>Virginia</b>	<b>Plan Effective Date</b>	<b>October 1, 1991</b>
		<b>Plan Change Effective Date</b>	<b>October 1, 2007</b>
<b>Premium Due Date 1st of each month.</b>		<b>Renewal Date</b>	<b>October 1</b>

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

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

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

We are subject to regulations in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

**AMERITAS LIFE INSURANCE CORP.**

Corporate Secretary

President



**VIRGINIA**  
**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

**This notice contains important information about how to file complaints, grievances or appeals with us. Please read this and the Explanation of Benefits (EOB) that is sent in response to a claim or request for a pre-treatment estimate of benefits. The EOB will have information specific to that benefit determination.**

**WHO TO CONTACT**

If you need to contact us about your insurance, please see the following address:

Complaint Officer  
Quality Control  
P.O. Box 82657  
Lincoln, NE 68501-2657  
1-877-897-4328 (Toll-Free)  
402-309-2579 (FAX)

You may call us between the hours of 8:00 a.m. to 7:00 p.m. ET Monday through Friday. After hours, you may leave a message and we will return your call. Consultants are available for discussions with treating providers 40 hours per week during typical working hours.

If you have been unable to contact us or if you need additional help, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

In writing: Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
Richmond area: 804-371-9741  
In Virginia: 1-800-552-7945  
Out-of-State: 1-877-310-6560

Since this coverage includes an option to seek services from a participating provider (PPO), both the Virginia Department of Health and the Virginia Bureau of Insurance are also available to assist you.

If you have any questions regarding an appeal, or grievance concerning the health care services that you have been provided, that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

**Contacting the Managed Care Ombudsman at the Bureau of Insurance:**

In writing: Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
Toll-free: 1-877-310-6560  
In Richmond area: 804-371-9032  
Email: [ombudsman@scc.Virginia.gov](mailto:ombudsman@scc.Virginia.gov)  
Web Page: Information regarding the ombudsman may be found by accessing the state corporation commission's web page at: [www.scc.virginia.gov](http://www.scc.virginia.gov)

**Contacting The Office of Licensure and Certification (OLC)**

In writing: Virginia Department of Health  
9960 Mayland Drive, Suite 401

Richmond, VA 23233  
Toll-free: 1-800-955-1819  
Richmond metro area: 804-367-2106  
Fax: 804-527-4503  
Email: mchip@vdh.virginia.gov  
Web Page: Information regarding The Office of Licensure and Certification may be found by accessing the Department of Health's web page at [www.vdh.virginia.gov/olc](http://www.vdh.virginia.gov/olc).

## **HOW GRIEVANCES AND APPEALS ARE HANDLED**

If you wish to file a complaint, grievance or appeal, please review the information below.

### **I. Definitions**

“Adverse Decision” means a determination by Private Review Agent, Ameritas Life Insurance Corp., that a dental service is not medically necessary and reimbursement for the service is either denied or reduced.

“Covered Person” means the policyholder, claimant or representatives, provider, agent or other entity which expresses a grievance or complaint involving our activities or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

“Grievance” means a complaint on behalf of an insured person submitted by a covered person including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

- (a) the availability, delivery, or quality of covered services;
- (b) benefits or claims payment, handling, or reimbursement for covered services;
- (c) matters pertaining to the contractual relationship between a covered person and the insurer.

### **II. Grievance and Appeal Procedures**

#### **A. Requesting an Appeal or Filing a Grievance**

**At any time**, you may file a grievance about the matters defined in the section above. You cannot be disenrolled or penalized in any way because a grievance or complaint was filed.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, or any of the regulatory agencies, use the contact information above and include your identification and/or policy number.

#### **B. Internal Reviews**

For situations or issues other than an adverse decision, the grievance will be reviewed by all appropriate internal parties. We will respond to a grievance within 30 days and will provide a written letter of our final decision no later than 60 days from the date of receipt of the grievance.

For those situations which meet the definition of an adverse decision and we receive a request for reconsideration of this decision, we will notify you and the provider within 10 working days following the request for reconsideration. If the decision is upheld and you request a formal appeal, we will provide a written letter of our final decision no later than 60 working days after receiving the required documentation.

For a formal appeal of an adverse decision, the case will be reviewed by a peer of the treating provider who was primarily responsible for the care under review. The licensed provider who renders the final decision on an appeal will not have participated in the adverse decision or any prior reconsideration

and will not be employed by or a director of the company.

You have the right to participate via a teleconference call or in person during the review process in order to present additional information regarding an appeal of an adverse decision.

### **C. Expedited Reviews**

Requests for reconsideration or appeal of prospective pre-treatment estimates related to urgent care will be reviewed within 1 business day of the request and receipt of all information necessary to make the determination. We will provide our decision by telephone or e-mail and send written confirmation within 24 hours of the decision.



**NOTICE OF  
PROTECTION PROVIDED BY  
VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - o \$300,000 in death benefits
  - o \$100,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 in hospital, medical and surgical insurance benefits
  - o \$300,000 in disability [income] insurance benefits
  - o \$300,000 in long-term care insurance benefits
  - o \$100,000 in other types of health insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association’s website at [www.valifega.org](http://www.valifega.org) or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION  
c/o APM Management Services, Inc.  
8001 Franklin Farms Drive, Suite 235  
Henrico, VA 23229  
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance

P. O. Box 1157

Richmond, VA 23218

804-371-9741

Toll Free Virginia only: 1-800-552-7945

<http://www.scc.virginia.gov/division/boi/index.htm>

**Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	All Eligible Employees

**DENTAL EXPENSE BENEFITS**

Deductible Amount:

Type 1 and Type 3 Procedures	\$0
Type 2 Procedures - Once per Lifetime	\$80

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,000

**ORTHODONTIC EXPENSE BENEFITS**

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





## INCREASED DENTAL MAXIMUM BENEFIT RIDER

To be attached to and made a part of Group Policy Number 10-17629 and each Certificate of Insurance issued under such policy. Issued to CITY OF SALEM VIRGINIA

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

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

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 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.

President



## PREMIUMS

### TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	\$33.08 per Insured Person
	\$25.20 One Dependent Only
	\$59.00 Two or More Dependents
Orthodontic Insurance	\$1.56 per Insured Person
	\$1.56 One Dependent Only
	\$6.24 Two or More Dependents

### ASSOCIATED GROUPS

CITY OF SALEM VIRGINIA SCHOOLS  
CITY OF SALEM VIRGINIA SCHOOLS

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

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

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

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

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

**ADJUSTMENTS IN PREMIUM RATES.** We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 60 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates

until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

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

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

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 60 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

**RENEWAL DATE** Renewal Date refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

## DEFINITIONS

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

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

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried child less than 25 years of age, for whom the Insured or the Insured's spouse, is legally responsible, including:
  - i. natural born children;
  - ii. adopted children, eligible from the date of placement for adoption;
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 25 or older who:
  - i. is Totally Disabled as defined below; and
  - ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

**TOTAL DISABILITY** describes the Insured's Dependent as:

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

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

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

Notice: The MCHIP is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 382. and the Virginia Department of Health pursuant to Title 32.1.

**LATE ENTRANT** refers to any person:

- a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or
- b. who has elected to become insured again after canceling a premium contribution agreement.

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

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

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

## **CONDITIONS FOR INSURANCE COVERAGE**

### *ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent from the moment of birth. Notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer issuing the policy within thirty-one days after the date of birth in order to have coverage continue beyond the thirty-one day period.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ***TERMINATION DATES***

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

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

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

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

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

**NOTICE REQUIREMENTS.** We will provide the Policyholder written notice of the termination of coverage. Any employer who assumes part or all of the cost of providing coverage under this Policy shall give written notice to Insureds in the event of termination or upon the receipt of notice of termination of such Policy not later than 15 days after receipt of the notice of termination from us.

If coverage is terminated as a result of non-payment of premium, the notice will include a specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least 15 days after such notice is mailed. Reimbursement will be made for all valid claims for services incurred prior to the date coverage is terminated.

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

### **Termination of Eligibility Under the Policy 90-Day Continuation Provision For Insureds and Dependents**

1. **Eligibility**

Whenever any person's eligibility under the policy is terminated and the person becomes ineligible for continued participation in this plan for any reason except for when the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting condition limitations under the group policy or plan the benefits of this plan shall be available at the same premium for the individual and the dependents covered by the plan.

2. **Benefits**

This continuation applies to all benefits payable under this policy.

3. **Continuation Period**

The continuation period is up to ninety days immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

- a. The application for the extended coverage is made to the group policyholder and the total premium for the ninety-day period is paid to the group policyholder prior to the termination.
- b. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy; and
- c. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.

## DENTAL EXPENSE BENEFITS

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

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan.

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

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.
3. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

## TABLE OF DENTAL PROCEDURES

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

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

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

**TYPE 1 PROCEDURES**  
**PAYMENT BASIS - Usual and Customary**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

**ROUTINE ORAL EVALUATION**

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

**COMPREHENSIVE EVALUATION: D0150, D0180**

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

**ROUTINE EVALUATION: D0120, D0145**

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

**COMPLETE SERIES OR PANORAMIC**

- D0210 Intraoral - complete series of radiographic images.
- D0330 Panoramic radiographic image.

**COMPLETE SERIES/PANORAMIC: D0210, D0330**

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

**OTHER XRAYS**

- D0220 Intraoral - periapical first radiographic image.
- D0230 Intraoral - periapical each additional radiographic image.
- D0240 Intraoral - occlusal radiographic image.
- D0250 Extraoral - first radiographic image.
- D0260 Extraoral - each additional radiographic image.

**PERIAPICAL: D0220, D0230**

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

**BITEWINGS**

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

**BITEWINGS: D0270, D0272, D0273, D0274**

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

**VERTICAL BITEWINGS: D0277**

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

**PROPHYLAXIS (CLEANING) AND FLUORIDE**

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.

## TYPE 1 PROCEDURES

D1208 Topical application of fluoride.

FLUORIDE: D1206, D1208

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

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

### SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

### APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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



**TYPE 2 PROCEDURES**  
**PAYMENT BASIS - Usual and Customary**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

**LIMITED ORAL EVALUATION**

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

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

**ORAL PATHOLOGY/LABORATORY**

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

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

**SEALANT**

D1351 Sealant - per tooth.

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

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

**AMALGAM RESTORATIONS (FILLINGS)**

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

**RESIN RESTORATIONS (FILLINGS)**

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

## TYPE 2 PROCEDURES

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

### GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

### STAINLESS STEEL CROWN (PREFABRICATED CROWN)

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

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

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

### RECEMENT

- D2910 Recement inlay, onlay, or partial coverage restoration.
- D2915 Recement cast or prefabricated post and core.
- D2920 Recement crown.
- D2921 Reattachment of tooth fragment, incisal edge or cusp.
- D6092 Recement implant/abutment supported crown.
- D6093 Recement implant/abutment supported fixed partial denture.
- D6930 Recement fixed partial denture.

### SEDATIVE FILLING

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

### ENDODONTICS MISCELLANEOUS

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

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

- Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.
- D3330 Endodontic therapy, molar.
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - bicuspid.
- D3348 Retreatment of previous root canal therapy - molar.

## TYPE 2 PROCEDURES

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

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

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

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

### SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - bicuspid (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3427 Periradicular surgery without apicoectomy.

### SURGICAL PERIODONTICS

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

### BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

### GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

### OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

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

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

## TYPE 2 PROCEDURES

### NON-SURGICAL PERIODONTICS

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

#### CHEMOTHERAPEUTIC AGENTS: D4381

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

#### PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

### FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

#### FULL MOUTH DEBRIDEMENT: D4355

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

### PERIODONTAL MAINTENANCE

- D4910 Periodontal maintenance.

#### PERIODONTAL MAINTENANCE: D4910

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

### DENTURE REPAIR

- D5510 Repair broken complete denture base.
- D5520 Replace missing or broken teeth - complete denture (each tooth).
- D5610 Repair resin denture base.
- D5620 Repair cast framework.
- D5630 Repair or replace broken clasp.
- D5640 Replace broken teeth - per tooth.

### DENTURE RELINES

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

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

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

### NON-SURGICAL EXTRACTIONS

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

### SURGICAL EXTRACTIONS

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

## TYPE 2 PROCEDURES

### OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Surgical access of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Surgical reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

### BIOPSY OF ORAL TISSUE

- D7285 Biopsy of oral tissue - hard (bone, tooth).
- D7286 Biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.

## TYPE 2 PROCEDURES

D7288 Brush biopsy - transepithelial sample collection.

### PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.

D9221 Deep sedation/general anesthesia - each additional 15 minutes.

D9241 Intravenous conscious sedation/analgesia - first 30 minutes.

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

### PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.

D9440 Office visit - after regularly scheduled hours.

D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

### OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.

D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

### MISCELLANEOUS

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

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

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

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

**TYPE 3 PROCEDURES**  
**PAYMENT BASIS - Usual and Customary**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

**INLAY RESTORATIONS**

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

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

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

**ONLAY RESTORATIONS**

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

**CROWNS SINGLE RESTORATIONS**

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic substrate.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

## TYPE 3 PROCEDURES

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

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

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

### CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

### POST AND CORE

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

D2954 Prefabricated post and core in addition to crown.

### FIXED CROWN AND PARTIAL DENTURE REPAIR

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

### CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

### PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

- D5110 Complete denture - maxillary.  
D5120 Complete denture - mandibular.  
D5130 Immediate denture - maxillary.  
D5140 Immediate denture - mandibular.  
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).  
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).  
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).  
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).  
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).  
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).  
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).

## TYPE 3 PROCEDURES

D5810 Interim complete denture (maxillary).  
D5811 Interim complete denture (mandibular).  
D5820 Interim partial denture (maxillary).  
D5821 Interim partial denture (mandibular).  
D5863 Overdenture - complete maxillary.  
D5864 Overdenture - partial maxillary.  
D5865 Overdenture - complete mandibular.  
D5866 Overdenture - partial mandibular.  
D6053 Implant/abutment supported removable denture for completely edentulous arch.  
D6054 Implant/abutment supported removable denture for partially edentulous arch.  
D6078 Implant/abutment supported fixed denture for completely edentulous arch.  
D6079 Implant/abutment supported fixed denture for partially edentulous arch.  
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6053, D6078

- 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, D6053 and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6054, D6079

- 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, D6054 and D6079 are considered at an alternate benefit of D5213/D5214.

### DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

### ADD TOOTH/CLASP TO EXISTING PARTIAL

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

### DENTURE REBASES

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

### TISSUE CONDITIONING

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

### PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.  
D6059 Abutment supported porcelain fused to metal crown (high noble metal).  
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).  
D6061 Abutment supported porcelain fused to metal crown (noble metal).  
D6062 Abutment supported cast metal crown (high noble metal).  
D6063 Abutment supported cast metal crown (predominantly base metal).  
D6064 Abutment supported cast metal crown (noble metal).  
D6065 Implant supported porcelain/ceramic crown.  
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).  
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).  
D6068 Abutment supported retainer for porcelain/ceramic FPD.

## TYPE 3 PROCEDURES

- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
- D6094 Abutment supported crown - (titanium).
- D6194 Abutment supported retainer crown for FPD - (titanium).
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.
- D6245 Pontic - porcelain/ceramic.
- D6250 Pontic - resin with high noble metal.
- D6251 Pontic - resin with predominantly base metal.
- D6252 Pontic - resin with noble metal.
- D6545 Retainer - cast metal for resin bonded fixed prosthesis.
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
- D6600 Inlay - porcelain/ceramic, two surfaces.
- D6601 Inlay - porcelain/ceramic, three or more surfaces.
- D6602 Inlay - cast high noble metal, two surfaces.
- D6603 Inlay - cast high noble metal, three or more surfaces.
- D6604 Inlay - cast predominantly base metal, two surfaces.
- D6605 Inlay - cast predominantly base metal, three or more surfaces.
- D6606 Inlay - cast noble metal, two surfaces.
- D6607 Inlay - cast noble metal, three or more surfaces.
- D6608 Onlay - porcelain/ceramic, two surfaces.
- D6609 Onlay - porcelain/ceramic, three or more surfaces.
- D6610 Onlay - cast high noble metal, two surfaces.
- D6611 Onlay - cast high noble metal, three or more surfaces.
- D6612 Onlay - cast predominantly base metal, two surfaces.
- D6613 Onlay - cast predominantly base metal, three or more surfaces.
- D6614 Onlay - cast noble metal, two surfaces.
- D6615 Onlay - cast noble metal, three or more surfaces.
- D6624 Inlay - titanium.
- D6634 Onlay - titanium.
- D6710 Crown - indirect resin based composite.
- D6720 Crown - resin with high noble metal.
- D6721 Crown - resin with predominantly base metal.
- D6722 Crown - resin with noble metal.
- D6740 Crown - porcelain/ceramic.
- D6750 Crown - porcelain fused to high noble metal.
- D6751 Crown - porcelain fused to predominantly base metal.
- D6752 Crown - porcelain fused to noble metal.
- D6780 Crown - 3/4 cast high noble metal.
- D6781 Crown - 3/4 cast predominantly base metal.
- D6782 Crown - 3/4 cast noble metal.
- D6783 Crown - 3/4 porcelain/ceramic.
- D6790 Crown - full cast high noble metal.
- D6791 Crown - full cast predominantly base metal.
- D6792 Crown - full cast noble metal.

## TYPE 3 PROCEDURES

D6794 Crown - titanium.

D6940 Stress breaker.

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

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

### TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

## ORTHODONTIC EXPENSE BENEFITS

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

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

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

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

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (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.

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

1. for a Program begun before the Insured became covered under this section.
2. in the first 12 months that a person is insured if the person is a Late Entrant.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. To replace lost, missing or stolen orthodontic appliances.

## COORDINATION OF BENEFITS

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

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:
  - a. Any group or blanket insurance policy.
  - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
  - c. Any labor/management, trustee plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.
  - d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
2. "Plan" does **not** include the following:
  - a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.
  - b. Coverages for school type accidents only, including athletic injuries.
3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
  - a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.
  - b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
    - i. the parents are married;
    - ii. the parents are not separated (whether or not they ever have been married); or
    - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

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

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

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

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

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

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

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

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

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

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



## GENERAL PROVISIONS

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

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 180 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 180 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

**TIME OF PAYMENT.** We will pay all benefits immediately when we receive due proof or in accordance with Virginia Code, whichever is more favorable to the Insured. Virginia Code requires that clean claims shall be paid or denied within forty (40) days from receipt of the claim. If a claim cannot be processed as a result of not receiving all of the necessary information, then we will notify the claimant within thirty (30) days from receipt of the claim providing them with the information necessary to process the claim. Payment will be made within forty (40) days from receipt of all necessary information.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly. If an insured visits a non-participating provider, the insured is responsible for applying any plan payment to the non-participating provider.

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

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

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

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

**INCONTESTABILITY.** All statements made by the policy owner or by the persons insured shall be deemed representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative. In any case where a rate or benefit varies by age, and the age of an insured has been misstated, an equitable adjustment of premiums benefits, or both will be made. Such adjustment will be made based on anticipated claims projections and/or actual past claims.

The validity of the Policy will not be contested after it has been in force for two years from its date of issue, except for nonpayment of premiums. Any statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall not be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and
2. Unless the statement is contained in a written instrument signed by him.

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

**ENTIRE CONTRACT.** The policy and any application of the Policyholder, and any individual applications of the persons insured shall constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will be considered representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

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

## GENERAL PROVISIONS (CONTINUED)

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

**ENTIRE CONTRACT.** The policy and the application of the Policyholder, and any individual applications of the persons insured shall constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will be considered representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

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

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

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

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

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

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

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

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

The Participation Requirements are as follows:

Percentage of Members-	20%
Number of Members-	246

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

We may terminate this policy on the earlier of:

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

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

**GRACE PERIOD.** This policy has a 90 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 90 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

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

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

**REQUEST FOR CLAIMS EXPERIENCE.** Upon request, we will provide the policyholder with a complete record of the policyholder's claim experience incurred under this policy. This record shall include all claims incurred for the lessor of:

1. the period of time since the policy was issued or issued for delivery, or
2. the period of time since the policy was last renewed, reissued or extended, if already issued.

This record shall be made available promptly to the Policyholder upon request made not less than sixty days prior to the date upon which the premiums or contractual terms of the policy may be amended.

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

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

**CLAIMS FOR BENEFITS**

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

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

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

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

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

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

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

## **APPEAL PROCEDURE**

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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

*Application is Hereby Made to*

AMERITAS LIFE INSURANCE CORP.

by: CITY OF SALEM VIRGINIA

whose main office address is: 114 N BROAD ST  
SALEM, VA 24153-3734

for Group Policy No. 10-17629

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

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

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

CITY OF SALEM VIRGINIA

(Full or Corporate Name of Applicant)

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

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

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

