Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

BLANKET DENTAL AND EYE CARE INSURANCE POLICY

Limited Benefit, Please Read Carefully

The Policyholder **AMERICAN UNIVERSITY**

Policy Number **10-64647-2024**

State of Delivery **District of Columbia**

Policy Effective Date **August 1, 2024**

Policy Termination Date **August 1, 2026**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the blanket 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.

CONFORMITY TO LAW: Any provision in this Policy that is in conflict with the requirements of any state and/or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed

Notice of Grievance Procedures

In accordance with Chapter 60 of Title 22
of the District of Columbia Municipal Regulations
Health Benefits Plan Members Bill of Rights

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328

Please read this notice carefully. This notice contains important information about how to file grievances with us. You also have the right to ask us to assist you in filing a grievance, or review our decisions involving your requests for service or your requests to have your claims paid.

I. Definitions

"Adverse Determination" means a denial, reduction, limitation, termination, failure to make a payment for a benefit, or a delay of benefit to a member, regarding determinations about: the medical necessity, appropriateness, or level of care, or health care setting; whether a benefit is experimental or investigational; a decision to rescind coverage; or a member's eligibility to participate in a plan.

"Grievance" means a written request by a member or member representative for review of a decision by us to deny, reduce, limit, terminate or delay covered health care services to a member, including a determination about the medical necessity, appropriateness, or level of care, health care setting, or effectiveness of a treatment; a determination as to whether treatment is experimental; our decision to rescind coverage; failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan.

II. Levels of Review

The following levels of review will be available to a member:

Informal Internal Review

Formal Internal Review - following Informal Internal Review if grievance is not resolved

External Review - following a two-level internal review, the member has a right to request an external review. Request must be made within 4 months following receipt of an adverse formal internal review grievance decision.

A. Informal Internal Review

Any member dissatisfied with an adverse decision shall be provided an opportunity to discuss and review the decision with our quality control unit. The member has a right to designate a member representative to participate in the grievance process. A written decision to the member will be provided within 14 working days after the request for the informal internal review has been filed. The written explanation of a grievance decision following the informal internal review will also include notice to the member of their right to request a formal internal review.

B. Formal Internal Review

A member or member representative dissatisfied with the grievance decision may seek a formal internal review before a reviewer or a panel of health care professionals selected by us based upon the specific issues presented by the grievance.

Each request for a formal internal review shall be acknowledged by us in writing, to the member or member representative within 10 business days of receipt. If we have determined that there is insufficient information to complete the formal review, we shall notify the member that we cannot proceed with the grievance review without additional information, specifying what additional information is required and that we will assist the member in gathering the necessary information without further delay.

The reviewer or panel selected shall not have been involved in the grievance decision under review. In all reviews requiring medical expertise, the reviewer or panel shall include at least one medical reviewer trained and certified, by a recognized specialty board in the same specialty as the matter at issue. Each medical reviewer shall be a health care provider possessing a non-restricted license to practice and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

Each formal internal review shall be concluded as soon as possible after receipt of all necessary documentation by us, but in no event later than 30 business days after we have received notice of the request for a formal internal review.

C. External Review

The member has a right to request an external review after exhausting our internal grievance process. The member has 4 months after the receipt of an adverse formal internal review decision to file a request for an external review with the Director of the Department of Health. The member also has a right to request external review if a grievance decision has not been rendered within 30 business days after the filing of a grievance.

D. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. a statement of the reviewer's understanding of the grievance;
2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
3. a description of the process to request the next level of reviews, as applicable. These instructions will include telephone numbers and titles of persons to contact and the applicable time frames. These instructions will be in at least 12-point typeface

E. Getting Assistance

You may contact us by submitting a request for review to:

Attn: Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328
FAX: 402-309-2579

If you are dissatisfied with the resolution reached through our internal grievance system regarding medical necessity, then you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW
Suite 900S
Washington, D.C. 20001
1 (877) 685-6391

If you are dissatisfied with the resolution reached through our internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases, Commissioner
Department of Insurance, Securities and Banking
1050 First St, NE
Suite 801
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

The District of Columbia established the Office of the Health Care Ombudsman and Bill of Rights within the District of Columbia Department of Health Care Finance. This office was created to counsel and provide assistance to uninsured District of Columbia residents and individuals insured by health benefits plans in the District of Columbia regarding matters pertaining to their health care coverage. Contact the Office of Health Care Ombudsman & Bill of Rights if you need help:

Understanding your health care rights and responsibilities;
Resolving problems with health care coverage, access to health care, or your health care bills;
Appealing your health plan's decision; and
Finding other health care resources.

You may contact the Office of Health Care Ombudsman and Bill of Rights at the following:

Government of the District of Columbia
Office of Health Care Ombudsman & Bill of Rights
441 4th Street, NW
Suite 900S
Washington, DC 20001
Direct Telephone Number: 202-724-7491 or 1-877-685-6391
General Fax: 202-442-6724
Confidental Fax: 202-478-1397
eMail: healthcareombudsman@dc.gov
Website: healthcareombudsman.dc.gov

F. Cultural and Linguistic Support

We want to be sure this information is helpful to you. Interpreting services are available toll free at 800-487-5553. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print for the visually impaired. We are prepared to help hearing impared members who access TDD or TTY "text telephone" systems when contacting us.

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care insurance, life insurance and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subject to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq.),* provides insolvency protection for certain types of insurance policies and contracts. The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or an owner under a health benefit plan, disability income insurance, long-term care insurance, life insurance, or annuity contract issued by a member insurer or the individual insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also generally covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability income insurance benefits;
  - $500,000 for health benefit plans;
  - $100,000 for coverage not defined as disability income insurance; health benefit plans; or long-term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life (except in the event of health benefit plans in which the Guaranty Association is liable for no more than $500,000).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner, regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protections

To learn more about the above referenced protections, please visit either:

District of Columbia
Life and Health Insurance Guaranty Association
www.dclifega.org
410-248-0407

District of Columbia
Department of Insurance, Securities and Banking
disb.dc.gov
202-727-8000

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association will cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

Non-Insurance Products/Services

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

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

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

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

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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.

Benefit Class

Each person who belongs to one of the "Classes of Person To Be Insured" as set forth in the application attached to this policy is eligible to be insured under this policy.

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,200

EYE CARE EXPENSE BENEFITS

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

Deductible Amount:

When a Participating Provider is used:	
Exams - Each Benefit Period	$10
Contact Lens Fitting and Evaluation - Each Benefit Period	$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$25
When a Non-Participating Provider is used:	
Exams - Each Benefit Period	$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$25

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

PREMIUM RATES

DENTAL CARE INSURANCE - Eligible Student Electing Dental
08/01/2024 to 08/01/2026

Student	$227.52
Student and Spouse	$454.08
Student and Child(ren)	$513.60
Student, Spouse & Child(ren)	$740.16

EYE CARE INSURANCE - Eligible Student Electing Vision
08/01/2024 to 08/01/2026

Student	$157.44
Student and Spouse	$305.76
Student and Child(ren)	$269.28
Student, Spouse & Child(ren)	$417.60

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. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured, a child of the Insured's spouse or a child of the Insured's Domestic Partner or party to a Civil Union, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

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

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

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

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

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial

two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

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

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

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

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

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

MASTER POLICY EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Master Policy Effective Date for the Policyholder is shown on the policy cover and in the application attached to the master policy. The effective date of coverage for an Insured is shown in the Company'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. Stated times are based on Standard Time of the residence of the Insured.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBILITY. The members of the eligible class(es) are shown on the Schedule of Benefits. A member of the eligible class is defined by the Policyholder. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Insured must actively attend classes for at least the first 31 days after the Insured's effective date. Home study, correspondence, Internet and television (TV) courses do not fulfill the eligibility requirements that the Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

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

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

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

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. The Effective Date for each Member and his or her Dependents, will be the Master Policy Effective Date or the date premium is received for that Insured, if later.

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

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

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

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. The Effective Date for each Member and his or her Dependents, will be the Master Policy Effective Date or the date premium is received for that Insured, if later.

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 last day of the period for which premium is paid: or
2. 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. date on which the Insured's coverage terminates;
2. the last day of the period for which the premium is paid;
3. the date 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."

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 Maximum Covered Expense as covered under your plan.

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

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

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 dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

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

1. for initial placement of any dental prosthesis or prosthetic crown 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 dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. 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.

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

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

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

TABLE OF DENTAL PROCEDURES

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

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

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

Class Number 1

TYPE 1 PROCEDURES

Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$15.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$12.00
D0150	Comprehensive oral evaluation - new or established patient.	$24.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$24.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - comprehensive series of radiographic images.	$50.00
D0330	Panoramic radiographic image.	$40.00

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.	$9.00
D0230	Intraoral - periapical each additional radiographic image.	$7.00
D0240	Intraoral - occlusal radiographic image.	$13.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$16.00
D0251	Extra-oral posterior dental radiographic image.	$16.00

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.	$8.00
D0272	Bitewings - two radiographic images.	$14.00
D0273	Bitewings - three radiographic images.	$17.00
D0274	Bitewings - four radiographic images.	$22.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$33.00

BITEWINGS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWINGS: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$33.00
D1120	Prophylaxis - child.	$23.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1206	Topical application of fluoride varnish.	$13.00
D1208	Topical application of fluoride-excluding varnish.	$13.00
D9932	Cleaning and inspection of removable complete denture, maxillary.	$33.00
D9933	Cleaning and inspection of removable complete denture, mandibular.	$33.00
D9934	Cleaning and inspection of removable partial denture, maxillary.	$33.00
D9935	Cleaning and inspection of removable partial denture, mandibular.	$33.00

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per benefit period.

Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

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

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

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

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

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

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

SEALANTS AND CARIES MEDICAMENTS

D1351	Sealant - per tooth.	$18.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$19.00
D1353	Sealant repair - per tooth.	$18.00
D1354	Application of caries arresting medicament-per tooth.	$13.00
D1355	Caries preventive medicament application - per tooth.	$13.00

SEALANT: D1351, D1352, D1353

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

D1354, D1355, also contribute(s) to this limitation.

Benefits are considered for persons age 15 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer-fixed, unilateral-per quadrant.	$117.00
D1516	Space maintainer - fixed - bilateral, maxillary.	$191.00
D1517	Space maintainer - fixed - bilateral, mandibular.	$191.00
D1520	Space maintainer-removable, unilateral-per quadrant.	$183.00
D1526	Space maintainer - removable - bilateral, maxillary.	$223.00
D1527	Space maintainer - removable - bilateral, mandibular.	$223.00
D1551	Re-cement or re-bond bilateral space maintainer-maxillary.	$24.00
D1552	Re-cement or re-bond bilateral space maintainer-mandibular.	$24.00
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant.	$24.00
D1556	Removal of fixed unilateral space maintainer-per quadrant.	$33.00
D1557	Removal of fixed bilateral space maintainer-maxillary.	$33.00
D1558	Removal of fixed bilateral space maintainer-mandibular.	$33.00
D1575	Distal shoe space maintainer - fixed, unilateral-per quadrant.	$117.00

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

Benefits are considered for persons age 14 and under.

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.	$176.00
D8220	Fixed appliance therapy.	$176.00

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$19.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$19.00

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.	$22.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$44.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$44.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$32.00
D2150	Amalgam - two surfaces, primary or permanent.	$41.00
D2160	Amalgam - three surfaces, primary or permanent.	$49.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$59.00

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.	$39.00
D2331	Resin-based composite - two surfaces, anterior.	$49.00
D2332	Resin-based composite - three surfaces, anterior.	$61.00
D2335	Resin-based composite - four or more surfaces (anterior).	$68.00
D2391	Resin-based composite - one surface, posterior.	$43.00
D2392	Resin-based composite - two surfaces, posterior.	$54.00
D2393	Resin-based composite - three surfaces, posterior.	$68.00
D2394	Resin-based composite - four or more surfaces, posterior.	$75.00
D2410	Gold foil - one surface.	$32.00
D2420	Gold foil - two surfaces.	$41.00
D2430	Gold foil - three surfaces.	$49.00
D2990	Resin infiltration of incipient smooth surface lesions.	$39.00

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.

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.	$83.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth.	$76.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$76.00
D2930	Prefabricated stainless steel crown - primary tooth.	$69.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$74.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2932	Prefabricated resin crown.	$83.00
D2933	Prefabricated stainless steel crown with resin window.	$83.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$83.00

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

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

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

RECEMENT

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	$26.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	$13.00
D2920	Re-cement or re-bond crown.	$25.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$61.00
D6092	Re-cement or re-bond implant/abutment supported crown.	$25.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	$25.00
D6930	Re-cement or re-bond fixed partial denture.	$35.00

SEDATIVE FILLING

D2940	Placement of interim direct restoration.	$23.00
D2991	Application of hydroxyapatite regeneration medicament - per tooth.	$14.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$43.00
D3221	Pulpal debridement, primary and permanent teeth.	$43.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$65.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$58.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$50.00
D3333	Internal root repair of perforation defects.	$71.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).	$71.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$48.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$140.00
D3357	Pulpal regeneration - completion of treatment.	$140.00
D3430	Retrograde filling - per root.	$55.00
D3450	Root amputation - per root.	$132.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$111.00
D3921	Decoronation or submergence of an erupted tooth.	$36.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

DENTURE REPAIR

D5511	Repair broken complete denture base, mandibular.	$41.00
D5512	Repair broken complete denture base, maxillary.	$41.00
D5520	Replace missing or broken teeth - complete denture - per tooth.	$34.00
D5611	Repair resin partial denture base, mandibular.	$40.00
D5612	Repair resin partial denture base, maxillary.	$40.00
D5621	Repair cast partial framework, mandibular.	$47.00
D5622	Repair cast partial framework, maxillary.	$47.00
D5630	Repair or replace broken retentive/clasping materials per tooth.	$50.00
D5640	Replace missing or broken teeth - partial denture - per tooth.	$36.00

DENTURE RELINES

D5730	Reline complete maxillary denture (direct).	$75.00
D5731	Reline complete mandibular denture (direct).	$74.00
D5740	Reline maxillary partial denture (direct).	$67.00
D5741	Reline mandibular partial denture (direct).	$67.00
D5750	Reline complete maxillary denture (indirect).	$111.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5751	Reline complete mandibular denture (indirect).	$109.00
D5760	Reline maxillary partial denture (indirect).	$111.00
D5761	Reline mandibular partial denture (indirect).	$111.00
D5765	Soft liner for complete or partial removable denture-indirect.	$111.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - primary tooth.	$36.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$36.00

PALLIATIVE

D9110	Palliative treatment of dental pain - per visit.	$27.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9219	Evaluation for moderate sedation, deep sedation or general anesthesia.	$20.00
D9222	Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof.	$41.00
D9223	Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof.	$41.00
D9239	Administration of moderate sedation - intravenous first 15 minute increment, or any portion thereof.	$34.00
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof.	$34.00

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$27.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$19.00
D9440	Office visit - after regularly scheduled hours.	$33.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$20.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$26.00
D9952	Occlusal adjustment - complete.	$129.00

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.	$22.00
D2951	Pin retention - per tooth, in addition to restoration.	$12.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$39.00

DESENSITIZATION: D9911

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

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

TYPE 2 PROCEDURES

Maximum Covered Expense

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

TYPE 3 PROCEDURES

Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$137.00
D2520	Inlay - metallic - two surfaces.	$163.00
D2530	Inlay - metallic - three or more surfaces.	$175.00
D2610	Inlay - porcelain/ceramic - one surface.	$151.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$164.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$179.00
D2650	Inlay - resin-based composite - one surface.	$156.00
D2651	Inlay - resin-based composite - two surfaces.	$154.00
D2652	Inlay - resin-based composite - three or more surfaces.	$160.00

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.	$177.00
D2543	Onlay - metallic - three surfaces.	$197.00
D2544	Onlay - metallic - four or more surfaces.	$205.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$177.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$198.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$204.00
D2662	Onlay - resin-based composite - two surfaces.	$166.00
D2663	Onlay - resin-based composite - three surfaces.	$171.00
D2664	Onlay - resin-based composite - four or more surfaces.	$182.00

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

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

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

Frequency is waived for accidental injury.

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

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

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$77.00
D2712	Crown - 3/4 resin-based composite (indirect).	$192.00
D2720	Crown - resin with high noble metal.	$197.00
D2721	Crown - resin with predominantly base metal.	$151.00
D2722	Crown - resin with noble metal.	$185.00
D2740	Crown - porcelain/ceramic.	$213.00
D2750	Crown - porcelain fused to high noble metal.	$207.00
D2751	Crown - porcelain fused to predominantly base metal.	$178.00
D2752	Crown - porcelain fused to noble metal.	$190.00
D2753	Crown-porcelain fused to titanium and titanium alloys.	$190.00
D2780	Crown - 3/4 cast high noble metal.	$197.00
D2781	Crown - 3/4 cast predominantly base metal.	$171.00
D2782	Crown - 3/4 cast noble metal.	$179.00
D2783	Crown - 3/4 porcelain/ceramic.	$213.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$197.00
D2791	Crown - full cast predominantly base metal.	$171.00
D2792	Crown - full cast noble metal.	$179.00
D2794	Crown - titanium and titanium alloys.	$197.00

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

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

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	$43.00

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.	$68.00
D2954	Prefabricated post and core in addition to crown.	$57.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	$34.00
D2981	Inlay repair necessitated by restorative material failure.	$27.00
D2982	Onlay repair necessitated by restorative material failure.	$27.00
D2983	Veneer repair necessitated by restorative material failure.	$27.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$38.00
D9120	Fixed partial denture sectioning.	$38.00

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$124.00
D3320	Endodontic therapy, premolar tooth (excluding final restorations).	$146.00
D3330	Endodontic therapy, molar tooth (excluding final restorations).	$191.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$73.00
D3346	Retreatment of previous root canal therapy - anterior.	$154.00
D3347	Retreatment of previous root canal therapy - premolar.	$178.00
D3348	Retreatment of previous root canal therapy - molar.	$221.00

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.	$45.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3356	Pulpal regeneration - interim medication replacement.	$30.00
D3410	Apicoectomy - anterior.	$127.00
D3421	Apicoectomy - premolar (first root).	$147.00
D3425	Apicoectomy - molar (first root).	$159.00
D3426	Apicoectomy (each additional root).	$57.00
D3471	Surgical repair of root resorption - anterior.	$114.00
D3472	Surgical repair of root resorption - premolar.	$115.00
D3473	Surgical repair of root resorption - molar.	$116.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.	$56.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.	$58.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	$59.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$81.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$40.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$111.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$56.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$203.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$102.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant.	$66.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant.	$50.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site.	$33.00
D4270	Pedicle soft tissue graft procedure.	$150.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	$185.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	$89.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.	$158.00
D4276	Combined connective tissue and pedicle graft, per tooth.	$185.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.	$159.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$63.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$185.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$71.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

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

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$122.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$41.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$21.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$30.00

ANTIMICROBIAL AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	$25.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	$17.00
D4910	Periodontal maintenance.	$25.00

PERIODONTAL MAINTENANCE: D4346, D4910

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

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

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

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

Procedure D4346 is limited to persons age 14 and over.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$221.00
D5120	Complete denture - mandibular.	$214.00
D5130	Immediate denture - maxillary.	$239.00
D5140	Immediate denture - mandibular.	$231.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).	$159.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).	$184.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	$256.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	$256.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).	$159.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).	$184.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	$256.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	$256.00
D5225	Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).	$159.00
D5226	Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).	$184.00
D5227	Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).	$159.00
D5228	Immediate mandibular partial denture-flexible base(including any clasps, rests and teeth).	$184.00
D5282	Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.	$137.00
D5283	Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.	$137.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5284	Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.	$137.00
D5286	Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.	$137.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$159.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$184.00
D5810	Interim complete denture (maxillary).	$97.00
D5811	Interim complete denture (mandibular).	$103.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.	$86.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.	$90.00
D5863	Overdenture - complete maxillary - natural tooth borne.	$221.00
D5864	Overdenture - partial maxillary - natural tooth borne.	$256.00
D5865	Overdenture - complete mandibular - natural tooth borne.	$221.00
D5866	Overdenture - partial mandibular - natural tooth borne.	$256.00
D5876	Add metal substructure to acrylic complete denture - per arch.	$73.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary.	$221.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular.	$221.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary.	$256.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular.	$256.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary.	$221.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular.	$221.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	$256.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	$256.00
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular.	$103.00
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary.	$97.00

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

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

Frequency is waived for accidental injury.

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

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

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

Frequency is waived for accidental injury.

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

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$12.00
D5411	Adjust complete denture - mandibular.	$12.00
D5421	Adjust partial denture - maxillary.	$13.00
D5422	Adjust partial denture - mandibular.	$12.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture - per tooth.	$28.00
D5660	Add clasp to existing partial denture-per tooth.	$33.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$80.00
D5711	Rebase complete mandibular denture.	$85.00
D5720	Rebase maxillary partial denture.	$77.00
D5721	Rebase mandibular partial denture.	$81.00
D5725	Rebase hybrid prosthesis.	$64.00

TISSUE CONDITIONING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5850	Tissue conditioning, maxillary.	$22.00
D5851	Tissue conditioning, mandibular.	$24.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$184.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$201.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$201.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$184.00
D6062	Abutment supported cast metal crown (high noble metal).	$201.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$201.00
D6064	Abutment supported cast metal crown (noble metal).	$217.00
D6065	Implant supported porcelain/ceramic crown.	$184.00
D6066	Implant supported crown - porcelain fused to high noble alloys.	$201.00
D6067	Implant supported crown - high noble alloys.	$201.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$184.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$201.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$201.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$184.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$201.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$201.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$217.00
D6075	Implant supported retainer for ceramic FPD.	$184.00
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys.	$201.00
D6077	Implant supported retainer for metal FPD - high noble alloy.	$201.00
D6082	Implant supported crown-porcelain fused to predominantly base alloys.	$151.00
D6083	Implant supported crown-porcelain fused to noble alloys.	$166.00
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys.	$166.00
D6086	Implant supported crown-predominantly base alloys.	$151.00
D6087	Implant supported crown-noble alloys.	$166.00
D6088	Implant supported crown-titanium and titanium alloys.	$166.00
D6094	Abutment supported crown - titanium and titanium alloys.	$201.00
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys.	$166.00
D6098	Implant supported retainer-porcelain fused to predominantly base alloys.	$151.00
D6099	Implant supported retainer for FPD-porcelain fused to noble alloys.	$166.00
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys.	$166.00
D6121	Implant supported retainer for metal FPD-predominantly base alloys.	$151.00
D6122	Implant supported retainer for metal FPD-noble alloys.	$166.00
D6123	Implant supported retainer for metal FPD-titanium and titanium alloys.	$166.00
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys.	$201.00
D6195	Abutment supported retainer-porcelain fused to titanium and titanium alloys.	$166.00
D6205	Pontic - indirect resin based composite.	$166.00
D6210	Pontic - cast high noble metal.	$201.00
D6211	Pontic - cast predominantly base metal.	$201.00
D6212	Pontic - cast noble metal.	$217.00
D6214	Pontic - titanium and titanium alloys.	$201.00
D6240	Pontic - porcelain fused to high noble metal.	$201.00
D6241	Pontic - porcelain fused to predominantly base metal.	$201.00
D6242	Pontic - porcelain fused to noble metal.	$184.00
D6243	Pontic-porcelain fused to titanium and titanium alloys.	$166.00
D6245	Pontic - porcelain/ceramic.	$184.00
D6250	Pontic - resin with high noble metal.	$201.00
D6251	Pontic - resin with predominantly base metal.	$184.00
D6252	Pontic - resin with noble metal.	$217.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$67.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$67.00
D6549	Resin retainer - for resin bonded fixed prosthesis.	$67.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces.	$164.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.	$180.00
D6602	Retainer inlay - cast high noble metal, two surfaces.	$147.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces.	$162.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6604	Retainer inlay - cast predominantly base metal, two surfaces.	$127.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.	$140.00
D6606	Retainer inlay - cast noble metal, two surfaces.	$134.00
D6607	Retainer inlay - cast noble metal, three or more surfaces.	$147.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces.	$177.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.	$195.00
D6610	Retainer onlay - cast high noble metal, two surfaces.	$162.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces.	$178.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces.	$140.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.	$154.00
D6614	Retainer onlay - cast noble metal, two surfaces.	$147.00
D6615	Retainer onlay - cast noble metal, three or more surfaces.	$162.00
D6624	Retainer inlay - titanium.	$162.00
D6634	Retainer onlay - titanium.	$178.00
D6710	Retainer crown - indirect resin based composite.	$166.00
D6720	Retainer crown - resin with high noble metal.	$201.00
D6721	Retainer crown - resin with predominantly base metal.	$104.00
D6722	Retainer crown - resin with noble metal.	$167.00
D6740	Retainer crown - porcelain/ceramic.	$184.00
D6750	Retainer crown - porcelain fused to high noble metal.	$217.00
D6751	Retainer crown - porcelain fused to predominantly base metal.	$201.00
D6752	Retainer crown - porcelain fused to noble metal.	$184.00
D6753	Retainer crown-porcelain fused to titanium and titanium alloys.	$166.00
D6780	Retainer crown - 3/4 cast high noble metal.	$217.00
D6781	Retainer crown - 3/4 cast predominantly base metal.	$201.00
D6782	Retainer crown - 3/4 cast noble metal.	$184.00
D6783	Retainer crown - 3/4 porcelain/ceramic.	$184.00
D6784	Retainer crown 3/4-titanium and titanium alloys.	$166.00
D6790	Retainer crown - full cast high noble metal.	$201.00
D6791	Retainer crown - full cast predominantly base metal.	$201.00
D6792	Retainer crown - full cast noble metal.	$184.00
D6794	Retainer crown - titanium and titanium alloys.	$201.00
D6940	Stress breaker.	$56.00

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

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

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

Frequency is waived for accidental injury.

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

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

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

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

Frequency is waived for accidental injury.

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

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932. D2933 or D2934 has been performed within 12.

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

TYPE 3 PROCEDURES

Maximum Covered Expense

Replacement is limited to 1 of any of these procedures per 5 year(s).
D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

SURGICAL EXTRACTIONS

D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$43.00
D7220	Removal of impacted tooth - soft tissue.	$54.00
D7230	Removal of impacted tooth - partially bony.	$72.00
D7240	Removal of impacted tooth - completely bony.	$84.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$95.00
D7250	Removal of residual tooth roots (cutting procedure).	$45.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only.	$84.00
D7252	Partial extraction for immediate implant placement.	$43.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$106.00
D7261	Primary closure of a sinus perforation.	$106.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$64.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$64.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D7280	Exposure of an unerupted tooth.	$99.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$71.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$30.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$37.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$19.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$47.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$24.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$68.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$170.00
D7410	Excision of benign lesion up to 1.25 cm.	$68.00
D7411	Excision of benign lesion greater than 1.25 cm.	$87.00
D7412	Excision of benign lesion, complicated.	$95.00
D7413	Excision of malignant lesion up to 1.25 cm.	$91.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$67.00
D7415	Excision of malignant lesion, complicated.	$74.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$91.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$67.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$68.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$87.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$68.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$87.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$20.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$60.00
D7472	Removal of torus palatinus.	$60.00
D7473	Removal of torus mandibularis.	$60.00
D7485	Reduction of osseous tuberosity.	$98.00
D7490	Radical resection of maxilla or mandible.	$91.00
D7509	Marsupialization of odontogenic cyst.	$30.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$30.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$35.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$28.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$76.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$76.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$100.00
D7910	Suture of recent small wounds up to 5 cm.	$13.00
D7911	Complicated suture - up to 5 cm.	$15.00
D7912	Complicated suture - greater than 5 cm.	$22.00
D7961	Buccal/labial frenectomy (frenulectomy).	$73.00
D7962	Lingual frenectomy (frenulectomy).	$73.00
D7963	Frenuloplasty.	$91.00
D7970	Excision of hyperplastic tissue - per arch.	$56.00
D7972	Surgical reduction of fibrous tuberosity.	$89.00
D7979	Non-surgical sialolithotomy.	$42.00
D7980	Surgical sialolithotomy.	$84.00
D7983	Closure of salivary fistula.	$27.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Incisional biopsy of oral tissue - hard (bone, tooth).	$91.00
D7286	Incisional biopsy of oral tissue - soft.	$49.00
D7287	Exfoliative cytological sample collection.	$24.00
D7288	Brush biopsy - transepithelial sample collection.	$24.00

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

COVERED EXPENSES
Covered Expenses include the lesser of:

a. the charge for the covered procedure furnished; or
b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

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

PARTICIPATING PROVIDERS
A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS
A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP’s Customer Care Division for details at (800) 877-7195.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy’s termination. You will have six months following the date of service to submit your claim.

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

PROOF OF LOSS
Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS
This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS
This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to $100.00
Frames			
Single Frame	Once every 12 months	Up to $150.00	Up to $ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to $150.00	Up to $105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

COORDINATION OF BENEFITS

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

GENERAL PROVISIONS

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

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

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

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

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

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

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

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

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

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

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

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.

GENERAL PROVISIONS (CONTINUED)

PAYMENT OF PREMIUMS. The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized representative within 20 days after the receipt of the premium. All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the Plan Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to Insureds or their dependents who cancel coverage under the policy; unless the Insured enters the armed forces. Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Student Dental Insurance at the time of initial enrollment. The named Insured may purchase optional coverage for all Dependent family members. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree. Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 3 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made.

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

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

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

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

i. necessary to calculate premiums;

ii. necessary to determine a person's eligibility, 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 errs 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.

TERMINATION OF THE POLICY. This policy will terminate as of the Master Policy Termination Date shown on the policy cover and in the application attached to this policy.

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.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: AMERICAN UNIVERSITY

whose main office address is: 4400 MASSACHUSETTS AVE NW
WASHINGTON, DC 20016-8002

for Group Policy No. 10-64647

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.

AMERICAN UNIVERSITY

(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