## Filing at a Glance

Company: Ameritas Life Insurance Corp.

| | | |
|---|---|---|
| Product Name: Indiv. 9000 AR Rev. 05-11 | SERFF Tr Num: AMFA-127200927 | State: Arkansas |
| TOI: H10I Individual Health - Dental | SERFF Status: Closed-Approved-Closed | State Tr Num: 49021 |
| Sub-TOI: H10I.000 Health - Dental | Co Tr Num: INDIV. 9000 AR REV. 05-11 | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Rosalind Minor |
| | Author: Janis Landon | Disposition Date: 07/08/2011 |
| | Date Submitted: 06/09/2011 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

Project Name: Indiv. 9000 AR Rev. 05-11
Project Number: Indiv. 9000 AR Rev. 05-11
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Janis Landon
Filing Description:
Re: Ameritas Life Insurance Corp.
NAIC # 943-61301
FEIN # 47-0098400
Individual Dental Policy Form Filing

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 07/08/2011
State Status Changed: 07/08/2011
Created By: Janis Landon
Corresponding Filing Tracking Number:

Forms: Indiv. 9000 AR Rev. 05-11 - Individual [Dental and Eye Care] Insurance Policy
GR 6400 Ed. 6-11 – Application
OOC Rev. 05-11 – Outline of Coverage
Optionals and Variables – Indiv O&V Rev. 05-11

920 Ed. 05-11 - Laser Vision Correction Benefit Rider
930 Ed. 05-11 - Hearing Care Expense Benefits Rider

Enclosed for your review and approval are the above referenced forms. This policy will replace recently approved policy Indiv. 9000 AR Ed. 11-09 under Serff #AMFA-126819688 on October 4, 2010. A red-lined version detailing the difference between what was approved and what is currently being filed is attached for your reference. The policy provides dental insurance to those individuals who may not have the benefit of a group dental policy. This product can be purchased as a stand-alone dental policy or as a dental policy that includes limited eye care benefits. The eye care benefit is not available as a stand-alone product. With this new filing, we are now offering Lasik and Hearing Care riders. As information, these identical riders have been previously approved by your Department, under different form numbers, for use with our Group Dental and Eye Care products.

The policy provides for coverage of dental expense benefits, including orthodontia, eye care expense benefits and an optional increased maximum benefit. When sold with a dental policy, the “Combined Option” would provide for a dental and eye care combination deductible, frequency and maximum. The combined deductible and maximum would apply to all covered dental and eye care expenses. The combined frequency would apply to only dental and eye care exams. For example, once the combined deductible has been met for the dental expenses, a deductible would no longer be required for the eye exam.

We would like the policy to be available for issue upon your approval. Forms will be made available in electronic format or paper as requested.

The application currently used with the individual policy is GR 6205 Ed. 11-09. That application will remain in force for distributions not selling Lasik and Hearing. This new application, form GR 6400 Ed. 05-11, will be used by distributions offering the Hearing and Lasik in addition to Dental and Eye Care.

The Outline of Coverage to be used with this policy is form OOC Rev. 05-11. A red-lined version detailing the difference between what was approved and what is currently being filed is attached for your reference. The previously approved Outline of Coverage will remain inforce for those distributions that will not be selling hearing and lasik.

We are requesting approval of these forms with the variability as noted within the items bracketed and defined within the Optionals and Variables. These variable provisions reflect the plan design options and features, which are selected by the applicant. These include varying deductibles, coinsurance percentages, maximums, claim allowance options, and coverage provisions including the ability to include a PPO benefit option, as applicable. In our PPO option, an insured has the full freedom of choice to visit any provider (no gatekeeper requirement) but visiting a participating provider may reduce out-of-pocket expenses for covered procedures.

If your state requires the filing of individual rates, they are included within this filing.

Nothing in this filing includes any provisions contrary to standard industry practice.

Thank you for your consideration of this filing.  If you have any questions or comments, please feel free to contact me at 800-745-1112, Ext. 82444, FAX 402-309-2573 or eMail jlandon@ameritas.com.

Sincerely,

Janis Landon, ACS, FLMI
Senior Contract Analyst

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Janis Landon, Senior Contract Analyst | jlandon@ameritas.com |
| 475 Fallbrook Blvd. | 800-745-1112 [Phone]  82444 [Ext] |
| Lincoln, NE 68521 | 402-309-2573 [FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| Ameritas Life Insurance Corp. | CoCode: 61301 | State of Domicile: Nebraska |
| 5900 O Street | Group Code: 943 | Company Type: |
| P O Box 81889 | Group Name: | State ID Number: |
| Lincoln, NE  68501-1889 | FEIN Number: 47-0098400 | |
| (800) 756-1112 ext. [Phone] | | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $200.00 |
| Retaliatory? | No |
| Fee Explanation: | 4 forms x $50.00 per form = $200.00 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Ameritas Life Insurance Corp. | $200.00 | 06/09/2011 | 48500996 |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 07/08/2011 | 07/08/2011 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 06/24/2011 | 06/24/2011 | Janis Landon | 07/01/2011 | 07/01/2011 |

# Disposition

Disposition Date: 07/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMFA-127200927* | *State:* | *Arkansas* |
| *Filing Company:* | *Ameritas Life Insurance Corp.* | *State Tracking Number:* | *49021* |
| *Company Tracking Number:* | *INDIV. 9000 AR REV. 05-11* | | |
| *TOI:* | *H10I Individual Health - Dental* | *Sub-TOI:* | *H10I.000 Health - Dental* |
| *Product Name:* | *Indiv. 9000 AR Rev. 05-11* | | |
| *Project Name/Number:* | *Indiv. 9000 AR Rev. 05-11 /Indiv. 9000 AR Rev. 05-11* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document *(revised)*** | Health - Actuarial Justification | Approved-Closed | No |
| **Supporting Document** | Health - Actuarial Justification | Replaced | No |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Optionals & Variables | Approved-Closed | Yes |
| **Supporting Document** | Redlines | Approved-Closed | Yes |
| **Form** | INDIVIDUAL DENTAL [EYE] [AND] [HEARING] CARE INSURANCE POLICY | Approved-Closed | Yes |
| **Form** | Application | Approved-Closed | Yes |
| **Form** | Laser Vision Correction Benefit Rider | Approved-Closed | Yes |
| **Form** | Hearing Care Expense Benefits Rider | Approved-Closed | Yes |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 06/24/2011 |
| Submitted Date | 06/24/2011 |
| Respond By Date | |

Dear Janis Landon,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment:

Under the "Trend" portion of the actuarial memorandum, it is stated that...."Trend increases can be applied on a quarterly....". It appears that the sentence was not completed. Also, are you stating that you will implement quarterly trend rate increases? If so, what is the quarterly factor? Generally, we do not allow trend increases, but we will review.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 07/01/2011 |
| Submitted Date | 07/01/2011 |

Dear Rosalind Minor,

**Comments:**

## Response 1

Comments: Attached please find a revised Actuarial Memo.

We are requesting that filed rates are allowed to increase as described in the trend table included in the manual. Once a member enrollees, the rate is guaranteed for 12 months, but the rate being offered to new members would increase from trend every quarter or once a year.

**Related Objection 1**

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

Under the "Trend" portion of the actuarial memorandum, it is stated that...."Trend increases can be applied on a quarterly....". It appears that the sentence was not completed. Also, are you stating that you will implement quarterly trend rate increases? If so, what is the quarterly factor? Generally, we do not allow trend increases, but we will review.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Health - Actuarial Justification

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMFA-127200927* | *State:* | *Arkansas* |
| *Filing Company:* | *Ameritas Life Insurance Corp.* | *State Tracking Number:* | *49021* |
| *Company Tracking Number:* | *INDIV. 9000 AR REV. 05-11* | | |
| *TOI:* | *H10I Individual Health - Dental* | *Sub-TOI:* | *H10I.000 Health - Dental* |
| *Product Name:* | *Indiv. 9000 AR Rev. 05-11* | | |
| *Project Name/Number:* | *Indiv. 9000 AR Rev. 05-11 /Indiv. 9000 AR Rev. 05-11* | | |

Sincerely,

Janis Landon

# Form Schedule

**Lead Form Number: Indiv. 9000 Rev. 05-11**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 07/08/2011 | Indiv. 9000 AR Rev. 05-11 | Policy/Contract/Fraternal Certificate | INDIVIDUAL DENTAL [EYE] [AND] [HEARING] CARE INSURANCE POLICY | Revised | Replaced Form #: Indiv. 9000 AR Rev. 09-10<br>Previous Filing #: AMFA-126819688 | 50.000 | Indiv. 9000 AR Rev. 05-11.pdf |
| Approved-Closed 07/08/2011 | GR 6400 Ed. 6-11 | Application/Enrollment Form | Application | Initial | | 50.000 | GR6400.pdf |
| Approved-Closed 07/08/2011 | 920 Ed. 05-11 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Laser Vision Correction Benefit Rider | Initial | | 50.000 | 920 Ed. 05-11.pdf |
| Approved-Closed 07/08/2011 | 930 Ed. 05-11 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Hearing Care Expense Benefits Rider | Initial | | 50.000 | 930 Ed. 05-11.pdf |

A STOCK COMPANY
LINCOLN, NEBRASKA

# INDIVIDUAL DENTAL [EYE] [AND] [HEARING] CARE INSURANCE POLICY

**The Policyholder**

| | | | |
|---|---|---|---|
| | | **Policy Number** | **[10-123456]** |
| **State of Delivery** | **XXXXXX** | **Plan Effective Date** | **XXXXXX** |
| **Premium Due Date 1st of each month.** | | **Renewal Date** | **XXXXXX** |

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

This policy is issued to You in consideration of Your application and the payment of premiums, as provided herein.

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

Rates for this policy are subject to adjustment at time of renewal and for other limited circumstances, such as changes in coverage, described herein.

You are entitled to have the premium paid refunded if, after You examine the policy, You are not satisfied with the policy for any reason and notify us in writing not later than the [10th] day after the date the policy is delivered to You. If this policy is cancelled by then, it is void from the date the policy was issued.

This policy takes effect upon the effective date noted above and terminates in accordance with the termination provisions expressed in the policy.

This Policy is renewable at Your option unless:
(1) Your Renewal Premium is not received before the Grace Period ends;
(2) We refuse to renew all Policies of this form in Your state of residence; or
(3) Subject to the termination provisions provided herein.
No refusal of renewal will affect an existing claim.

**AMERITAS LIFE INSURANCE CORP.**

Corporate Secretary

President

## IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: _____
Address: _____
Telephone Number: _____

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

**Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.**

AR-Complaint Ed. 01-05

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

AR Guaranty Ed. 01-05

COVERAGE

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

EXCLUSIONS FROM COVERAGE

However, persons owning such policies 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 incorporated in another state whose guaranty association protects insureds who live outside that state);
* The insurer was not authorized to do business in this state;
* Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

* Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
* Any policy of reinsurance (unless an assumption certificate was issued);
* Interest rate yields that exceed an average rate;
* Dividends and voting rights and experience rating credits;
* Credits given in connection with the administration of a policy by a group contract holder;
* Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
* Unallocated annuity contracts (which give rights to group contract holders, not individuals);
* Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
* Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
* Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
* Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
* Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

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Indiv TOC

## DEFINITIONS

**ACTUAL CHARGE / ACTUAL FEE:**
The amount charged by a Provider for services provided.

**CHILD:**
The Child of the Policyholder. Also, a Child of the Policyholder's spouse [or Domestic Partner]. The Child must also meet the definition of Dependent.

**[COINSURANCE:**
Shared responsibility between the covered person and us. The level We will pay toward the expenses incurred for services is shown on the schedule.]

**COMPANY:**
Ameritas Life Insurance Corp. "We", "Us" and "Our" refers to our Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

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

**[DENTAL CARE SERVICE:**
A service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.]

**DEPENDENT:**

a. Your spouse [or Domestic Partner].

b. each unmarried Child less than [19] years of age, to include:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iiv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   v. stepchildren if such children are Dependents.

[c. each unmarried child age [19] but less than [24] who is:

i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

ii. primarily dependent on You, Your spouse for support and maintenance.]

d. each unmarried Child age [19] or older who:

i. is Totally Disabled as defined below; and

ii. becomes Totally Disabled while insured as a Dependent under b. or c. above.

We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof and for notifying us when such dependency and disability has terminated. Any costs for providing continuing proof will be at Our expense. When a handicapped Dependent child reaches the age under the contract that under normal circumstances would cause the Dependent to be terminated or converted to an adult premium, the premium rate shall remain at the child rate.

Dependent shall not include Your parents, grandparents, or any other such individual that is not listed above.

**DEPENDENT UNIT:**
All of the people who are insured as the Dependents of the Policyholder.

**[DOMESTIC PARTNER:**
Two unrelated people who share the necessities of life similar to that of a spouse. They must live together and have an emotional and financial commitment to one another. ]

**ELIMINATION PERIOD:**
A waiting period that may be required before coverage for a particular procedure will be considered. Certain Covered Expenses may be subject to an Elimination Period. Please refer to Dental Expense Benefits for details.

**EMERGENCY:**
A sudden, serious dental condition. If not treated immediately it would result in serious harm to the dental health of the covered person. Coverage at the emergency benefit level for an Emergency is limited to Palliative care only.

**[EYE CARE SERVICE:**
Service provided to a person to diagnose and correct visual acuity .]

**INSURED:**
The Policyholder and a person:

a. Who is a Dependent of the Policyholder
and
b. For whom the insurance has become effective.

**LATE ENTRANT:**
Any Dependent:

a. Whose Effective Date of insurance is more than 31 days from the date the Dependent becomes eligible for insurance.
   or
b. Who has elected to become insured again after having been terminated.

**MAXIMUM AMOUNT:**
The maximum amount payable for each covered person per benefit period. The Maximum Amount is shown on the Schedule of Benefits. No further benefits are payable once the Maximum Benefits are reached.

**[PALLIATIVE:**
Treatment used to relieve, ease, or alleviate the acute severity of dental pain, swelling, or bleeding.]

**POLICYHOLDER:**
Stated on the face page of the policy. The words "You" and "Your" refer to the Policyholder.

**PROVIDER:**
Any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

**[TAKEOVER:**
You may qualify for Takeover benefits if You Were previously covered under a dental plan. You must supply a valid Evidence of Coverage letter from the prior carrier indicating the dates you were covered under the prior plan. This must include the termination date of the prior plan that is no more than 30 days prior to the date you applied for coverage under this Policy. The benefits under the prior plan must have been similar to the benefits included in this Policy. ]

**TOTAL DISABILITY:**
A Dependent

1. Continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

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

## SCHEDULE OF BENEFITS

REFER TO THE TABLE OF DENTAL PROCEDURES FOR A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES.

REFER TO THE DENTAL EXPENSE BENEFITS AND LIMITATIONS SECTIONS FOR INFORMATION ABOUT ELIMINATION [WAITING] PERIODS AND GENERAL PLAN LIMITATIONS.

The Insurance for You and each of Your covered Dependents will be based on this Schedule of Benefits.

**DENTAL EXPENSE BENEFITS**

[When you select a Participating Provider, a discounted fee is charged for covered services, which is intended to provide Insureds, reduced out-of-pocket costs.]

**Deductible Amount:**

| | |
|---|---|
| Combined Types 1, 2, 3, and 4 Procedures - Each Benefit Period | [$0, $25, $50, $75, $100]* |

[On the date that three family members have satisfied their own Deductible no other family member will be required to satisfy their Deductible. This applies to a single Benefit Period only. 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.]

[Dental expenses incurred by an individual on or after [January 1, 2009], but before [April 1, 2009], will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under Your dental insurance policy in force prior to [April 1, 2009];

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred; and

c. You qualify for Takeover as defined.]

**Coinsurance Percentage:**

| | |
|---|---|
| Type 1 Procedures | [25%-100%] |
| Type 2 Procedures | [0-100% ] |
| Type 3 Procedures | [0-100 %] |
| Type 4 Procedures | [0-100%] |

| | |
|---|---|
| **Maximum Amount - Each Benefit Period.** | [ $1,500]* |

***You and/or your dependents may be required to be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.***

200 Ed. 11-09

**[ORTHODONTIC EXPENSE BENEFITS**

| | |
|---|---|
| **Deductible Amount:** | [$0-200] |
| **Coinsurance Percentage:** | [25%-50%] |
| **Maximum Amount - During Lifetime** | [$200, $500, $600, $3,000] |

[The Maximum Amount shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under a prior carrier , and on [April 1, 2009] is:

   i. insured under the policy,

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force; and

   iii. who qualifies for Takeover, as defined.

The modification will result in a reduction of the Maximum Amount based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on Orthodontic Expense Benefits, Limitations.]

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

**[EYE CARE EXPENSE BENEFITS**

| | |
|---|---|
| **Deductible Amount:** | |
| Exam - Each Benefit Period | [$ 10] |
| Lenses - Other than contact lenses - Each Benefit Period | [$ 25]* |
| Frames and Contact Lenses - Each Benefit Period | [$ 25]* |
| **[Maximum Amount - Each Benefit Period.** | [$150]] |

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

**[LASER VISION CORRECTION EXPENSE BENEFITS**

| | |
|---|---|
| [Deductible Amount - [each Benefit Period]] | $[50] |
| Coinsurance Percentage: | [100%] |

***[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]]***

**[HEARING CARE EXPENSE BENEFITS**

Deductible Amount:

| | |
|---|---|
| [Exams] - [each Benefit Period] | [$0] |
| [Hearing Aids] - [each Benefit Period] | [$0] |
| [Hearing Aid Maintenance] - [each Benefit Period] | [$0] |
| [Hearing Miscellaneous] - [each Benefit Period] | [$0]] |

[If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and
ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

| | |
|---|---|
| [Exams] | [100%*] |
| [Hearing Aids] | [50%] |
| [Hearing Aid Maintenance] | [100%*] |
| [Hearing Miscellaneous] | [100%*]] |

*refer to the **SCHEDULE OF HEARING CARE SERVICES** page regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

| | |
|---|---|
| [1st 12 month Period] | $[400] |
| [2nd 12 month Period] | $[600] |
| [3rd 12 month Period] | $[800] |
| [4th 12 month Period or thereafter] | $[1,000] |

The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

**EXCEPTION:** If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured’s initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[**COMBINED DENTAL AND EYE CARE EXPENSE BENEFITS**

***Combined Dental And Eye Care Deductible Amount:** **[**$0- 200]
Each Benefit Period
*The deductibles listed with the (*) above are subject to the maximum deductible amount listed here.*

***Combined Dental and Eye Care Maximum - Each Benefit Period** [$500-2,000]
*The maximums listed with the (*) above are subject to the maximum amount listed here.*

**Combined Dental and Eye Care Exam Frequencies – Each Benefit Period**
Routine Exams for Dental and Eye Care are limited to * each Benefit Period.

Dental Exams will include:
[D0120 Periodic oral evaluation]
[D0150 Comprehensive oral evaluation - new or established patient.]
[ D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine Eye Care exam is a vision examination as defined on the Schedule of Eye Care Services.

The above frequencies for Dental and Eye Care Exams are subject to the plan frequencies as defined within the Table of Dental Procedures and the Eye Care Insurance provision.]

## [INCREASED DENTAL MAXIMUM BENEFIT

[It is hereby agreed that the policy is amended by adding the Increased Dental Maximum Benefit provision as defined below: ]

| | |
|---|---|
| Carry Over Amount Per Insured Person – Each Benefit Period. | [$125, $250, $400] |
| [PPO Bonus - Each Benefit Period. | [$50,$100, $150, $200]] |
| Benefit Threshold Per Insured Person – Each Benefit Period. | [$250, $500, $750] |
| Maximum Carry Over Amount. | [$500, $1,000, $1,200, $1,500, $2,000] |

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

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

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

[After the first Benefit Period following the effective date of this provision, the Carry Over Amount Per Insured Person will be increased by the PPO Bonus if all of the following are met.

a) The insured person has submitted a claim for covered dental expenses incurred during the preceding benefit period.

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider.

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

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

The Carry Over Amount [and the PPO Bonus] can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless either of the following applies.

a) During any Benefit Period, dental expense benefits are paid in excess of the Benefit Threshold. In this instance, there will be no additional Carry Over Amount [or PPO Bonus] for that Benefit Period.

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

[The Carry Over Amount [and the PPO Bonus, if applicable] accrued prior to [January 1, 2009] will apply to the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits if proof is furnished to us that such Carry Over Amount was incurred under the policy in force immediately prior to [January 1, 2009] except as noted below. [This proof must be furnished to us within 12 months of the Policy Effective

Date and not be for a Date of Services more than 12 months prior to the date the proof is furnished.] Any qualified Carry Over Amount under a prior policy will apply toward the total Maximum Carry Over Amount under this policy. In no event will the Carry Over Amount under a prior policy plus any accumulated Carry Over Amount, if applicable, under this policy exceed the Maximum Carry Over Amount. Any future Carry Over Amounts accumulated or forfeited in subsequent Benefit Periods will be calculated as outlined above. Please note that if the first Benefit Period is for a period of less than 12 months the Carry Over Amount will be accumulated in the second Benefit Period without a claim having to be filed but the Carry Over Amount in all subsequent Benefit Periods may be forfeited as per the rules in b. above.]

[The Carry Over Amount for those Insured on [January 1, 2009] will be $[500] and will apply to the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits for the remainder of the Benefit Period except as noted below. In no event will the Carry Over Amount listed here plus any accumulated Carry Over Amount, if applicable, under this policy exceed the Maximum Carry Over Amount. Any future Carry Over Amounts accumulated or forfeited in subsequent Benefit Periods will be calculated as outlined above.]

Carry Over Eligibility [and the PPO Bonus] will be determined at the time the first claim in a Benefit Period is received for covered expenses incurred during that Benefit Period.

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

## PREMIUMS

## TABLE OF [MONTHLY] PREMIUM RATES

| | |
|---|---|
| **[Dental Care Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)]. |
| **Eye Care Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)]. |
| **Orthodontic Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)].] |

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

**PREMIUM DUE DATE:**
The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If We agree with You that the payment of premiums shall be on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made. Please see the General Provisions section of this policy for Grace Period information.

**ADJUSTMENTS IN PREMIUM RATES**:
We will not change the initial premium shown on the cover of this policy in the middle of Your policy year, unless any of the following are met.

- Family members are added or deleted.
- Coverage is increased or decreased.
- You move to a different zip code, county or state.
- Premium payment method is changed.
- Any other terms and conditions of this policy change.

The premium change will be effective on the first of the month following the date of such change.

At policy renewal, Your premiums may change for any of the reasons stated above or as a result of any of the following.

- A new rate table applies.
- Any covered person's age classification increases.

We will provide written notice at least [60] days prior to the effective date of any renewal premium change.

**RENEWAL DATE**:
Renewal Date refers to the date each calendar year that the coverage issued under this policy is considered for renewal. The Renewal Date is shown on the policy cover.

**PREMIUM REFUND:**
We will be liable for the return of unearned premiums to You only for the [3, 6, 9, 12] months before the date We receive evidence that a return is due.

## CONDITIONS FOR INSURANCE COVERAGE

*ELIGIBILITY*

**EFFECTIVE DATE:**
The Effective Date for You is the Effective Date listed on the cover page of this Policy. You must be at least [18] to be a Policyholder.

**[DEPENDENT EFFECTIVE DATE:**
You have the option of insuring Your Dependents. You must be covered under this policy in order to insure your dependents. To elect coverage, You must agree in writing to pay the insurance premiums.

Dependents may be added within 31 days of becoming eligible for coverage under this policy. After the expiration of this 31 day period Dependents may only be added pursuant to the Late Entrant provision and Our review of the application.

The Effective Date for Dependents will be either of the following.

1. The first of the month for which the Policyholder pays applicable premiums , if that date is within 31 days after the date he or she qualifies for insurance as a Dependent.

[2. The date We accept the Dependent for insurance when the Dependent is a Late Entrant. The Dependent will be subject to any limitation concerning Late Entrants.]

For dependent children, a newborn child will be considered an eligible dependent without imposition of late entrant status until 30 days after they've reached their 2nd birthday.]

**[COVERAGE FOR NEWBORN AND ADOPTED CHILDREN:**
A newborn Child will be covered from the date of birth.

Coverage for a newborn Child shall consist of coverage for covered dental procedures needed as a result of congenital defects or birth abnormalities such as cleft lip, cleft palate and premature birth. This coverage is subject to applicable Deductibles, Coinsurance percentages, maximums and limitations.

The initial coverage provided newborn children shall continue for a period of at least 90 days. For coverage to continue beyond this initial 90-day period, You must notify Us of the birth of the newborn Child. You must also pay any additional premium required to keep the coverage in force. An additional premium for the initial period of coverage may be charged.

An adopted Child will be covered from the date You have filed a petition to adopt the Child if You have filed for coverage within 60 days after filing the petition for adoption. Any additional premium may be required.]

## *TERMINATION DATES*

**POLICY TERMINATION:**
Upon termination of the policy, all coverage for Dependents will terminate. We can terminate Your policy upon the earliest of any of the following.

- The last day through which the premium was paid.
- The last day [of the month] in which You request termination of insurance coverage to be effective or the date such written request is received by Us, whichever is later.
- The last day [of the month] in which You, or a covered person, commits fraud or intentional misrepresentation of a material fact, as determined by Us.
- The last day [of the month] in which a covered person permits a person not authorized by Us to use his or her identification card, or a covered person uses another covered person's identification card that he or she is not authorized to use.
- The last day [of the month] in which a covered person fails to comply with the policy provisions, as determined by Us.
- The last day [of the month] in which You enter full-time military, naval, or air service.
- The last day [of the month] in which You move outside the service area, as determined by Us.
- The last day [of the month] in which We have a right or defense to take such action by law.
- The last day [of the month] in which We cease to offer this type of policy or cease to do business in the individual markets as allowed by state law.

**[DEPENDENT TERMINATION:**
Coverage can terminate under the policy for a Dependent, even if the policy does not terminate for the reasons stated above, on the earliest of any of the following.

- The last day [of the month] for which the premium was paid for Dependent coverage.
- The last day [of the month] in which the Dependent no longer qualifies as a Dependent or meets eligibility criteria.
- The last day [of the month] after which You provide 30 days notice to Us of Your voluntary termination of coverage
- The last day [of the month] in which the Dependent is no longer a resident of the service area, as determined by Us.
- The last day [of the month] in which the Dependent enters full-time military, naval, or air service.
- The last day [of the month] in which the Dependent commits fraud or intentional misrepresentation of a material fact, as determined by Us.
- The last day [of the month] in which the policy terminates.]

**YOUR DUTY TO NOTIFY US:**
You are responsible to notify Us of any of the events stated above which would result in the termination of the policy or a covered person. If You fail to provide timely notification of these events We will terminate Your policy. The termination date and premium refund (if any) will be determined based on when We should have received notification. This will be determined by Us.

**OTHER COVERAGE:**
Dual coverage by You or of a spouse and/or Dependents under another policy issued by Us is prohibited. If You have coverage under any other carrier We will not coordinate benefits.

**CONTINUATION OF COVERAGE:**
If Dependent coverage ceases according to the Termination Section, some or all of the insurance coverages may be continued. This will be via a new individual policy. The policy will be in the Dependent's name. The policy will be at the then prevailing rates and benefits schedule. The Dependent must be an adult in order to elect continuation. The new policy will be issued without evidence of insurability. The person's history will transfer.

If a person loses coverage due to a change in marital status he or she may wish to continue coverage. We will offer another policy. This policy will be one which We are then issuing which most nearly reflects the coverage of the policy which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability. The person's history will transfer.

In the event of the Policyholder's death the spouse may become the Policyholder. The spouse must have been covered under the policy.

Should the Policyholder die while having Dependents insured, the Dependents of the deceased Policyholder will be eligible to continue coverage provided all other policy provisions are satisfied.

If We accept premium for coverage past the termination date of an insured family member, the coverage shall continue during the period for which an identifiable premium was accepted. A misstatement of age will void this provision.

Contact Us for details.

**REFUND AT DEATH:**
If the Policyholder dies and no continuation is elected, We provide for the refund of unused premiums upon the death of the Policyholder during the contract period. The amount of premium refund shall be prorated from the beginning of the month following the date of death of the Policyholder to the end of the contract period for which the premium has been paid.

## GENERAL PROVISIONS

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

**TIME LIMIT ON CERTAIN DEFENSES:**
(a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary. (b) After two years, We won't reduce or deny benefits due to a preexisting condition.

**GRACE PERIOD:**
Unless, not less than five days before the premium due date, We have delivered to You, or have mailed to Your last address as shown by Our records, a written notice of Our intention not to extend or renew this policy beyond the period for which the premium has been accepted, a grace period of at least [31 days] will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force subject to Our right to cancel the policy in accordance with the policy's cancellation provision. Premium is due and payable for the entire term of the grace period.

**REINSTATEMENT OF POLICY:**
If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the Insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the Insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement. In addition, no more than 2 reinstatements will be allowed per 12 month time period.

If this policy is terminated due to a lack of premium payment, You may request reinstatement. We will reinstate Your policy provided all the following are met.
1. The coverage has not been terminated for more than [three months].
2. You pay the premiums that were due during the gap in coverage.
3. We approve the application.
The Policy’s history will be resumed.

**[REINSTATEMENT OF DEPENDENTS:**
Dependents may be reinstated one time after a period not greater than three months. This is subject to Our approval and the Late Entrant provision.]

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

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

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

**PROOF OF LOSS:**
For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to Us at Our designated office before the 91st day after the termination of the period for which We are liable. For a claim for any other loss, a written proof of loss must be provided to Us at Our designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible. It can not be later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT.** We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

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

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

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

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

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

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

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

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

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

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

**MEDICARE:**
This policy is not related to or duplicative of Medicare coverage.

**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. The amount will not exceed $5,000. It will be paid to any relative by blood or connection by marriage of the Insured who is considered by Us to be equitably entitled to the benefit.

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

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

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

**[NON-INSURANCE PRODUCTS/SERVICES:**
From time to time We may arrange for third- party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. These discounted goods or services are not insurance. We are not responsible for any 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 relations team.

[Dental procedures not payable under Your plan may also be subject to a discounted fee in accordance with a participating provider's contract.]

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. ]

**UTILIZATION REVIEW PROGRAM:**
Generally, utilization review means a set of criteria designed to evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used are clearly documented and applied. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

## DENTAL EXPENSE BENEFITS

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

**[PARTICIPATING AND NON-PARTICIPATING PROVIDERS:**
A Participating Provider is a Provider who has entered into an agreement to provide services to Insureds at a specific fee ("MAC"). 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. You 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". You 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 for services by a Participating 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:**
Refer to the period shown in the Table of Dental Procedures.

**COVERED EXPENSES:**
Covered Expenses include both of the following.

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

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

Benefits payable for Covered Expenses will be based on the lesser of any of the following.

1. The actual charge of the Provider.
2. [The usual and customary ("U&C") charge as determined by us, [if services are provided by a Non-Participating Provider.]
3. The Maximum Allowable Charge ("MAC") as determined by us, [if services are provided by a Participating Provider, who is a general dentist.]
4. The Maximum Allowable Benefit ("MAB") as determined by us, [if services are provided by a Non-Participating Provider.]
5. The Maximum Procedure Allowance ("MPA") as determined by us, [if services are provided by a Non-Participating Provider.]
6. The Maximum Covered Expense as determined by us, [if services are provided by a Non-Participating Provider.]]

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

**[MAC:**
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. It is derived from the array of Provider charges within a particular ZIP code area.]

[**MAB:**
The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MPA:**
The Maximum Procedure Allowance is derived from the array of submitted provider charges within a ZIP code area. The MPA is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MAXIMUM COVERED EXPENSE:**
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 Policy.]

**COVERAGE FOR GENERAL ANESTHESIA.** Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or

3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

**ALTERNATIVE PROCEDURES:**
Occasionally two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care. In this case, 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. 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. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

We may request existing dental X-rays or any other existing diagnostic aids for the purpose of determining benefits payable under the policy. We strongly encourage pre-treatment estimates so You understand Your benefits before any treatment begins. Ask Your Provider to submit a claim form for this purpose.

**EXPENSES INCURRED:**
An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture.

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

**[LIMITATIONS:**
Dental Expenses will not include, and benefits will not be payable, for any of the following.

1. Covered Dental Expenses for Type [3] Procedures in the first [6] months the person is covered under this contract [unless you qualify for Takeover benefits as defined].

2. Covered Dental Expenses in the first [12] months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3. [Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth..

4. Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.

    a. Alter vertical dimension.
    b. Restore or maintain occlusion.
    c. Splint or replace tooth structure lost as a result of abrasion or attrition.

5. Covered Dental Expenses 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.

6. Covered Dental Expenses to replace lost or stolen appliances.

7. Covered Dental Expenses for any treatment which is for cosmetic purposes.

8. Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)

9. Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.

10. Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment.

11. Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.

12. Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. Covered Dental Expenses 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 © 2006 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.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- B/R means By Report.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

## TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION

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

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).
D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS

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

PERIAPICAL FILMS: D0220, D0230

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

BITEWING FILMS

D0270 Bitewing - single film.
D0272 Bitewings - two films.
D0273 Bitewings - three films.
D0274 Bitewings - four films.
D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride (prophylaxis not included) - child.
D1204 Topical application of fluoride (prophylaxis not included) - adult.

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

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

PROPHYLAXIS: D1110, D1120

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

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

## TYPE 2 PROCEDURES

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

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

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

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.

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

- 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.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

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

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

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.
D2915 Recement cast or prefabricated post and core.
D2920 Recement crown.
D6092 Recement implant/abutment supported crown.
D6093 Recement implant/abutment supported fixed partial denture.
D6930 Recement fixed partial denture.

SEDATIVE FILLING

D2940 Sedative filling.

ENDODONTICS MISCELLANEOUS

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

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Anterior (excluding final restoration).

## TYPE 2 PROCEDURES

D3320 Bicuspid (excluding final restoration).
D3330 Molar (excluding final restoration).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - bicuspid.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
D3425 Apicoectomy/periradicular surgery - molar (first root).
D3426 Apicoectomy/periradicular surgery (each additional root).

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4263 Bone replacement graft - first site in quadrant.
D4264 Bone replacement graft - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4271 Free soft tissue graft procedure (including donor site surgery).
D4273 Subepithelial connective tissue graft procedures, per tooth.
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Soft tissue allograft.
D4276 Combined connective tissue and double pedicle graft, per tooth.

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, D4271, D4273, D4275, D4276

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

# TYPE 2 PROCEDURES

## NON-SURGICAL PERIODONTICS

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

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

## FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

## PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

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

## DENTURE REPAIR

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

## DENTURE RELINES

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

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

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

## NON-SURGICAL EXTRACTIONS

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

## SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.

## TYPE 2 PROCEDURES

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Surgical removal of residual tooth roots (cutting procedure).

OTHER ORAL SURGERY

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

## TYPE 2 PROCEDURES

D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285 Biopsy of oral tissue - hard (bone, tooth).
D7286 Biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.
D9221 Deep sedation/general anesthesia - each additional 15 minutes.
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

## TYPE 2 PROCEDURES

- 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, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

## TYPE 3 PROCEDURES

PAYMENT BASIS - Usual and Customary

BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

INLAY RESTORATIONS

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

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

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

ONLAY RESTORATIONS

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

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

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

CROWNS SINGLE RESTORATIONS

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

D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

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

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

CORE BUILD-UP

D2950 Core buildup, including any pins.
D6973 Core build up for retainer, including any pins.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).

D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

DENTURE REBASES

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

TISSUE CONDITIONING

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

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).

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

D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

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

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

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

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

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

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

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

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

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

## CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.
D6972 Prefabricated post and core in addition to fixed partial denture retainer.

## BLEACHING (COSMETIC)

D9972 External bleaching - per arch.
D9973 External bleaching - per tooth.
D9974 Internal bleaching - per tooth.

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

## [ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the policy for orthodontic expenses incurred by an Insured.

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

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

**COVERED EXPENSES:**
Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

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

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

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

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

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

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

**[BENEFITS PAYABLE UPON TERMINATION:**
If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

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

1. [[for a Program begun on or after the Insured's [17, 18, 19] birthday.]

2. [for a Program begun before the Insured became covered under this section.]

3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]

4. before the Insured has been insured under this section for at least [12, 18, 24] consecutive months.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is entitled to benefits under any workers' compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

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

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

10. to replace lost or stolen appliances.]

## [EYE CARE INSURANCE

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

**AMOUNT PAYABLE.** The Amount Payable for Covered Expenses shall be the lesser of:

a. the charge for frames or supplies furnished; or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

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

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

[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.]

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

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

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

1. [Vision examinations more than once in any [12, 24 month] [benefit] period. [Coverage is subject to the Dental and Eye Care Exam Frequencies listed on the Schedule of Benefits.]

2. Prescribed lenses more than once in any [12, 24 month] [benefit] period.

3. Frames more than once in any [12, 24 month] [benefit] period.

4. Contact lenses more than once in any [12, 24 month][benefit] period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the [12, 24 month] [benefit] period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the [12, 24 month] [benefit] period.

5. Examinations performed or frames or lenses ordered before the Insured was covered under this section.

6. Any examination performed or frame or lens ordered after the Insured's coverage under this section ceases, subject to Extension of Benefits.

7. Sub-normal vision aids; orthoptic or vision training or any associated testing.

8. Non-prescription lenses.

9. Replacement or repair of lost or broken lenses or frames except at normal intervals.

10. Any eye examination or corrective eyewear required by an employer as a condition of employment.

11. Medical or surgical treatment of the eyes.

12. Any service or supply not shown on the Schedule of Eye Care Services.

13. Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

14. Lenses and frames during the first twelve months that a person is insured under this section, when the person is a Late Entrant, as defined.

**SCHEDULE OF EYE CARE SERVICES**

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

| **SERVICE** | **[MAXIMUM COVERED EXPENSE]** |
|---|---|
| **Vision Examination** | Up to $ [55.00] |
| May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses. Coverage is subject to the Combined Dental and Eye Care Exam Frequencies listed on the Schedule of Benefits, if applicable. | |
| **Materials** | |
| Frame | [$30.00] |
| Lenses | |
| Single Vision | [$35.00] |
| Bifocal | [$47.00] |
| Trifocal | [$57.00] |
| No line bifocal or progressive power | [$57.00] |
| Lenticular | [$85.00] |
| Contact Lenses | [$65.00] |

]

## [EYE CARE EXAM BENEFIT

Covered Expenses include one eye examination (exam) in any one Benefit Period.

If an Insured incurs Covered Expenses, We will pay benefits as stated below. The exam must be performed by an ophthalmologist or optometrist. An expense is incurred for the eye exam at the time an exam is performed. [An Insured may use a Participating Provider or a Non-Participating Provider.

[**VISION SERVE PLAN ("VSP"):**
Provides claim reimbursement services for your eye care exam. Please submit your claim to "VSP" at P.O. Box 997105, Sacramento, CA 95899-7105]

**AMOUNT PAYABLE:**
[The amount payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services. When making an appointment, tell the provider that you are a [VSP] member.]

The Amount Payable for Covered Expenses performed by a [Non-Participating] Provider is the lesser of:

1. the [Non-Participating] Provider's charge, or

2. the Maximum Covered Expense for such services or supplies as shown on the Schedule of Benefits.

[When using a Non-Participating Provider, you will be required to pay the provider in full at the time of service. You can request reimbursement from [VSP] by completing a claim form and submitting it [with a copy of an itemized paid receipt, that indicates the services provided and the amount charged (handwritten receipts must be provided on a provider's letterhead)] to [VSP] within [six months] after the date of service.]

Covered Expenses for an eye exam will be subject to all deductibles, coinsurance percentages, maximums and limitations applicable to Type 1 dental procedures.

No benefits will be payable for expenses incurred for any exam required by an employer as a condition of employment.]

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## [DENTAL EXPENSE BENEFITS

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

**[PARTICIPATING AND NON-PARTICIPATING PROVIDERS:**
A Participating Provider is a Provider who has entered into an agreement to provide at a specific fee ("MAC") services to Insureds. 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. You 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". You 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.]

**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:**
Refers to the period shown in the Table of Dental Procedures.

**COVERED EXPENSES:**
Covered Expenses include both of the following.

1. Only those expenses for dental procedures performed by a Provider;.
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 limited to the lesser of any of the following.

1. The actual charge of the Provider.
2. [The usual and customary ("U&C") as determined by us, [if services are provided by a Non-Participating Provider.]
3. The Maximum Allowable Charge ("MAC") as determined by us, [if services are provided by a Participating Provider, who is a general dentist.]
4. The Maximum Allowable Benefit ("MAB") as determined by us,[if services are provided by a Non-Participating Provider.]
5. The Maximum Procedure Allowance ("MPA") as determined by us, [if services are provided by a Non-Participating Provider.]
6. The Maximum Covered Expense as determined by us, [if services are provided by a Non-Participating Provider.]]

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90$^{th}$] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

**[MAC:**
The charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing Provider fees within the ZIP code area. It is derived from the array of Provider charges within a particular ZIP code area.]

[**MAB:**
The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MPA:**
The Maximum Procedure Allowance is derived from the array of submitted provider charges within a ZIP code area. The MPA is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MAXIMUM COVERED EXPENSE:**
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 Policy.]

**COVERAGE FOR GENERAL ANESTHESIA.** Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

4. a person with a diagnosed serious mental or physical condition; or

5. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

**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 x-ray films, 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:**
Dental Expenses will not include, and benefits will not be payable, for any of the following.

1. Covered Dental Expenses for Type [3] Procedures in the first [6] months the person is covered under this contract [unless You qualify for Takeover benefits as defined].

2. Covered Dental Expenses in the first [12] months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3.a. Covered Dental Expenses 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, unless the insured person is covered on [mo/dy/yr]. For those insured persons covered on [mo/dy/yr], see 3.b.

3.b. Limitation 3a will be waived for those insured persons whose coverage was effective on [mo/dy/yr], and

The person was insured under the prior contract on the date it was replaced by this contract; and

i. the person has the tooth extracted while insured under the prior contract; and

ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

4. Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.

(a) Alter vertical dimension.
(b) Restore or maintain occlusion.
(c) Splint or replace tooth structure lost as a result of abrasion or attrition.

5. Covered Dental Expenses 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.

6. Covered Dental Expenses to replace lost or stolen appliances.

7. Covered Dental Expenses for any treatment which is for cosmetic purposes.

8. Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)

9. Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision).

10. Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment.

11. Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.

12. Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. Covered Dental Expenses because of war or any act of war, declared or not.]

## [ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the policy for orthodontic expenses incurred by an Insured.

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

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

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

**COVERED EXPENSES:**
Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90$^{th}$] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

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

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

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

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

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

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

**[BENEFITS PAYABLE UPON TERMINATION:**
If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

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

1. [for a Program begun on or after the Insured's [17, 18, 19] birthday.]

2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and are both:

   a. insured under this policy;
   b. currently undergoing a Treatment Program on [mo/dy/yr]; and
   c. qualifies for Takeover as defined..

3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]

4. [before the Insured has been insured under this section for at least [12, 18, 24] consecutive months unless the Insured qualifies for Takeover, as defined.

5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

6. if the Insured's insurance under this section terminates.

7. for which the Insured is entitled to benefits under any workers' compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

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

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

11. to replace lost or stolen appliances.]

# application

## individual insurance form

5900 O Street / P.O. Box 81889
Lincoln, NE 68501-1889

☐ **Dental** ☐ **Dental with Eye Care** ☐ **Dental with Eye Care Exam**
☐ **Dental with Hearing & Lasik** ☐ **Dental with Eye Care Hearing & Lasik**

**Plan selected**_____

## policyholder information

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner (if applicable) ☐ Civil Union (if allowed by state law)

Social Security number _____ Affiliation, if applicable_____

Policyholder's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Phone number_____

Street address_____ Apt. #_____ City_____ State_____ ZIP_____

Billing address, if different from above_____ Apt. #_____ City_____ State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Have you been covered under another dental policy within the last 30 days? . . . . . ☐ Yes ☐ No

**If yes:** 1. Please provide an Evidence of Coverage letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits.
2. Please complete the attached Replacement form.

Applicants and Dependents cannot have the same type of coverage under another Ameritas plan (i.e. no two Ameritas dental plans, no two Ameritas eye care plans).

## dependent coverage information

List all eligible dependents to be covered. (Policyholder must be enrolled to cover dependents.)

| print full legal name (last, first. MI) | relationship | sex | date of birth | social security number |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Premium payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Premium method: . . . . . ☐ EFT ☐ ACH ☐ Credit Card ☐ Check ☐ Direct Bill

## agreements by Ameritas

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information.

Any policy including riders and rate notifications issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., insurance under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

## agreements by policyholder

I hereby apply for insurance, for which I am eligible. I agree to be responsible for my premiums and those of my enrolled dependents. I acknowledge receipt of the outline of coverage. I understand coverage is NOT in force until the Company issues a Policy showing a Policy Effective Date.

☐ I consent to receiving my Policy, Explanation of Benefits, and other plan information electronically and I will electronically affirm my consent to do so. I understand I need Internet access and that I can withdraw my consent at any time per the notification instructions below. I understand I can receive any of the documents in paper form if I choose.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties. I understand that it is my responsibility to give notice to Ameritas of changes in my e-mail address or any information above, as well as my status and my family's status that affect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice electronically through e-mail or in writing to Ameritas or its designee:

Ameritas Life Insurance Corp., PO Box 81889, Lincoln, NE 68501-1889 / 800-487-5533 / e-mail: group@ameritas.com

**I understand the policy I am applying for provides dental/eye care/hearing and Lasik benefits only and is not a Medicare supplement.**

X_____
**Policyholder Signature** **Date**

X_____
**Insurance Producer Name and/or Number (if applicable)** **Date**

# regulatory notes

## Review your policy carefully

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements below.)

**Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que fi gura en su tarjeta de identifi cación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico and Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**Ameritas Life Insurance Corp.**
**Laser Vision Correction Benefit Rider**
**PO Box 81889**
**Lincoln, NE 68501-1889**

This Laser Vision Correction Benefit Rider is attached to and made a part of Policy Number [010-999999] issued to You. It is hereby agreed that the Policy issued has been amended to provide benefits for the Covered Procedures as described below.

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

**Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):**

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

| 1st Benefit Period | 2nd Benefit Period | 3rd Benefit Period | 4th + Benefit Period |
|---|---|---|---|
| **[0, $100, $250 per eye]** | **[$100, $200, $250, $500 per eye]** | **[$250, $300, $500, $750 per eye]** | **[$500, $750 per eye]** |

**Exclusions and Limitations**

- [No benefit will be payable in the first [12, 24] months the person is covered under this contract. After this [12, 24] month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule. ]
- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- [No benefit will be payable for any Insured under the age of [18, 19, 20, 21].]
- [No benefit will be payable in the first [6, 12] months that a person is insured if the person is a Late Entrant. After this [6, 12] month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.]
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

**Definitions**

**[Covered Procedures** means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)]

**Benefit Period.** Your benefits are based on a [Calendar] [Policy] Year. A [Calendar] [Policy] Year runs from [date] through [date]. Benefit Period means the period from [date] of any year through [date] 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 [date] of that year.

**Provider**. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on ***Effective Date***
Ameritas Life Insurance Corp.

[JoAnn M. Martin]
President
920 Ed. 05-11

## HEARING CARE EXPENSE BENEFITS RIDER

**PO Box 81889**
**Lincoln, NE 68501-1889**

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

**AMOUNT PAYABLE.** The Amount Payable for Covered Expenses shall be the lesser of:

a. the actual charge for services or supplies furnished; or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

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

**COVERED EXPENSES.** Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

[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.]

**EXPENSES INCURRED.** An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or [45] days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

**The Coordination of Benefit Provision, if any, in the Policy does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.**

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

1. examinations performed or supplies furnished before the Insured was covered under this section.

2. any examination performed or supply furnished after the Insured's coverage under this

section ceases.

3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

4. replacement of hearing aids except once every [5] years from the date of placement of the hearing aid.
   [This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
   a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and
   b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
   c. at least [3] years has passed since placement of the previous hearing aid.]

5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.

6. hearing care services or supplies in the first [12] months that a person is insured if the person is a Late Entrant, except hearing examinations. After this [12] month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.

7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.

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

9. any procedure not shown in the Schedule of Hearing Care Services.

10. any treatment which is for cosmetic purposes.

11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.

12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.

13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.

14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.

15. a hearing aid dispensed without the direction and supervision of a provider licensed to

perform hearing aid examinations and/or hearing aid dispensing.

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

17. removal of foreign bodies or ear wax from the ear or any part of the ear.]

**SCHEDULE OF HEARING CARE SERVICES**

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

| SERVICE | MAXIMUM COVERED EXPENSE |
|---|---|
| [COMPREHENSIVE HEARING EXAMINATION<br>May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.] | Up to $[75] per Benefit Period |
| [HEARING AIDS<br>A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license. | See Hearing Aid Maximum Amount on the Schedule of Benefits] |
| [HEARING AID MAINTENANCE<br>Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.] | Up to $[40] per Benefit Period |
| [HEARING MISCELLANEOUS<br>[Coverage for treatment of tinnitus.] [Assistive hearing devices such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, or loop system etc.] | Up to $[100]] [per Benefit Period] |

This provision is effective on ***Effective Date***

Ameritas Life Insurance Corp.

[JoAnn M. Martin]
President

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 07/08/2011 |

**Comments:**

**Attachment:**

ar-readability-alic.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Application | Approved-Closed | 07/08/2011 |

**Comments:**

Two applications may be used with this policy:

1) Policy GR 6205 Ed. 11-09 which was previously approved on 1/5/2010 (see below).

2) Policy GR 6400 Ed. 6-11 which we are currently seeking approval for under this filing (see Forms Tab).

**Attachment:**

GR 6205 Ed. 11-09.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Health - Actuarial Justification | Approved-Closed | 07/08/2011 |

**Comments:**

**Attachment:**

act memo - AR revised 6-30-11.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Outline of Coverage | Approved-Closed | 07/08/2011 |

**Comments:**

**Attachment:**

Outline of Coverage Rev. 05-11.pdf

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Optionals & Variables | Approved-Closed | 07/08/2011 |

**Comments:**

**Attachment:**

Opts-Var-2011-Individual.pdf

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Redlines | Approved-Closed | 07/08/2011 |

**Comments:**

**Attachments:**

Outline of Coverage Rev. 05-11-rl.pdf
Opts-Var-2011-Individual-rl.pdf
Indiv. 9000 AR Rev. 05-11 - rl.pdf
GR6400-hl.pdf
certification of red-lines.pdf

**STATE OF ARKANSAS**

**CERTIFICATE OF READABILITY**

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

| FORM NO: | FLESCH SCORE: | FORM NAME: |
|---|---|---|
| Indiv. 9000 AR Rev. 05-11 | 50 | Individual Policy |
| GR 6400 Ed. 6-11 | 50 | Application |
| 920 Ed. 05-11 | 50 | Laser Vision Correction Benefit Rider |
| 930 Ed. 05-11 | 50 | Hearing Care Expense Benefits Rider |
| | | |
| | | |
| | | |

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Gail M. Garcia

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o, ou, email=ggarcia@ameritas.com, c=US
Date: 2010.09.16 16:42:43 -05'00'

TYPED NAME: Gail Garcia, Vice President - Group Compliance
TITLE:

DATE: 06/09/2011

# application

## individual insurance form

5900 O Street / P.O. Box 81889
Lincoln, NE 68501-1889

☐ **Dental** ☐ **Dental with Eye Care Policy** ☐ **Dental with Eye Care Exam**

**Plan selected**_____

## policyholder information

Marital Status ☐ Single ☐ Married ☐ Domestic Partner (if applicable)

Social Security number _____ Affiliation, if applicable_____

Policyholder's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Phone number_____

Street address_____ Apt. #_____ City_____ State_____ ZIP_____

Billing address, if different from above_____ Apt. #_____ City_____ State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Have you been covered under another dental policy within the last 30 days? . . . . . ☐ Yes ☐ No

**If yes:** 1. Please provide an Evidence of Coverage letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits.
2. Please complete the attached Replacement form.

Applicants and Dependents cannot have the same type of coverage under another Ameritas plan (i.e. no two Ameritas dental plans, no two Ameritas eye care plans).

## dependent coverage information

List all eligible dependents to be covered. (Policyholder must be enrolled to cover dependents.)

| print full legal name (last, first. MI) | relationship | sex | date of birth | social security number |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Premium payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Premium method: . . . . . ☐ EFT ☐ ACH ☐ Credit Card ☐ Cash

## agreements by Ameritas

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information.

Any policy including riders and rate notifications issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., insurance under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

## agreements by policyholder

I hereby apply for insurance, for which I am eligible. I agree to be responsible for my premiums and those of my enrolled dependents. I acknowledge receipt of the outline of coverage. I understand coverage is NOT in force until the Company issues a Policy showing a Policy Effective Date.

☐ I consent to receiving my Policy, Explanation of Benefits, and other plan information electronically and I will electronically affirm my consent to do so. I understand I need Internet access and that I can withdraw my consent at any time per the notification instructions below. I understand I can receive any of the documents in paper form if I choose.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties. I understand that it is my responsibility to give notice to Ameritas of changes in my e-mail address or any information above, as well as my status and my family's status that affect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice electronically through e-mail or in writing to Ameritas or its designee:

Ameritas Life Insurance Corp., PO Box 81889, Lincoln, NE 68501-1889 / 800-487-5533 / e-mail: group@ameritas.com

**I understand the policy I am applying for provides dental or dental and eye care benefits only and is not a Medicare supplement.**

X_____
**Policyholder Signature** **Date**

X_____
**Insurance Producer Name and/or Number (if applicable)** **Date**

# regulatory notes

## Review your policy carefully

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements below.)

**Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que fi gura en su tarjeta de identifi cación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico and Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**Note for Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

**DENTAL INSURANCE**
**Ameritas Life Insurance Corp.**
**PO Box 81889**
**Lincoln, NE 68501-1889**
**1-800-487-5533**

## Outline of Coverage

**THIS POLICY PROVIDES DENTAL [EYE] [AND HEARING] BENEFITS**
**THIS IS NOT A MEDICARE SUPPLEMENT POLICY**

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance policy and only the actual policy provisions will control benefit administration. The policy sets forth the definitions of the capitalized terms referred to below.

The policy itself sets forth in detail the rights and obligations of both you and Ameritas Life Insurance Corp. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. **DENTAL [and EYE CARE] [and HEARING] COVERAGE.** This policy is designed to provide coverage for certain dental (and eye care and hearing) services. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

3. **BENEFITS.** We will review benefits subject to the limitations and exclusions described here and more specifically in the policy. [When you visit a Participating Provider, a discounted fee is charged for covered services. This is intended to reduce your out-of-pocket costs. The Provider may bill you the difference between the plan payment and the discounted fee amount. If you visit a non-Participating Provider, the Provider may bill you the difference between the plan payment and the dentist's actual charge. Plan payment may be based on usual and customary charges or a set scheduled allowance as described in your policy. ]

**DENTAL**
Deductible Amount
[Combined Type 1, Type 2, and Type 3 Procedures - Each Benefit Period $50]

| | [Participating Provider] | [Non-Participating Provider] |
|---|---|---|
| Coinsurance Percentages | {XXX} | {XXX} |
| Type 1 Procedures | {XXX} | {XXX} |
| Type 2 Procedures | {XXX} | {XXX} |
| Type 3 Procedures | {XXX} | {XXX} |
| Type 4 Procedures | {XXX} | {XXX} |
| Maximum Amount Each Benefit Period | {XXX} | {XXX} |

[**ORTHODONTIC**

| | |
|---|---|
| Deductible Amount = Once per lifetime | {XXX} |
| Coinsurance Percentage | {XXX} |
| Maximum Benefit During Lifetime | {XXX}] |

[**EYE CARE**

| | |
|---|---|
| Deductible Amount | {XXX} |
| Maximum Amount | |
| Each Benefit Period | {XXX}] |

[**HEARING CARE**

| | |
|---|---|
| Deductible Amount | |
| [Exams] - [each Benefit Period] | [$0] |
| [Hearing Aids] - [each Benefit Period] | [$0] |
| [Hearing Aid Maintenance] - [each Benefit Period] | [$0] |
| [Hearing Miscellaneous] - [each Benefit Period] | [$0]] |
| Coinsurance Percentage | |
| [Exams] | [100%] |
| [Hearing Aids] | [50%] |
| [Hearing Aid Maintenance] | [100%] |
| [Hearing Miscellaneous] | [100%]] |
| [[Hearing Aid] Maximum Amount [(per ear)]: | |
| [1st 12 month Period] | $[400] |
| [2nd 12 month Period] | $[600] |
| [3rd 12 month Period] | $[800] |
| [4th 12 month Period or thereafter] | $[1,000] |

[**LASIK**

| | |
|---|---|
| Deductible Amount | {XXX} |
| Coinsurance Percentage | {XXX} |
| Lifetime Maximum Benefit per Eye | |
| 1st Benefit Period | [0, $100, $250 per eye] |
| 2nd Benefit Period | [$100, $200, $250, $500 per eye] |
| 3rd Benefit Period | [$250, $300, $500, $750 per eye] |
| 4th + Benefit Period | [$500, $750 per eye] |

[**FUSION** (Applies to both Dental and Eye Care Procedures)

| | |
|---|---|
| Deductible Amount | {XXX} Type 1, 2 3 or 4 Procedures |
| Maximum Amount | |
| Each Benefit Period | {XXX}] |

**4. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE POLICY:**

YOUR POLICY CONTAINS A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES. Certain Covered Expenses may be subject to a Waiting Period (an Elimination Period). Please refer to your policy for details.

[Alternate Benefit Provision – At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit paid will be based on the charge for the least expensive procedure. ]

Certain expenses are not covered. For instance, procedures begun prior to your Effective Date are not covered. This policy does not provide benefits for lost or stolen appliances or cosmetic procedures. It also does not cover hospitalization or prescription drugs. This is not a complete list of exclusions. A full list is in your policy.

**5. RENEWABILITY.** The policy is renewable by payment of the premium in effect at the beginning of each renewal period. Policy termination is governed by the termination provisions in the policy.

**RETAIN FOR YOUR RECORDS.**
**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.**
**THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**

**OPTIONALS AND VARIABLES**
**Indiv. 9000 Rev. 05-11**

**No change will be made to any policy or certificate in violation of state statutes.**

**General Items**

**1)** We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.

**2)** If the plan design does not include a Late Entrant provision, then all Late Entrant provisions and references will be deleted.

**3)** If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.

**4)** References to Dental and/or Eye Care will be added/removed if the plan design does not contain Dental or Eye Care as selected by the Policyholder.

**5) <u>POLICY COVER PAGE – Indiv. 9000 Rev. 05-11</u>**

a. All information, including dates, will be completed to reflect the Policyholder and policy information.

b. The policy description will indicate whether coverage is for “Dental" or “Dental and Eye Care”, Insurance.

c. Officer signatures and names - The names and signatures of the officers may be amended as necessary to reflect changes in company officers.

**Section Numbers listed are not intended to be page numbers but rather a reference for the Policyholder to locate appropriate plan provisions. These numbers are listed on the bottom, right hand side of each section.**

**6) <u>TABLE OF CONTENTS PAGE – Indiv TOC</u>**

This table will be amended to add or delete references to specific benefits based upon Policyholder selection, i.e., dental with eye care, orthodontic expense benefits, etc.

**7) <u>DEFINITIONS – 100 Ed. 11-09</u>**

i. If the Policyholder elects to add "Domestic Partner" coverage, then the applicable definition and reference to "Domestic Partner" will be added. This variable will not be used if such partnership is not recognized by state law where the policy is delivered.

ii. The ages contained in the definition for Dependent could be changed downward and upward depending on state law and Policyholder selection but never lower than state law.

iii. The dates within the Benefit Period definition will be based on the Policyholder’s plan year.

**8) <u>SCHEDULE OF BENEFITS – 200 Rev. 05-11</u>**

The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances which are based on the plan design selected by the Policyholder.

If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

a) **BENEFIT CLASS & OPTIONS**

i. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.

ii. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder

**Dental Expense Benefits**

b) **DEDUCTIBLE AMOUNT**

Deductible Amounts can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, Daily, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Type 1, Type 2, and Type 3 benefits. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed as such.

*When the plan selected includes a maximum on the number of deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:*

On the date that three [or two] 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, however.

*When plan selected includes a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, either on the dental page or by rider. It also could be added to the Schedule of Benefits:*

If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and

ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

c) **COINSURANCE PERCENTAGE**

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

| | |
|---|---|
| Type 1 Procedures | 25% - 100% |
| Type 2, 3, or 4 Procedures | 0% - 100% |

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

| Coinsurance Percentage: | Participating Provider | Non-Participating Provider |
|---|---|---|
| [Type 1 Procedures] | [25% - 100%] | [25% - 100%] |
| [Type 2 Procedures] | [0% - 100%] | [0% - 100%] |
| [Type 3 Procedures] | [0% - 100%] | [0% - 100%] |
| [Type 4 Procedures] | [0% - 100] | [0% - 100%] |

The difference between participating and non-participating providers will not exceed state allowances. If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:

| | |
|---|---|
| Type 1 Procedures: | |
| Step 1. | 70% |
| Step 2. | 80% |
| Step 3. | 90% |
| Step 4. | 100% |
| Type 2 Procedures: | |
| Step 1. | 50% |
| Step 2. | 60% |
| Step 3. | 80% |
| Step 4. | 90% |
| Type 3 and Type 4 Procedures: | |
| Step 1. | 25% |
| Step 2. | 35% |
| Step 3. | 50% |
| Step 4. | 60% |

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. Below are the Incentive Method descriptive paragraph options that can be selected:

<u>Progressive Incentive:</u>
[For those persons insured on [January 1, 2009] Step 2 applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

*If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits the last sentence above will be included.*

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

<u>Effective Date Incentive:</u>
[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

d) **MAXIMUM AMOUNT**

The Maximum Amount can range between $250 to $3,000 in increments of $50 dependent upon plan selection.

Maximum Amount - Each Benefit Period [$200-3,000]

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as such.

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [$500] [per Lifetime, in any Benefit Period].

e) **ELIMINATION (WAITING) PERIODS**

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, this entire paragraph will be removed.

**Orthodontic Expense Benefits -**

| | |
|---|---|
| Deductible Amount | [$0-200] |
| Coinsurance Percentage | [25%-65%] |
| Maximum Benefit During Lifetime | [$200 - $3,000] |

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "Each Benefit Period" or both.

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

The paragraphs regarding the Orthodontic Maximum being reduced will be removed entirely if the plan design selected does not include Takeover.

**Eye Care Expense Benefits –**

Deductible Amount:

| | |
|---|---|
| Exam - Each Benefit Period | [$ 0 - 25] |
| Lenses - Other than contact lenses - Each Benefit Period | [$ 0 - 25] |
| Frames and Contact Lenses - Each Benefit Period | [$ 0- 25] |

The Deductible Amount for Eye Care Expense Benefits can range from $0 to $25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a $25 Deductible on Lenses and Frames - Each Benefit Period.

The Maximum Amount for Eye Care Expense Benefits can range from $50 to $300 in $25 increments or may be removed entirely if not included in the selected plan design.

**Increasing Eye Care Maximum**

If this plan is selected, the Member's eye care maximum will increase each benefit period up to the greatest amount in either the 3rd or 4th benefit period.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

| | | |
|---|---|---|
| **[Maximum Amount -** | **1st Benefit Period** | [$0-350] |
| | **2nd Benefit Period** | [$0-350] |
| | **3rd Benefit Period** | [$50-400] |
| | **4th + Benefit Period** | [$50-400]] |

**Laser Vision Correction Expense Benefits**

The Deductible Amount for Laser Vision Correction Expense Benefits can range from $0 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

> [For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.
>
> For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.
>
> or
>
> Step 1 applies during the first Benefit Period the person becomes insured.]
>
> *If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.*
>
> Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.
>
> If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

**Hearing Care Expense Benefits**

Deductible Amounts for Hearing Expense Benefits can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

> If an Insured incurs Covered Expenses:
>
> i. during the last <u>three</u> months of any Benefit Period; and
>
> ii. these expenses are applied towards the Deductible Amount for that Benefit Period,
>
> Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from $400 - $1,500 dollars in $50 increments.

**Combined Expense Benefits –**

The Deductible Amount for Combined Expense Benefits can range from $10 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Combined Maximum Amount for can range from $250 to $3,000 in increments of $50 based on plan selection.

The Combined Exam Frequencies can range from 1 to 3 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

**9) <u>INCREASED DENTAL MAXIMUM BENEFIT – 210 ED. 11-09</u>**

If the PPO Bonus or Increased Maximum Takeover options are not selected, references to those options will be removed.

The Carry Over Amount may be one of the following: $125, $250, or $400.
The PPO Bonus Amount may be one of the following: $50, $100, $150, or $200
The Benefit Threshold Amount may be one of the following: $250, $500, or $750
The Maximum Carry Over Amount can range from $250 to $3,000 in increments of $50.

The sentence "[This proof must be furnished to us within 12 months of the Policy Effective Date and not be for a Date of Services more than 12 months prior to the date the proof is furnished.]" may be removed if an option to transfer Carry Over Amounts from a prior carrier is selected.

The dollar amount of the Increased Maximum Takeover can range from $250 to $600 in $50 increments.

**10) <u>TABLE OF MONTHLY PREMIUM RATES – 300 ED. 11-09</u>**

i. The rate table will reflect the rate structure selected by the Policyholder, which could include: Policyholder/Dependent Unit, Policyholder/Spouse/Children Only/Spouse and Children, or One Dependent/Two or More Dependents

ii. The 3 month variable could be modified to extend to a longer period, i.e., 6 or 12 based on plan selection.

iii. The 31 day advance written notice could be modified to 45, 60 etc. days, but never less than the number required by the state law.

iv. Based on the case criteria, the policy can be issued with an expanded rate guarantee period of 24 months. This extended period is conditional upon the items listed within the provision. A 12-month guarantee period is the standard provision.

**11) CONDITIONS FOR INSURANCE COVERAGE – 400 REV. 05-11**

If the Late Entrant provision is not included in the plan selected then all references to late entrants and associated penalties will be removed.

Dependent children may be included on the Policy at birth or within 31 days for their 2nd or 3rd birthday.

The age 18 requirement to be a Policyholder will be adjusted up or down to reflect state law regarding the age of minors for a particular state.

Depending on the plan design, termination dates could be the last day of the month or the day of a specific event.

**12) GENERAL PROVISIONS – 500 Ed. 11-09**

The section entitled Non-Insurance Products/Services may be removed entirely if it does not apply to the plan design selected. Additionally, the sentence regarding the discounted fee may be removed if it does not apply to the plan design selected.

**13) DENTAL EXPENSE BENEFITS – 600 ED. 11-09**

a) **PARTICIPATING PROVIDER (PPO) OPTION.** When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

b) **PROCEDURE CLASSIFICATION.** Typically our dental procedures are grouped into Type 1, Type 2, and Type 3. However, we may choose to designate these procedural groups with other terms such as "Level 2" or "Type A". When Type 1 and Type 2 benefits only are written, any references to Type 3 procedures or limitations on Type 3 procedures are deleted.

c) **COVERED EXPENSES**. The basis on which we will pay dental benefits is based on the plan selected by the Policyholder. Several options are available. Benefits will be the lesser of: (1) the actual charge of the provider; and any one or more of the possibilities shown in the paragraph COVERED EXPENSES. This includes the usual and customary (“U&C”) as determined by us; Maximum Covered Expense (which is a scheduled basis), Maximum Allowable Benefit (“MAB”), Maximum Procedure Allowance (“MPA”), and Maximum Allowable Charge (“MAC”).

d) **USUAL AND CUSTOMARY ("U&C")** If percentiles differ from one Benefit Type to another, the specific percentiles for each Benefit Type will be listed. For Example, This plan utilizes the 90th percentile of U&C for Type 1 benefits, 80th percentile for Type 2 benefits, and 80th percentile for Type 3 benefits.

e) **EXPENSES INCURRED**. In the paragraph EXPENSES INCURRED, if appliances are not covered, the first sentence is deleted. If dental prosthesis or prosthetic crowns are not covered, the second sentence is deleted entirely or modified. If root canal therapy is not covered, the third sentence is deleted.

f) **LIMITATIONS.** When only certain Type benefits (i.e., Type 1 and Type 2 only) are written, any references to other Type procedures or limitations are deleted.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

The time limitation of 6-months in the Limitation concerning an elimination period for a specific procedure Type, normally Type 3, could be changed to reflect 3, 9, 12, 18 or 24 months based on various anti-selection factors. Normally it remains at 6 months. Multiple limitations will be included if the time limitation applies to multiple Benefit types such as Type 2 and Type 1 as well as Type 3 or this limitation will be removed entirely if no time limitation exists.

The Late Entrant limitation which is filed variable at 12-months could be shortened or lengthened based upon plan selected.

We have several late entrant options that can be selected by the Policyholder:

i. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

ii. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

iii. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

The limit on replacement of teeth extracted prior to coverage under this plan may vary. We have several plan options that can be selected by the Policyholder:

NO PRIOR EXTRACTION COVERAGE. Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

LIMITED PRIOR EXTRACTION COVERAGE. Provides for a procedure to replace teeth extracted while insured was under a prior plan, applies to initial insureds only. A 12-month maximum time period between extraction (while insured under prior plan) and replacement (while insured under our plan).

FULL PRIOR EXTRACTION COVERAGE provides benefits for a procedure performed to replace a tooth or teeth extracted before the person's effective date under our plan.

FOREVER PRIOR EXTRACTION COVERAGE provides for a procedure to replace a tooth or teeth extracted while under a prior plan, applies to initial insureds only. No coverage for missing teeth for 24 months, then full prior extraction coverage.

50% of amount otherwise payable to replace the missing tooth will be paid the first 24 months, then full prior extraction coverage. (The allowance will be cut in half at the procedure level and then the regular coinsurance will be applied.)

For 'Initial Insureds', the insureds will be eligible for full prior extraction coverage. Insureds who become effective after the policy effective date will not be eligible for prior extraction coverage.

EFFECTIVE DATE: No coverage for missing teeth for 36 months from Policyholder effective date, then full prior extraction coverage.

The 90-day extension of coverage for certain procedures could be modified if required by the Policyholder. The clause regarding dental appliances could be deleted if prosthetic dental appliances are not covered.

**14) TABLE OF DENTAL PROCEDURES – 700 ED. 11-09**

a) The entire lists of procedures, including procedure definition, American Dental Association (ADA) code numbers, etc., are optional and can be removed, regrouped or modified by rider. Additional ADA codes can be added as necessary. Procedures may be moved between types, grouped or designated in another way, such as "Level 2" or "Type A". If this were to occur, we would print new pages with the procedures listed under the appropriate type. The numbers and definitions are variable to allow for changes by the ADA and our own coverage philosophy.

b) Limitations which are included on the Dental Expense Benefits page that are specific to certain procedures may be included within the procedural category within this Table.

**15) ORTHODONTIC EXPENSE BENEFITS – 800 ED. 11-09**

a) The Usual and Customary paragraph can be removed entirely if a plan design to pay the actual charge of the provider is selected.

b) The Maximum Amount definition can be changed to allow for a definition of a Maximum that is each Benefit Period or that is both per Lifetime and per Benefit Period.

c) The reference to "eight calendar quarters" or "calendar quarters" in TREATMENT PROGRAM and EXPENSES INCURRED may be modified for more or fewer quarters, or to change "quarters" to "months", "semi-annual", or "annual" payments, etc.

d) If a plan is selected that provides for an amount of Orthodontic Expenses to be covered "up front" then the following sentence will be added to the last paragraph under Expense Incurred. This could be a specified dollar amount or a percentage of the Orthodontic Maximum Amount.

However, the first payment will be [25 percent] of the total allowed Covered Expense.

e) Limitation No. 1 is deleted when we offer "adult" ortho. Adult ortho would provide benefits for Policyholder and spouse, and adult, Dependent children..

f) The Limitation regarding the Late Entrant provision can be modified similar to the options for Late Entrants listed for Dental Expense Benefits.

g) The time limitation of 12 months can be changed based on our coverage philosophy

h) Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

**16) EYE CARE INSURANCE – 900 ED. 11-09**

a) Frequency limitations may be on a rolling frequency basis (every 12 or 24 months) or on a benefit period basis. The type of frequency provision is dependent upon the plan design selected by the Policyholder. Therefore, the Benefit Period definition will be included if the plan design includes a benefit period frequency limitation. If the frequency limitation is a rolling frequency, then this paragraph will not print.

b) The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

c) The frequency limitation in Limitation Nos. 1, 2, 3 or 4 will either be a 12 or 24 month period (rolling frequency) or a benefit period frequency depending upon the plan design selected by the Policyholder as referenced in item a) above.

d) Any limitation could be deleted entirely or any of the sub-items based on the plan design selected by the Policyholder.

e) The entire list of services is optional and can be removed or modified based on the plan design selected by the Policyholder. The dollar amounts listed are variable and provided for illustrative purposes. The actual dollar amount allowance will be based on the most recent approved rate for each procedure for states that require rate filing and approval. The scheduled amounts are reviewed at least annually in light of market conditions.

f) The available plan design options provide for either a scheduled amount (Maximum Covered Expense) per service or may be an aggregate Eye Care Maximum, i.e., $250 for any services selected by the Insured. This will be reflected in the Schedule of Eye Care Services. If the aggregate amount is selected the following will be added to the Schedule of Eye Care Services.

[Maximum Amount - Each Benefit Period [$50 - $300]]

**17) EYE CARE EXAM BENEFIT – 910 ED. 11-09**

The Eye Care Exam Benefit is optional and may be removed entirely if it is not included in the plan design.

**18). LASER VISION CORRECTION BENEFIT RIDER – 920 Ed. 05-11**

Benefits are lifetime maximums and payable per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

The lifetime maximum per eye may vary by benefit period as shown. The policyholder will select the lifetime maximum amounts. The available dollar maximums are shown in the bracketed portions of the form. The policyholder will also select the number of Benefit Periods the dollar amount may be increased by.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

a. There may or may not be an elimination period. If there is an elimination period, the period may be 12 months.
b. No benefit will be payable for an Insured Person under a defined age which may vary from 18 – 21 as shown.
c. There may or may not be a Late Entrant provision. If there is a Late Entrant provision, the waiting period may be 6 or 12 months.

The numbers and definitions of the procedure codes listed are variable to allow for changes by HCPCS and our own coverage philosophy.

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

Officer Name and Signature. We wish to reserve the right to change the officer name and signature should they change in the future.

**19). HEARING CARE EXPENSE BENEFITS PAGES – 930 Ed. 05-11**

Any limitation could be deleted entirely or any of the sub-items based on our coverage philosophy or policyholder negotiation.

The entire list of procedures are optional and can be removed or modified. The dollar amounts listed are variable and provided for illustrative purposes. The Policyholder can select an option that includes all of the procedures, exams only, or materials only (hearing aids, maintenance, and/or miscellaneous).

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the policyholder's plan year.

The Late Entrant provision which is filed variable at 12-months could be shortened or lengthened based upon Policyholder negotiations.

We have several late entrant options that can be selected by the Policyholder:

a. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

b. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

c. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

**DENTAL INSURANCE**
**Ameritas Life Insurance Corp.**
**PO Box 81889**
**Lincoln, NE 68501-1889**
**1-800-487-5533**

**Outline of Coverage**

**THIS POLICY PROVIDES DENTAL [EYE] [AND HEARING] CARE BENEFITS**
**THIS IS NOT A MEDICARE SUPPLEMENT POLICY**

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance policy and only the actual policy provisions will control benefit administration. The policy sets forth the definitions of the capitalized terms referred to below.

The policy itself sets forth in detail the rights and obligations of both you and Ameritas Life Insurance Corp. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. **DENTAL [and EYE CARE] [and HEARING] COVERAGE.** This policy is designed to provide coverage for certain dental (and eye care and hearing) services. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

3. **BENEFITS.** We will review benefits subject to the limitations and exclusions described here and more specifically in the policy. [When you visit a Participating Provider, a discounted fee is charged for covered services. This is intended to reduce your out-of-pocket costs. The Provider may bill you the difference between the plan payment and the discounted fee amount. If you visit a non-Participating Provider, the Provider may bill you the difference between the plan payment and the dentist's actual charge. Plan payment may be based on usual and customary charges or a set scheduled allowance as described in your policy. ]

**DENTAL**
Deductible Amount
[Combined Type 1, Type 2, and Type 3 Procedures - Each Benefit Period $50]

| | [Participating Provider] | [Non-Participating Provider] |
|---|---|---|
| Coinsurance Percentages | {XXX} | {XXX} |
| Type 1 Procedures | {XXX} | {XXX} |
| Type 2 Procedures | {XXX} | {XXX} |
| Type 3 Procedures | {XXX} | {XXX} |
| Type 4 Procedures | {XXX} | {XXX} |
| Maximum Amount Each Benefit Period | {XXX} | {XXX} |

[**ORTHODONTIC**

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Deductible Amount = Once per lifetime {XXX}
Coinsurance Percentage {XXX}
Maximum Benefit During Lifetime {XXX}]

[**EYE CARE**
Deductible Amount {XXX}
Maximum Amount
Each Benefit Period {XXX}]

[**HEARING CARE**
Deductible Amount
[Exams] - [each Benefit Period] [$0]
[Hearing Aids] - [each Benefit Period] [$0]
[Hearing Aid Maintenance] - [each Benefit Period] [$0]
[Hearing Miscellaneous] - [each Benefit Period] [$0]]
Coinsurance Percentage
[Exams] [100%]
[Hearing Aids] [50%]
[Hearing Aid Maintenance] [100%]
[Hearing Miscellaneous] [100%]]
[[Hearing Aid] Maximum Amount [(per ear)]:
[1st 12 month Period] $[400]
[2nd 12 month Period] $[600]
[3rd 12 month Period] $[800]
[4th 12 month Period or thereafter] $[1,000]

[**LASIK**
Deductible Amount {XXX}
Coinsurance Percentage {XXX}
Lifetime Maximum Benefit per Eye
1st Benefit Period [0, $100, $250 per eye]
2nd Benefit Period [$100, $200, $250, $500 per eye]
3rd Benefit Period [$250, $300, $500, $750 per eye]
4th + Benefit Period [$500, $750 per eye]

[**FUSION** (Applies to both Dental and Eye Care Procedures)
Deductible Amount {XXX} Type 1, 2 3 or 4 Procedures
Maximum Amount
Each Benefit Period {XXX}]

**4. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE POLICY:**

YOUR POLICY CONTAINS A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES. Certain Covered Expenses may be subject to a Waiting Period (an Elimination Period). Please refer to your policy for details.



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[Alternate Benefit Provision – At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit paid will be based on the charge for the least expensive procedure. ]

Certain expenses are not covered. For instance, procedures begun prior to your Effective Date are not covered. This policy does not provide benefits for lost or stolen appliances or cosmetic procedures. It also does not cover hospitalization or prescription drugs. This is not a complete list of exclusions. A full list is in your policy.

**5. RENEWABILITY.** The policy is renewable by payment of the premium in effect at the beginning of each renewal period. Policy termination is governed by the termination provisions in the policy.

**RETAIN FOR YOUR RECORDS.**
**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.**
**THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**



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**OPTIONALS AND VARIABLES**
**Indiv. 9000 Rev. 05-11**

**No change will be made to any policy or certificate in violation of state statutes.**

**General Items**

**1)** We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.

**2)** If the plan design does not include a Late Entrant provision, then all Late Entrant provisions and references will be deleted.

**3)** If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.

**4)** References to Dental and/or Eye Care will be added/removed if the plan design does not contain Dental or Eye Care as selected by the Policyholder.

**5) POLICY COVER PAGE – Indiv. 9000 Rev. 05-11**

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a. All information, including dates, will be completed to reflect the Policyholder and policy information.

b. The policy description will indicate whether coverage is for "Dental" or "Dental and Eye Care", Insurance.

c. Officer signatures and names - The names and signatures of the officers may be amended as necessary to reflect changes in company officers.

**Section Numbers listed are not intended to be page numbers but rather a reference for the Policyholder to locate appropriate plan provisions. These numbers are listed on the bottom, right hand side of each section.**

**6) TABLE OF CONTENTS PAGE – Indiv TOC**

This table will be amended to add or delete references to specific benefits based upon Policyholder selection, i.e., dental with eye care, orthodontic expense benefits, etc.

**7) DEFINITIONS – 100 Ed. 11-09**

i. If the Policyholder elects to add "Domestic Partner" coverage, then the applicable definition and reference to "Domestic Partner" will be added. This variable will not be used if such partnership is not recognized by state law where the policy is delivered.

ii. The ages contained in the definition for Dependent could be changed downward and upward depending on state law and Policyholder selection but never lower than state law.

iii. The dates within the Benefit Period definition will be based on the Policyholder's plan year.

**8) SCHEDULE OF BENEFITS – 200 Rev. 05-11**

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The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances which are based on the plan design selected by the Policyholder.

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If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

a) **BENEFIT CLASS & OPTIONS**

i. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.

ii. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder

**Dental Expense Benefits**

b) **DEDUCTIBLE AMOUNT**

Deductible Amounts can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, Daily, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Type 1, Type 2, and Type 3 benefits. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed as such.

*When the plan selected includes a maximum on the number of deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:*

On the date that three [or two] 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, however.

*When plan selected includes a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, either on the dental page or by rider. It also could be added to the Schedule of Benefits:*

If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and

ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

c) **COINSURANCE PERCENTAGE**

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

| | |
|---|---|
| Type 1 Procedures | 25% - 100% |
| Type 2, 3, or 4 Procedures | 0% - 100% |

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

| Coinsurance Percentage: | Participating Provider | Non-Participating Provider |
|---|---|---|
| [Type 1 Procedures] | [25% - 100%] | [25% - 100%] |
| [Type 2 Procedures] | [0% - 100%] | [0% - 100%] |
| [Type 3 Procedures] | [0% - 100%] | [0% - 100%] |
| [Type 4 Procedures] | [0% - 100] | [0% - 100%] |

The difference between participating and non-participating providers will not exceed state allowances.
If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:

| | |
|---|---|
| Type 1 Procedures: | |
| Step 1. | 70% |
| Step 2. | 80% |
| Step 3. | 90% |
| Step 4. | 100% |
| Type 2 Procedures: | |
| Step 1. | 50% |
| Step 2. | 60% |
| Step 3. | 80% |
| Step 4. | 90% |
| Type 3 and Type 4 Procedures: | |
| Step 1. | 25% |
| Step 2. | 35% |
| Step 3. | 50% |
| Step 4. | 60% |

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. Below are the Incentive Method descriptive paragraph options that can be selected:

<u>Progressive Incentive:</u>
[For those persons insured on [January 1, 2009] Step 2 applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

*If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits the last sentence above will be included.*

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Effective Date Incentive:
[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

d) **MAXIMUM AMOUNT**

The Maximum Amount can range between $250 to $3,000 in increments of $50 dependent upon plan selection.

Maximum Amount - Each Benefit Period [$200-3,000]

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as such.

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [$500] [per Lifetime, in any Benefit Period].

e) **ELIMINATION (WAITING) PERIODS**

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, this entire paragraph will be removed.

**Orthodontic Expense Benefits -**

| | |
|---|---|
| Deductible Amount | [$0-200] |
| Coinsurance Percentage | [25%-65%] |
| Maximum Benefit During Lifetime | [$200 - $3,000] |

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "Each Benefit Period" or both.

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

The paragraphs regarding the Orthodontic Maximum being reduced will be removed entirely if the plan design selected does not include Takeover.

**Eye Care Expense Benefits –**

Deductible Amount:

| | |
|---|---|
| Exam - Each Benefit Period | [$ 0 - 25] |
| Lenses - Other than contact lenses - Each Benefit Period | [$ 0 - 25] |
| Frames and Contact Lenses - Each Benefit Period | [$ 0- 25] |

The Deductible Amount for Eye Care Expense Benefits can range from $0 to $25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a $25 Deductible on Lenses and Frames - Each Benefit Period.

The Maximum Amount for Eye Care Expense Benefits can range from $50 to $300 in $25 increments or may be removed entirely if not included in the selected plan design.

**Deleted:** 50

**Increasing Eye Care Maximum**

If this plan is selected, the Member's eye care maximum will increase each benefit period up to the greatest amount in either the 3rd or 4th benefit period.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

| | | |
|---|---|---|
| **[Maximum Amount -** | **1st Benefit Period** | [$0-350] |
| | **2nd Benefit Period** | [$0-350] |
| | **3rd Benefit Period** | [$50-400] |
| | **4th + Benefit Period** | [$50-400]] |

**Laser Vision Correction Expense Benefits**

The Deductible Amount for Laser Vision Correction Expense Benefits can range from $0 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

> [For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.
>
> For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.
>
> or
>
> Step 1 applies during the first Benefit Period the person becomes insured.]
>
> *If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.*
>
> Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.
>
> If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

**Hearing Care Expense Benefits**

Deductible Amounts for Hearing Expense Benefits can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

> If an Insured incurs Covered Expenses:
>
> i. during the last three months of any Benefit Period; and
>
> ii. these expenses are applied towards the Deductible Amount for that Benefit Period,
>
> Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from $400 - $1,500 dollars in $50 increments.

**Combined Expense Benefits –**

The Deductible Amount for Combined Expense Benefits can range from $10 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Combined Maximum Amount for can range from $250 to $3,000 in increments of $50 based on plan selection.

The Combined Exam Frequencies can range from 1 to 3 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

**9) INCREASED DENTAL MAXIMUM BENEFIT – 210 ED. 11-09**

If the PPO Bonus or Increased Maximum Takeover options are not selected, references to those options will be removed.

The Carry Over Amount may be one of the following: $125, $250, or $400.
The PPO Bonus Amount may be one of the following: $50, $100, $150, or $200
The Benefit Threshold Amount may be one of the following: $250, $500, or $750
The Maximum Carry Over Amount can range from $250 to $3,000 in increments of $50.

The sentence "[This proof must be furnished to us within 12 months of the Policy Effective Date and not be for a Date of Services more than 12 months prior to the date the proof is furnished.]" may be removed if an option to transfer Carry Over Amounts from a prior carrier is selected.

The dollar amount of the Increased Maximum Takeover can range from $250 to $600 in $50 increments.

**10) TABLE OF MONTHLY PREMIUM RATES – 300 ED. 11-09**

i. The rate table will reflect the rate structure selected by the Policyholder, which could include: Policyholder/Dependent Unit, Policyholder/Spouse/Children Only/Spouse and Children, or One Dependent/Two or More Dependents

ii. The 3 month variable could be modified to extend to a longer period, i.e., 6 or 12 based on plan selection.

iii. The 31 day advance written notice could be modified to 45, 60 etc. days, but never less than the number required by the state law.

iv. Based on the case criteria, the policy can be issued with an expanded rate guarantee period of 24 months. This extended period is conditional upon the items listed within the provision. A 12-month guarantee period is the standard provision.

**11) CONDITIONS FOR INSURANCE COVERAGE – 400 REV. 05-11**

Deleted: ED. 11-09

If the Late Entrant provision is not included in the plan selected then all references to late entrants and associated penalties will be removed.

Dependent children may be included on the Policy at birth or within 31 days for their 2nd or 3rd birthday.

The age 18 requirement to be a Policyholder will be adjusted up or down to reflect state law regarding the age of minors for a particular state.

Depending on the plan design, termination dates could be the last day of the month or the day of a specific event.

**12) GENERAL PROVISIONS – 500 Ed. 11-09**

The section entitled Non-Insurance Products/Services may be removed entirely if it does not apply to the plan design selected. Additionally, the sentence regarding the discounted fee may be removed if it does not apply to the plan design selected.

**13) DENTAL EXPENSE BENEFITS – 600 ED. 11-09**

a) **PARTICIPATING PROVIDER (PPO) OPTION.** When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

b) **PROCEDURE CLASSIFICATION.** Typically our dental procedures are grouped into Type 1, Type 2, and Type 3. However, we may choose to designate these procedural groups with other terms such as "Level 2" or "Type A". When Type 1 and Type 2 benefits only are written, any references to Type 3 procedures or limitations on Type 3 procedures are deleted.

c) **COVERED EXPENSES**. The basis on which we will pay dental benefits is based on the plan selected by the Policyholder. Several options are available. Benefits will be the lesser of: (1) the actual charge of the provider; and any one or more of the possibilities shown in the paragraph COVERED EXPENSES. This includes the usual and customary (“U&C”) as determined by us; Maximum Covered Expense (which is a scheduled basis), Maximum Allowable Benefit (“MAB”), Maximum Procedure Allowance (“MPA”), and Maximum Allowable Charge (“MAC”).

d) **USUAL AND CUSTOMARY ("U&C")** If percentiles differ from one Benefit Type to another, the specific percentiles for each Benefit Type will be listed. For Example, This plan utilizes the 90th percentile of U&C for Type 1 benefits, 80th percentile for Type 2 benefits, and 80th percentile for Type 3 benefits.

e) **EXPENSES INCURRED**. In the paragraph EXPENSES INCURRED, if appliances are not covered, the first sentence is deleted. If dental prosthesis or prosthetic crowns are not covered, the second sentence is deleted entirely or modified. If root canal therapy is not covered, the third sentence is deleted.

f) **LIMITATIONS.** When only certain Type benefits (i.e., Type 1 and Type 2 only) are written, any references to other Type procedures or limitations are deleted.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

The time limitation of 6-months in the Limitation concerning an elimination period for a specific procedure Type, normally Type 3, could be changed to reflect 3, 9, 12, 18 or 24 months based on various anti-selection factors. Normally it remains at 6 months. Multiple limitations will be included if the time limitation applies to multiple Benefit types such as Type 2 and Type 1 as well as Type 3 or this limitation will be removed entirely if no time limitation exists.

The Late Entrant limitation which is filed variable at 12-months could be shortened or lengthened based upon plan selected.

We have several late entrant options that can be selected by the Policyholder:

i. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

ii. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

iii. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

The limit on replacement of teeth extracted prior to coverage under this plan may vary. We have several plan options that can be selected by the Policyholder:

NO PRIOR EXTRACTION COVERAGE. Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

LIMITED PRIOR EXTRACTION COVERAGE. Provides for a procedure to replace teeth extracted while insured was under a prior plan, applies to initial insureds only. A 12-month maximum time period between extraction (while insured under prior plan) and replacement (while insured under our plan).

FULL PRIOR EXTRACTION COVERAGE provides benefits for a procedure performed to replace a tooth or teeth extracted before the person's effective date under our plan.

FOREVER PRIOR EXTRACTION COVERAGE provides for a procedure to replace a tooth or teeth extracted while under a prior plan, applies to initial insureds only. No coverage for missing teeth for 24 months, then full prior extraction coverage.

50% of amount otherwise payable to replace the missing tooth will be paid the first 24 months, then full prior extraction coverage. (The allowance will be cut in half at the procedure level and then the regular coinsurance will be applied.)

For 'Initial Insureds', the insureds will be eligible for full prior extraction coverage. Insureds who become effective after the policy effective date will not be eligible for prior extraction coverage.

EFFECTIVE DATE: No coverage for missing teeth for 36 months from Policyholder effective date, then full prior extraction coverage.

The 90-day extension of coverage for certain procedures could be modified if required by the Policyholder. The clause regarding dental appliances could be deleted if prosthetic dental appliances are not covered.

**14) TABLE OF DENTAL PROCEDURES – 700 ED. 11-09**

a) The entire lists of procedures, including procedure definition, American Dental Association (ADA) code numbers, etc., are optional and can be removed, regrouped or modified by rider. Additional ADA codes can be added as necessary. Procedures may be moved between types, grouped or designated in another way, such as "Level 2" or "Type A". If this were to occur, we would print new pages with the procedures listed under the appropriate type. The numbers and definitions are variable to allow for changes by the ADA and our own coverage philosophy.

b) Limitations which are included on the Dental Expense Benefits page that are specific to certain procedures may be included within the procedural category within this Table.

**15) ORTHODONTIC EXPENSE BENEFITS – 800 ED. 11-09**

a) The Usual and Customary paragraph can be removed entirely if a plan design to pay the actual charge of the provider is selected.

b) The Maximum Amount definition can be changed to allow for a definition of a Maximum that is each Benefit Period or that is both per Lifetime and per Benefit Period.

c) The reference to "eight calendar quarters" or "calendar quarters" in TREATMENT PROGRAM and EXPENSES INCURRED may be modified for more or fewer quarters, or to change "quarters" to "months", "semi-annual", or "annual" payments, etc.

d) If a plan is selected that provides for an amount of Orthodontic Expenses to be covered "up front" then the following sentence will be added to the last paragraph under Expense Incurred. This could be a specified dollar amount or a percentage of the Orthodontic Maximum Amount.

However, the first payment will be [25 percent] of the total allowed Covered Expense.

e) Limitation No. 1 is deleted when we offer "adult" ortho. Adult ortho would provide benefits for Policyholder and spouse, and adult, Dependent children..

f) The Limitation regarding the Late Entrant provision can be modified similar to the options for Late Entrants listed for Dental Expense Benefits.

g) The time limitation of 12 months can be changed based on our coverage philosophy

h) Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

**16) EYE CARE INSURANCE – 900 ED. 11-09**

a) Frequency limitations may be on a rolling frequency basis (every 12 or 24 months) or on a benefit period basis. The type of frequency provision is dependent upon the plan design selected by the Policyholder. Therefore, the Benefit Period definition will be included if the plan design includes a benefit period frequency limitation. If the frequency limitation is a rolling frequency, then this paragraph will not print.

b) The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

c) The frequency limitation in Limitation Nos. 1, 2, 3 or 4 will either be a 12 or 24 month period (rolling frequency) or a benefit period frequency depending upon the plan design selected by the Policyholder as referenced in item a) above.

d) Any limitation could be deleted entirely or any of the sub-items based on the plan design selected by the Policyholder.

e) The entire list of services is optional and can be removed or modified based on the plan design selected by the Policyholder. The dollar amounts listed are variable and provided for illustrative purposes. The actual dollar amount allowance will be based on the most recent approved rate for each procedure for states that require rate filing and approval. The scheduled amounts are reviewed at least annually in light of market conditions.

f) The available plan design options provide for either a scheduled amount (Maximum Covered Expense) per service or may be an aggregate Eye Care Maximum, i.e., $250 for any services selected by the Insured. This will be reflected in the Schedule of Eye Care Services. If the aggregate amount is selected the following will be added to the Schedule of Eye Care Services.

[Maximum Amount - Each Benefit Period [$50 - $300]]

**17) EYE CARE EXAM BENEFIT – 910 ED. 11-09**

The Eye Care Exam Benefit is optional and may be removed entirely if it is not included in the plan design.

**18). LASER VISION CORRECTION BENEFIT RIDER – 920 Ed. 05-11**

Benefits are lifetime maximums and payable per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

The lifetime maximum per eye may vary by benefit period as shown. The policyholder will select the lifetime maximum amounts. The available dollar maximums are shown in the bracketed portions of the form. The policyholder will also select the number of Benefit Periods the dollar amount may be increased by.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

a. There may or may not be an elimination period. If there is an elimination period, the period may be 12 months.
b. No benefit will be payable for an Insured Person under a defined age which may vary from 18 – 21 as shown.
c. There may or may not be a Late Entrant provision. If there is a Late Entrant provision, the waiting period may be 6 or 12 months.

The numbers and definitions of the procedure codes listed are variable to allow for changes by HCPCS and our own coverage philosophy.

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

Officer Name and Signature. We wish to reserve the right to change the officer name and signature should they change in the future.

**19). HEARING CARE EXPENSE BENEFITS PAGES – 930 Ed. 05-11**

Any limitation could be deleted entirely or any of the sub-items based on our coverage philosophy or policyholder negotiation.

The entire list of procedures are optional and can be removed or modified. The dollar amounts listed are variable and provided for illustrative purposes. The Policyholder can select an option that includes all of the procedures, exams only, or materials only (hearing aids, maintenance, and/or miscellaneous).

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the policyholder's plan year.

The Late Entrant provision which is filed variable at 12-months could be shortened or lengthened based upon Policyholder negotiations.

We have several late entrant options that can be selected by the Policyholder:

a. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

b. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

c. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

A STOCK COMPANY
LINCOLN, NEBRASKA

# INDIVIDUAL DENTAL [EYE] [AND] [HEARING] CARE INSURANCE POLICY

Deleted: [AND EYE CARE] [AND HEARING AND LASIK]

**The Policyholder**

| | | | |
|---|---|---|---|
| | | **Policy Number** | **[10-123456]** |
| **State of Delivery** | **XXXXXX** | **Plan Effective Date** | **XXXXXX** |
| **Premium Due Date 1st of each month.** | | **Renewal Date** | **XXXXXX** |

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

This policy is issued to You in consideration of Your application and the payment of premiums, as provided herein.

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

Rates for this policy are subject to adjustment at time of renewal and for other limited circumstances, such as changes in coverage, described herein.

You are entitled to have the premium paid refunded if, after You examine the policy, You are not satisfied with the policy for any reason and notify us in writing not later than the [10th] day after the date the policy is delivered to You. If this policy is cancelled by then, it is void from the date the policy was issued.

This policy takes effect upon the effective date noted above and terminates in accordance with the termination provisions expressed in the policy.

This Policy is renewable at Your option unless:
(1) Your Renewal Premium is not received before the Grace Period ends;
(2) We refuse to renew all Policies of this form in Your state of residence; or
(3) Subject to the termination provisions provided herein.
No refusal of renewal will affect an existing claim.

**AMERITAS LIFE INSURANCE CORP.**

Corporate Secretary

President

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## IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: _____
Address: _____
Telephone Number: _____

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

**Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.**

AR-Complaint Ed. 01-05



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**LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

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

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.



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COVERAGE

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

EXCLUSIONS FROM COVERAGE

However, persons owning such policies 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 incorporated in another state whose guaranty association protects insureds who live outside that state);
* The insurer was not authorized to do business in this state;
* Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

* Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
* Any policy of reinsurance (unless an assumption certificate was issued);
* Interest rate yields that exceed an average rate;
* Dividends and voting rights and experience rating credits;
* Credits given in connection with the administration of a policy by a group contract holder;
* Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
* Unallocated annuity contracts (which give rights to group contract holders, not individuals);
* Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
* Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
* Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
* Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
* Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

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## DEFINITIONS

**ACTUAL CHARGE / ACTUAL FEE:**
The amount charged by a Provider for services provided.

**CHILD:**
The Child of the Policyholder. Also, a Child of the Policyholder's spouse [or Domestic Partner]. The Child must also meet the definition of Dependent.

**[COINSURANCE:**
Shared responsibility between the covered person and us. The level We will pay toward the expenses incurred for services is shown on the schedule.]

**COMPANY:**
Ameritas Life Insurance Corp. "We", "Us" and "Our" refers to our Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

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

**[DENTAL CARE SERVICE:**
A service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.]

**DEPENDENT:**

a. Your spouse [or Domestic Partner].

b. each unmarried Child less than [19] years of age, to include:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iiv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   v. stepchildren if such children are Dependents.



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[c. each unmarried child age [19] but less than [24] who is:

i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

ii. primarily dependent on You, Your spouse for support and maintenance.]

d. each unmarried Child age [19] or older who:

i. is Totally Disabled as defined below; and

ii. becomes Totally Disabled while insured as a Dependent under b. or c. above.

We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof and for notifying us when such dependency and disability has terminated. Any costs for providing continuing proof will be at Our expense. When a handicapped Dependent child reaches the age under the contract that under normal circumstances would cause the Dependent to be terminated or converted to an adult premium, the premium rate shall remain at the child rate.

Dependent shall not include Your parents, grandparents, or any other such individual that is not listed above.

**DEPENDENT UNIT:**
All of the people who are insured as the Dependents of the Policyholder.

**[DOMESTIC PARTNER:**
Two unrelated people who share the necessities of life similar to that of a spouse. They must live together and have an emotional and financial commitment to one another. ]

**ELIMINATION PERIOD:**
A waiting period that may be required before coverage for a particular procedure will be considered. Certain Covered Expenses may be subject to an Elimination Period. Please refer to Dental Expense Benefits for details.

**EMERGENCY:**
A sudden, serious dental condition. If not treated immediately it would result in serious harm to the dental health of the covered person. Coverage at the emergency benefit level for an Emergency is limited to Palliative care only.

**[EYE CARE SERVICE:**
Service provided to a person to diagnose and correct visual acuity .]

**INSURED:**
The Policyholder and a person:

a. Who is a Dependent of the Policyholder
and
b. For whom the insurance has become effective.

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**LATE ENTRANT:**
Any Dependent:

a. Whose Effective Date of insurance is more than 31 days from the date the Dependent becomes eligible for insurance.
or
b. Who has elected to become insured again after having been terminated.

**MAXIMUM AMOUNT:**
The maximum amount payable for each covered person per benefit period. The Maximum Amount is shown on the Schedule of Benefits. No further benefits are payable once the Maximum Benefits are reached.

**[PALLIATIVE:**
Treatment used to relieve, ease, or alleviate the acute severity of dental pain, swelling, or bleeding.]

**POLICYHOLDER:**
Stated on the face page of the policy. The words "You" and "Your" refer to the Policyholder.

**PROVIDER:**
Any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

**[TAKEOVER:**
You may qualify for Takeover benefits if You Were previously covered under a dental plan. You must supply a valid Evidence of Coverage letter from the prior carrier indicating the dates you were covered under the prior plan. This must include the termination date of the prior plan that is no more than 30 days prior to the date you applied for coverage under this Policy. The benefits under the prior plan must have been similar to the benefits included in this Policy. ]

**TOTAL DISABILITY:**
A Dependent

1. Continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

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

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## SCHEDULE OF BENEFITS

REFER TO THE TABLE OF DENTAL PROCEDURES FOR A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES.

REFER TO THE DENTAL EXPENSE BENEFITS AND LIMITATIONS SECTIONS FOR INFORMATION ABOUT ELIMINATION [WAITING] PERIODS AND GENERAL PLAN LIMITATIONS.

The Insurance for You and each of Your covered Dependents will be based on this Schedule of Benefits.

**DENTAL EXPENSE BENEFITS**

[When you select a Participating Provider, a discounted fee is charged for covered services, which is intended to provide Insureds, reduced out-of-pocket costs.]

**Deductible Amount:**

| | |
|---|---|
| Combined Types 1, 2, 3, and 4 Procedures - Each Benefit Period | [$0, $25, $50, $75, $100]* |

[On the date that three family members have satisfied their own Deductible no other family member will be required to satisfy their Deductible. This applies to a single Benefit Period only. 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.]

[Dental expenses incurred by an individual on or after [January 1, 2009], but before [April 1, 2009], will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under Your dental insurance policy in force prior to [April 1, 2009];

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred; and

c. You qualify for Takeover as defined.]

**Coinsurance Percentage:**

| | |
|---|---|
| Type 1 Procedures | [25%-100%] |
| Type 2 Procedures | [0-100% ] |
| Type 3 Procedures | [0-100 %] |
| Type 4 Procedures | [0-100%] |

| | |
|---|---|
| **Maximum Amount - Each Benefit Period.** | [ $1,500]* |

***You and/or your dependents may be required to be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.***

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**[ORTHODONTIC EXPENSE BENEFITS**

| | |
|---|---|
| **Deductible Amount:** | [$0-200] |
| **Coinsurance Percentage:** | [25%-50%] |
| **Maximum Amount - During Lifetime** | [$200, $500, $600, $3,000] |

[The Maximum Amount shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under a prior carrier , and on [April 1, 2009] is:

   i. insured under the policy,

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force; and

   iii. who qualifies for Takeover, as defined.

The modification will result in a reduction of the Maximum Amount based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on Orthodontic Expense Benefits, Limitations.]

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

**[EYE CARE EXPENSE BENEFITS**

**Deductible Amount:**

| | |
|---|---|
| Exam - Each Benefit Period | [$ 10] |
| Lenses - Other than contact lenses - Each Benefit Period | [$ 25]* |
| Frames and Contact Lenses - Each Benefit Period | [$ 25]* |

| | |
|---|---|
| **[Maximum Amount - Each Benefit Period.** | [$150]] |

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

**[LASER VISION CORRECTION EXPENSE BENEFITS**

| | |
|---|---|
| [Deductible Amount - [each Benefit Period]] | $[50] |
| Coinsurance Percentage: | [100%] |

***[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]]***

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**[HEARING CARE EXPENSE BENEFITS**

Deductible Amount:

| | |
|---|---|
| [Exams] - [each Benefit Period] | [$0] |
| [Hearing Aids] - [each Benefit Period] | [$0] |
| [Hearing Aid Maintenance] - [each Benefit Period] | [$0] |
| [Hearing Miscellaneous] - [each Benefit Period] | [$0]] |

[If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and
ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

| | |
|---|---|
| [Exams] | [100%*] |
| [Hearing Aids] | [50%] |
| [Hearing Aid Maintenance] | [100%*] |
| [Hearing Miscellaneous] | [100%*]] |

*refer to the **SCHEDULE OF HEARING CARE SERVICES** page regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

| | |
|---|---|
| [1st 12 month Period] | $[400] |
| [2nd 12 month Period] | $[600] |
| [3rd 12 month Period] | $[800] |
| [4th 12 month Period or thereafter] | $[1,000] |

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

**EXCEPTION:** If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

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[**COMBINED DENTAL AND EYE CARE EXPENSE BENEFITS**

***Combined Dental And Eye Care Deductible Amount:** **[**$0- 200]
Each Benefit Period
*The deductibles listed with the (*) above are subject to the maximum deductible amount listed here.*

***Combined Dental and Eye Care Maximum - Each Benefit Period** [$500-2,000]
*The maximums listed with the (*) above are subject to the maximum amount listed here.*

**Combined Dental and Eye Care Exam Frequencies – Each Benefit Period**
Routine Exams for Dental and Eye Care are limited to * each Benefit Period.

Dental Exams will include:
[D0120 Periodic oral evaluation]
[D0150 Comprehensive oral evaluation - new or established patient.]
[ D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine Eye Care exam is a vision examination as defined on the Schedule of Eye Care Services.

The above frequencies for Dental and Eye Care Exams are subject to the plan frequencies as defined within the Table of Dental Procedures and the Eye Care Insurance provision.]

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## [INCREASED DENTAL MAXIMUM BENEFIT

[It is hereby agreed that the policy is amended by adding the Increased Dental Maximum Benefit provision as defined below: ]

| | |
|---|---|
| Carry Over Amount Per Insured Person – Each Benefit Period. | [$125, $250, $400] |
| [PPO Bonus - Each Benefit Period. | [$50,$100, $150, $200]] |
| Benefit Threshold Per Insured Person – Each Benefit Period. | [$250, $500, $750] |
| Maximum Carry Over Amount. | [$500, $1,000, $1,200, $1,500, $2,000] |

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

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

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

[After the first Benefit Period following the effective date of this provision, the Carry Over Amount Per Insured Person will be increased by the PPO Bonus if all of the following are met.

a) The insured person has submitted a claim for covered dental expenses incurred during the preceding benefit period.

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider.

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

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

The Carry Over Amount [and the PPO Bonus] can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless either of the following applies.

a) During any Benefit Period, dental expense benefits are paid in excess of the Benefit Threshold. In this instance, there will be no additional Carry Over Amount [or PPO Bonus] for that Benefit Period.

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

[The Carry Over Amount [and the PPO Bonus, if applicable] accrued prior to [January 1, 2009] will apply to the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits if proof is furnished to us that such Carry Over Amount was incurred under the policy in force immediately prior to [January 1, 2009] except as noted below. [This proof must be furnished to us within 12 months of the Policy Effective

Date and not be for a Date of Services more than 12 months prior to the date the proof is furnished.] Any qualified Carry Over Amount under a prior policy will apply toward the total Maximum Carry Over Amount under this policy. In no event will the Carry Over Amount under a prior policy plus any accumulated Carry Over Amount, if applicable, under this policy exceed the Maximum Carry Over Amount. Any future Carry Over Amounts accumulated or forfeited in subsequent Benefit Periods will be calculated as outlined above. Please note that if the first Benefit Period is for a period of less than 12 months the Carry Over Amount will be accumulated in the second Benefit Period without a claim having to be filed but the Carry Over Amount in all subsequent Benefit Periods may be forfeited as per the rules in b. above.]

[The Carry Over Amount for those Insured on [January 1, 2009] will be $[500] and will apply to the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits for the remainder of the Benefit Period except as noted below. In no event will the Carry Over Amount listed here plus any accumulated Carry Over Amount, if applicable, under this policy exceed the Maximum Carry Over Amount. Any future Carry Over Amounts accumulated or forfeited in subsequent Benefit Periods will be calculated as outlined above.]

Carry Over Eligibility [and the PPO Bonus] will be determined at the time the first claim in a Benefit Period is received for covered expenses incurred during that Benefit Period.

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

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## PREMIUMS

## TABLE OF [MONTHLY] PREMIUM RATES

| | |
|---|---|
| **[Dental Care Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)]. |
| **Eye Care Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)]. |
| **Orthodontic Insurance** | [$xx.xx per Policyholder. |
| | $xx.xx Policyholder plus Spouse. |
| | $xx.xx Policyholder plus Children. |
| | $xx.xx Policyholder plus Spouse & Child(ren)].] |

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

**PREMIUM DUE DATE:**
The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If We agree with You that the payment of premiums shall be on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made. Please see the General Provisions section of this policy for Grace Period information.



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**ADJUSTMENTS IN PREMIUM RATES**:
We will not change the initial premium shown on the cover of this policy in the middle of Your policy year, unless any of the following are met.

- Family members are added or deleted.
- Coverage is increased or decreased.
- You move to a different zip code, county or state.
- Premium payment method is changed.
- Any other terms and conditions of this policy change.

The premium change will be effective on the first of the month following the date of such change.

At policy renewal, Your premiums may change for any of the reasons stated above or as a result of any of the following.

- A new rate table applies.
- Any covered person's age classification increases.

We will provide written notice at least [60] days prior to the effective date of any renewal premium change.

**RENEWAL DATE**:
Renewal Date refers to the date each calendar year that the coverage issued under this policy is considered for renewal. The Renewal Date is shown on the policy cover.

**PREMIUM REFUND:**
We will be liable for the return of unearned premiums to You only for the [3, 6, 9, 12] months before the date We receive evidence that a return is due.



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## CONDITIONS FOR INSURANCE COVERAGE

*ELIGIBILITY*

**EFFECTIVE DATE:**
The Effective Date for You is the Effective Date listed on the cover page of this Policy. You must be at least [18] to be a Policyholder.

**[DEPENDENT EFFECTIVE DATE:**
You have the option of insuring Your Dependents. You must be covered under this policy in order to insure your dependents. To elect coverage, You must agree in writing to pay the insurance premiums.

Dependents may be added within 31 days of becoming eligible for coverage under this policy. After the expiration of this 31 day period Dependents may only be added pursuant to the Late Entrant provision and Our review of the application.

The Effective Date for Dependents will be either of the following.

1. The first of the month for which the Policyholder pays applicable premiums , if that date is within 31 days after the date he or she qualifies for insurance as a Dependent.

[2. The date We accept the Dependent for insurance when the Dependent is a Late Entrant. The Dependent will be subject to any limitation concerning Late Entrants.]

For dependent children, a newborn child will be considered an eligible dependent without imposition of late entrant status until 30 days after they've reached their 2nd birthday.]

**[COVERAGE FOR NEWBORN AND ADOPTED CHILDREN:**
A newborn Child will be covered from the date of birth.

Coverage for a newborn Child shall consist of coverage for covered dental procedures needed as a result of congenital defects or birth abnormalities such as cleft lip, cleft palate and premature birth. This coverage is subject to applicable Deductibles, Coinsurance percentages, maximums and limitations.

The initial coverage provided newborn children shall continue for a period of at least 90 days. For coverage to continue beyond this initial 90-day period, You must notify Us of the birth of the newborn Child. You must also pay any additional premium required to keep the coverage in force. An additional premium for the initial period of coverage may be charged.

An adopted Child will be covered from the date You have filed a petition to adopt the Child if You have filed for coverage within 60 days after filing the petition for adoption. Any additional premium may be required.]



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## *TERMINATION DATES*

**POLICY TERMINATION:**
Upon termination of the policy, all coverage for Dependents will terminate. We can terminate Your policy upon the earliest of any of the following.

- The last day through which the premium was paid.
- The last day [of the month] in which You request termination of insurance coverage to be effective or the date such written request is received by Us, whichever is later.
- The last day [of the month] in which You, or a covered person, commits fraud or intentional misrepresentation of a material fact, as determined by Us.
- The last day [of the month] in which a covered person permits a person not authorized by Us to use his or her identification card, or a covered person uses another covered person's identification card that he or she is not authorized to use.
- The last day [of the month] in which a covered person fails to comply with the policy provisions, as determined by Us.
- The last day [of the month] in which You enter full-time military, naval, or air service.
- The last day [of the month] in which You move outside the service area, as determined by Us.
- The last day [of the month] in which We have a right or defense to take such action by law.
- The last day [of the month] in which We cease to offer this type of policy or cease to do business in the individual markets as allowed by state law.

**[DEPENDENT TERMINATION:**
Coverage can terminate under the policy for a Dependent, even if the policy does not terminate for the reasons stated above, on the earliest of any of the following.

- The last day [of the month] for which the premium was paid for Dependent coverage.
- The last day [of the month] in which the Dependent no longer qualifies as a Dependent or meets eligibility criteria.
- The last day [of the month] after which You provide 30 days notice to Us of Your voluntary termination of coverage
- The last day [of the month] in which the Dependent is no longer a resident of the service area, as determined by Us.
- The last day [of the month] in which the Dependent enters full-time military, naval, or air service.
- The last day [of the month] in which the Dependent commits fraud or intentional misrepresentation of a material fact, as determined by Us.
- The last day [of the month] in which the policy terminates.]

**YOUR DUTY TO NOTIFY US:**
You are responsible to notify Us of any of the events stated above which would result in the termination of the policy or a covered person. If You fail to provide timely notification of these events We will terminate Your policy. The termination date and premium refund (if any) will be determined based on when We should have received notification. This will be determined by Us.

**OTHER COVERAGE:**
Dual coverage by You or of a spouse and/or Dependents under another policy issued by Us is prohibited. If You have coverage under any other carrier We will not coordinate benefits.

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**CONTINUATION OF COVERAGE:**
If Dependent coverage ceases according to the Termination Section, some or all of the insurance coverages may be continued. This will be via a new individual policy. The policy will be in the Dependent's name. The policy will be at the then prevailing rates and benefits schedule. The Dependent must be an adult in order to elect continuation. The new policy will be issued without evidence of insurability. The person's history will transfer.

If a person loses coverage due to a change in marital status he or she may wish to continue coverage. We will offer another policy. This policy will be one which We are then issuing which most nearly reflects the coverage of the policy which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability. The person's history will transfer.

In the event of the Policyholder's death the spouse may become the Policyholder. The spouse must have been covered under the policy.

Should the Policyholder die while having Dependents insured, the Dependents of the deceased Policyholder will be eligible to continue coverage provided all other policy provisions are satisfied.

If We accept premium for coverage past the termination date of an insured family member, the coverage shall continue during the period for which an identifiable premium was accepted. A misstatement of age will void this provision.

Contact Us for details.

**REFUND AT DEATH:**
If the Policyholder dies and no continuation is elected, We provide for the refund of unused premiums upon the death of the Policyholder during the contract period. The amount of premium refund shall be prorated from the beginning of the month following the date of death of the Policyholder to the end of the contract period for which the premium has been paid.



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## GENERAL PROVISIONS

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

**TIME LIMIT ON CERTAIN DEFENSES:**
(a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary. (b) After two years, We won't reduce or deny benefits due to a preexisting condition.

**GRACE PERIOD:**
Unless, not less than five days before the premium due date, We have delivered to You, or have mailed to Your last address as shown by Our records, a written notice of Our intention not to extend or renew this policy beyond the period for which the premium has been accepted, a grace period of at least [31 days] will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force subject to Our right to cancel the policy in accordance with the policy's cancellation provision. Premium is due and payable for the entire term of the grace period.

**REINSTATEMENT OF POLICY:**
If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the Insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the Insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement. In addition, no more than 2 reinstatements will be allowed per 12 month time period.

If this policy is terminated due to a lack of premium payment, You may request reinstatement. We will reinstate Your policy provided all the following are met.
1. The coverage has not been terminated for more than [three months].
2. You pay the premiums that were due during the gap in coverage.
3. We approve the application.
The Policy’s history will be resumed.

**[REINSTATEMENT OF DEPENDENTS:**
Dependents may be reinstated one time after a period not greater than three months. This is subject to Our approval and the Late Entrant provision.]

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

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

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

**PROOF OF LOSS:**
For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to Us at Our designated office before the 91st day after the termination of the period for which We are liable. For a claim for any other loss, a written proof of loss must be provided to Us at Our designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible. It can not be later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT.** We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

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

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

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

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

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

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



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

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

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

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

**MEDICARE:**
This policy is not related to or duplicative of Medicare coverage.

**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. The amount will not exceed $5,000. It will be paid to any relative by blood or connection by marriage of the Insured who is considered by Us to be equitably entitled to the benefit.

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

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

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

**[NON-INSURANCE PRODUCTS/SERVICES:**
From time to time We may arrange for third- party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. These discounted goods or services are not insurance. We are not responsible for any 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 relations team.

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[Dental procedures not payable under Your plan may also be subject to a discounted fee in accordance with a participating provider's contract.]

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. ]



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**UTILIZATION REVIEW PROGRAM:**
Generally, utilization review means a set of criteria designed to evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used are clearly documented and applied. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

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## DENTAL EXPENSE BENEFITS

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

**[PARTICIPATING AND NON-PARTICIPATING PROVIDERS:**
A Participating Provider is a Provider who has entered into an agreement to provide services to Insureds at a specific fee ("MAC"). 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. You 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". You 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 for services by a Participating 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:**
Refer to the period shown in the Table of Dental Procedures.

**COVERED EXPENSES:**
Covered Expenses include both of the following.

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

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

Benefits payable for Covered Expenses will be based on the lesser of any of the following.

1. The actual charge of the Provider.
2. [The usual and customary ("U&C") charge as determined by us, [if services are provided by a Non-Participating Provider.]
3. The Maximum Allowable Charge ("MAC") as determined by us, [if services are provided by a Participating Provider, who is a general dentist.]
4. The Maximum Allowable Benefit ("MAB") as determined by us, [if services are provided by a Non-Participating Provider.]
5. The Maximum Procedure Allowance ("MPA") as determined by us, [if services are provided by a Non-Participating Provider.]
6. The Maximum Covered Expense as determined by us, [if services are provided by a Non-Participating Provider.]]

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]



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**[MAC:**
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. It is derived from the array of Provider charges within a particular ZIP code area.]

[**MAB:**
The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MPA:**
The Maximum Procedure Allowance is derived from the array of submitted provider charges within a ZIP code area. The MPA is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MAXIMUM COVERED EXPENSE:**
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 Policy.]

**COVERAGE FOR GENERAL ANESTHESIA.** Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or

3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

**ALTERNATIVE PROCEDURES:**
Occasionally two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care. In this case, 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. 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. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

We may request existing dental X-rays or any other existing diagnostic aids for the purpose of determining benefits payable under the policy. We strongly encourage pre-treatment estimates so You understand Your benefits before any treatment begins. Ask Your Provider to submit a claim form for this purpose.

**EXPENSES INCURRED:**
An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture.

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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:**
Dental Expenses will not include, and benefits will not be payable, for any of the following.

1. Covered Dental Expenses for Type [3] Procedures in the first [6] months the person is covered under this contract [unless you qualify for Takeover benefits as defined].

2. Covered Dental Expenses in the first [12] months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3. [Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth..

4. Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.

    a. Alter vertical dimension.
    b. Restore or maintain occlusion.
    c. Splint or replace tooth structure lost as a result of abrasion or attrition.

5. Covered Dental Expenses 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.

6. Covered Dental Expenses to replace lost or stolen appliances.

7. Covered Dental Expenses for any treatment which is for cosmetic purposes.

8. Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)

9. Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.

10. Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment.

11. Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.

12. Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. Covered Dental Expenses because of war or any act of war, declared or not.]

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## 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 © 2006 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.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- B/R means By Report.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

## TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION

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

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).
D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS

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

PERIAPICAL FILMS: D0220, D0230

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

BITEWING FILMS

D0270 Bitewing - single film.
D0272 Bitewings - two films.
D0273 Bitewings - three films.
D0274 Bitewings - four films.
D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride (prophylaxis not included) - child.
D1204 Topical application of fluoride (prophylaxis not included) - adult.

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## TYPE 1 PROCEDURES

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

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

PROPHYLAXIS: D1110, D1120

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

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

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## TYPE 2 PROCEDURES

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

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

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

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.

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

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- 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.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

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

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

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.
D2915 Recement cast or prefabricated post and core.
D2920 Recement crown.
D6092 Recement implant/abutment supported crown.
D6093 Recement implant/abutment supported fixed partial denture.
D6930 Recement fixed partial denture.

SEDATIVE FILLING

D2940 Sedative filling.

ENDODONTICS MISCELLANEOUS

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

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Anterior (excluding final restoration).

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## TYPE 2 PROCEDURES

D3320 Bicuspid (excluding final restoration).
D3330 Molar (excluding final restoration).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - bicuspid.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
D3425 Apicoectomy/periradicular surgery - molar (first root).
D3426 Apicoectomy/periradicular surgery (each additional root).

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4263 Bone replacement graft - first site in quadrant.
D4264 Bone replacement graft - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4271 Free soft tissue graft procedure (including donor site surgery).
D4273 Subepithelial connective tissue graft procedures, per tooth.
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Soft tissue allograft.
D4276 Combined connective tissue and double pedicle graft, per tooth.

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, D4271, D4273, D4275, D4276

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

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## TYPE 2 PROCEDURES

NON-SURGICAL PERIODONTICS

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

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

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

DENTURE RELINES

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

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

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

NON-SURGICAL EXTRACTIONS

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

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.

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## TYPE 2 PROCEDURES

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Surgical removal of residual tooth roots (cutting procedure).

OTHER ORAL SURGERY

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

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## TYPE 2 PROCEDURES

D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285 Biopsy of oral tissue - hard (bone, tooth).
D7286 Biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.
D9221 Deep sedation/general anesthesia - each additional 15 minutes.
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

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## TYPE 2 PROCEDURES

- 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, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

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

INLAY RESTORATIONS

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

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

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

ONLAY RESTORATIONS

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

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

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

CROWNS SINGLE RESTORATIONS

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

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D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

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

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

CORE BUILD-UP
D2950 Core buildup, including any pins.
D6973 Core build up for retainer, including any pins.

POST AND CORE
D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR
D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING
D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)
D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).

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D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

DENTURE REBASES

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

TISSUE CONDITIONING

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

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).

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

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D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

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

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

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

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

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

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

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

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

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

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

## CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.
D6972 Prefabricated post and core in addition to fixed partial denture retainer.

## BLEACHING (COSMETIC)

D9972 External bleaching - per arch.
D9973 External bleaching - per tooth.
D9974 Internal bleaching - per tooth.

BLEACHING: D9972

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- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

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## [ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the policy for orthodontic expenses incurred by an Insured.

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

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

**COVERED EXPENSES:**
Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

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

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

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

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

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

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

**[BENEFITS PAYABLE UPON TERMINATION:**
If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

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

1. [[for a Program begun on or after the Insured's [17, 18, 19] birthday.]

2. [for a Program begun before the Insured became covered under this section.]

3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]

4. before the Insured has been insured under this section for at least [12, 18, 24] consecutive months.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is entitled to benefits under any workers' compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

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

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

10. to replace lost or stolen appliances.]

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## [EYE CARE INSURANCE

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

**AMOUNT PAYABLE.** The Amount Payable for Covered Expenses shall be the lesser of:

a. the charge for frames or supplies furnished; or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

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

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

[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.]

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

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

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

1. [Vision examinations more than once in any [12, 24 month] [benefit] period. [Coverage is subject to the Dental and Eye Care Exam Frequencies listed on the Schedule of Benefits.]

2. Prescribed lenses more than once in any [12, 24 month] [benefit] period.

3. Frames more than once in any [12, 24 month] [benefit] period.

4. Contact lenses more than once in any [12, 24 month][benefit] period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the [12, 24 month] [benefit] period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the [12, 24 month] [benefit] period.

5. Examinations performed or frames or lenses ordered before the Insured was covered under this section.

6. Any examination performed or frame or lens ordered after the Insured's coverage under this section ceases, subject to Extension of Benefits.



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7. Sub-normal vision aids; orthoptic or vision training or any associated testing.

8. Non-prescription lenses.

9. Replacement or repair of lost or broken lenses or frames except at normal intervals.

10. Any eye examination or corrective eyewear required by an employer as a condition of employment.

11. Medical or surgical treatment of the eyes.

12. Any service or supply not shown on the Schedule of Eye Care Services.

13. Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

14. Lenses and frames during the first twelve months that a person is insured under this section, when the person is a Late Entrant, as defined.

**SCHEDULE OF EYE CARE SERVICES**

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

| **SERVICE** | **[MAXIMUM COVERED EXPENSE]** |
|---|---|
| **Vision Examination** | Up to $ [55.00] |
| May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses. Coverage is subject to the Combined Dental and Eye Care Exam Frequencies listed on the Schedule of Benefits, if applicable. | |
| **Materials** | |
| Frame | [$30.00] |
| Lenses | |
| Single Vision | [$35.00] |
| Bifocal | [$47.00] |
| Trifocal | [$57.00] |
| No line bifocal or progressive power | [$57.00] |
| Lenticular | [$85.00] |
| Contact Lenses | [$65.00] |

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## [EYE CARE EXAM BENEFIT

Covered Expenses include one eye examination (exam) in any one Benefit Period.

If an Insured incurs Covered Expenses, We will pay benefits as stated below. The exam must be performed by an ophthalmologist or optometrist. An expense is incurred for the eye exam at the time an exam is performed. [An Insured may use a Participating Provider or a Non-Participating Provider.

**[VISION SERVE PLAN ("VSP"):**
Provides claim reimbursement services for your eye care exam. Please submit your claim to "VSP" at P.O. Box 997105, Sacramento, CA 95899-7105]

**AMOUNT PAYABLE:**
[The amount payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services. When making an appointment, tell the provider that you are a [VSP] member.]

The Amount Payable for Covered Expenses performed by a [Non-Participating] Provider is the lesser of:

1. the [Non-Participating] Provider's charge, or

2. the Maximum Covered Expense for such services or supplies as shown on the Schedule of Benefits.

[When using a Non-Participating Provider, you will be required to pay the provider in full at the time of service. You can request reimbursement from [VSP] by completing a claim form and submitting it [with a copy of an itemized paid receipt, that indicates the services provided and the amount charged (handwritten receipts must be provided on a provider's letterhead)] to [VSP] within [six months] after the date of service.]

Covered Expenses for an eye exam will be subject to all deductibles, coinsurance percentages, maximums and limitations applicable to Type 1 dental procedures.

No benefits will be payable for expenses incurred for any exam required by an employer as a condition of employment.]

## [DENTAL EXPENSE BENEFITS

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

**[PARTICIPATING AND NON-PARTICIPATING PROVIDERS:**
A Participating Provider is a Provider who has entered into an agreement to provide at a specific fee ("MAC") services to Insureds. 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. You 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". You 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.]

**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:**
Refers to the period shown in the Table of Dental Procedures.

**COVERED EXPENSES:**
Covered Expenses include both of the following.

1. Only those expenses for dental procedures performed by a Provider;.
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 limited to the lesser of any of the following.

1. The actual charge of the Provider.
2. [The usual and customary ("U&C") as determined by us, [if services are provided by a Non-Participating Provider.]
3. The Maximum Allowable Charge ("MAC") as determined by us, [if services are provided by a Participating Provider, who is a general dentist.]
4. The Maximum Allowable Benefit ("MAB") as determined by us,[if services are provided by a Non-Participating Provider.]
5. The Maximum Procedure Allowance ("MPA") as determined by us, [if services are provided by a Non-Participating Provider.]
6. The Maximum Covered Expense as determined by us, [if services are provided by a Non-Participating Provider.]]

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

**[MAC:**
The charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing Provider fees within the ZIP code area. It is derived from the array of Provider charges within a particular ZIP code area.]

[**MAB:**
The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MPA:**
The Maximum Procedure Allowance is derived from the array of submitted provider charges within a ZIP code area. The MPA is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.]

[**MAXIMUM COVERED EXPENSE:**
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 Policy.]

**COVERAGE FOR GENERAL ANESTHESIA.** Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

4. a person with a diagnosed serious mental or physical condition; or

5. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

**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 x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so You understand Your benefits before any treatment begins. Ask Your provider to submit a claim form for this purpose.

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**[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:**
Dental Expenses will not include, and benefits will not be payable, for any of the following.

1. Covered Dental Expenses for Type [3] Procedures in the first [6] months the person is covered under this contract [unless You qualify for Takeover benefits as defined].

2. Covered Dental Expenses in the first [12] months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3.a. Covered Dental Expenses 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, unless the insured person is covered on [mo/dy/yr]. For those insured persons covered on [mo/dy/yr], see 3.b.

3.b. Limitation 3a will be waived for those insured persons whose coverage was effective on [mo/dy/yr], and

The person was insured under the prior contract on the date it was replaced by this contract; and

i. the person has the tooth extracted while insured under the prior contract; and

ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

4. Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.

(a) Alter vertical dimension.
(b) Restore or maintain occlusion.
(c) Splint or replace tooth structure lost as a result of abrasion or attrition.

5. Covered Dental Expenses 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.

6. Covered Dental Expenses to replace lost or stolen appliances.

7. Covered Dental Expenses for any treatment which is for cosmetic purposes.

8. Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)

9. Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision).

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10. Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment.

11. Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.

12. Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. Covered Dental Expenses because of war or any act of war, declared or not.]

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## [ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the policy for orthodontic expenses incurred by an Insured.

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

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

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

**COVERED EXPENSES:**
Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

**[USUAL AND CUSTOMARY ("U&C") :**
Benefits for a given procedure are paid according to the usual and customary charge for that procedure within a particular ZIP code area. [This plan utilizes the [90th] percentile of U&C, which means that [9 out of 10] providers in a specific area charge at or below the plan allowance for a procedure.]

The U&C is reviewed and updated periodically. The U&C can differ from the Actual Fee charged by the Provider and is not indicative of the appropriateness of the Provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage.]

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

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

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

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

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

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

**[BENEFITS PAYABLE UPON TERMINATION:**
If coverage terminates during a Program quarter, the quarterly benefit payable for that quarter will be pro-rated by day for the period of time that coverage was in-force and premium was received.]

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

1. [for a Program begun on or after the Insured's [17, 18, 19] birthday.]

2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on [mo/dy/yr] and are both:

   a. insured under this policy;
   b. currently undergoing a Treatment Program on [mo/dy/yr]; and
   c. qualifies for Takeover as defined..

3. [in the first [6, 12, 15, 18, 21, 24] months that a person is insured if the person is a Late Entrant.]

4. [before the Insured has been insured under this section for at least [12, 18, 24] consecutive months unless the Insured qualifies for Takeover, as defined.

5. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

6. if the Insured's insurance under this section terminates.

7. for which the Insured is entitled to benefits under any workers' compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

8. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

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

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

11. to replace lost or stolen appliances.]

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# application

## individual insurance form

AMERITAS LIFE INSURANCE CORP.
5900 O Street / P.O. Box 81889
Lincoln, NE 68501-1889

☐ Dental ☐ Dental with Eye Care ☐ Dental with Eye Care Exam
☐ Dental with Hearing & Lasik ☐ Dental with Eye Care Hearing & Lasik

**Plan selected**_____

## policyholder information

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner (if applicable) ☐ Civil Union (if allowed by state law)

Social Security number _____ Affiliation, if applicable_____

Policyholder's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Phone number_____

Street address_____ Apt. #_____ City_____ State_____ ZIP_____

Billing address, if different from above_____ Apt. #_____ City_____ State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Have you been covered under another dental policy within the last 30 days? . . . . . ☐ Yes ☐ No

**If yes:** 1. Please provide an Evidence of Coverage letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits.
2. Please complete the attached Replacement form.

Applicants and Dependents cannot have the same type of coverage under another Ameritas plan (i.e. no two Ameritas dental plans, no two Ameritas eye care plans).

## dependent coverage information

List all eligible dependents to be covered. (Policyholder must be enrolled to cover dependents.)

| print full legal name (last, first. MI) | relationship | sex | date of birth | social security number |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Premium payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Premium method: . . . . . ☐ EFT ☐ ACH ☐ Credit Card ☐ Check ☐ Direct Bill

## agreements by Ameritas

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information.

Any policy including riders and rate notifications issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., insurance under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

## agreements by policyholder

I hereby apply for insurance, for which I am eligible. I agree to be responsible for my premiums and those of my enrolled dependents. I acknowledge receipt of the outline of coverage. I understand coverage is NOT in force until the Company issues a Policy showing a Policy Effective Date.

☐ I consent to receiving my Policy, Explanation of Benefits, and other plan information electronically and I will electronically affirm my consent to do so. I understand I need Internet access and that I can withdraw my consent at any time per the notification instructions below. I understand I can receive any of the documents in paper form if I choose.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties. I understand that it is my responsibility to give notice to Ameritas of changes in my e-mail address or any information above, as well as my status and my family's status that affect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice electronically through e-mail or in writing to Ameritas or its designee:

Ameritas Life Insurance Corp., PO Box 81889, Lincoln, NE 68501-1889 / 800-487-5533 / e-mail: group@ameritas.com

**I understand the policy I am applying for provides dental/eye care/hearing and Lasik benefits only and is not a Medicare supplement.**

X_____
**Policyholder Signature** **Date**

X_____
**Insurance Producer Name and/or Number (if applicable)** **Date**

# regulatory notes

## Review your policy carefully

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements below.)

**Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que fi gura en su tarjeta de identifi cación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico and Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

AMERITAS GROUP
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

475 Fallbrook Blvd. / Lincoln, NE 68521-9033
(402) 467-1122 / (800) 745-1112 / Facsimile: (402) 309-2573

June 8, 2011

The individual policy, application, Outline of Coverage, and Optionals and Variables have recently been approved by your Department. We certify that the only revisions made to these forms are those that are shown in the red-lined documents attached herein.

Janis Landon

Digitally signed by Janis Landon
DN: cn=Janis Landon, o=Ameritas Life Insurance Corp., ou=Group Compliance, email=jlandon@ameritas.com, c=US
Date: 2011.06.07 13:05:00 -05'00'

Janis Landon
Senior Contract Analyst

# Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|
| 06/06/2011 | Supporting Document | Health - Actuarial Justification | 07/01/2011 | act memo - AR.pdf (Superceded) |