ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

AMERITAS LIFE INSURANCE CORP.

AND

NEVADA COUNTY

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Administrative Services Agreement

This Administrative Services Agreement ("Agreement") is between **Nevada County** ("Plan Sponsor"), and Ameritas Life Insurance Corp., a Nebraska corporation ("Ameritas"), and is effective upon the date set forth herein. Throughout the Agreement Ameritas and Plan Sponsor may be referred to individually as "Party" or collectively as "Parties."

WHEREAS, Plan Sponsor has established and will administer an employee Dental and Eye Care benefit plan ("Plan") according to the Employee Retirement Income Security Act of 1974 ("ERISA") or the Public Health Service Act ("PHSA"), as applicable, for its employees and their dependents;

WHEREAS, Plan Sponsor desires to utilize the services of Ameritas to assist in its duties to administer the Plan; and

WHEREAS, Ameritas has agreed to provide such non-fiduciary administrative services in connection with the Plan such as processing of claims and other services under the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual promises contained in this Agreement, Plan Sponsor and Ameritas hereby agree as follows:

Section I. Scope of Agreement

Ameritas agrees to perform certain non-fiduciary administrative services, such as claim processing and other services specified herein for the Plan, as amended, as described in Addendum A.

Section II. Services to be Provided by Ameritas

Ameritas shall perform the following administrative services in connection with the Plan:

A. Process claims and determine the Plan benefits applicable to Covered Employees and their dependents (collectively, "Covered Persons"), including coordination of benefits, where applicable, in accordance with the terms of the Plan and as specified to Ameritas by Plan Sponsor, using Ameritas' claim paying system as specified to Ameritas by Plan Sponsor. Ameritas will process claims incurred on or after the Effective Date of this Agreement and received while this Agreement is still in effect.

B. Notify a Covered Person of the initial denial of a claim (benefits) and his or her right of review of the denial as specified by the Plan Sponsor and in accordance with the terms of the Plan.

C. Issue checks in payment of benefits payable under the Plan which, subject to the terms of this Agreement, shall be paid through the bank account as set forth in Section IV. of this Agreement.

D. Answer benefits and claims questions and inquiries of Covered Persons and providers through toll free telephone number.

E. Communicate with Plan Sponsor as is necessary to verify eligibility of Covered Persons.

F. Provide to Plan Sponsor estimated Plan benefit costs after the Initial Term, and Plan design and underwriting services in connection with benefit revisions, addition of new benefits, and extensions of coverage to new Covered Persons, as requested by the Plan Sponsor.

G. Bond all of its employees who will be handling funds of Plan Sponsor.

H. Prepare reports regarding the Plan for use by Plan Sponsor in accounting for and managing the Plan, which shall include the standard reports identified in Addendum D.

I. Prepare and provide form 1099 MED for each provider of services, in accordance with IRS rules.

J. Provide Plan identification cards, Ameritas PPO dentist lists, if applicable, and a description of the Plan, as set forth in Addendum A, for each of the Plan Sponsor eligible employees.

K. Assist Plan Sponsor upon requests in connection with the general administration of the Plan, administration and record keeping systems for the ongoing operation of the Plan and reconciliation of claims paid. As mutually agreed by the Parties, Ameritas will provide forms, including claims forms, related to the general administration of the Plan.

L. Maintain all benefit payment records as to requests for benefits for a period of seven (7) years following the month in which the final benefit payment was made, or such longer period as required by applicable law. In the event of discontinuance of this Agreement, Ameritas, upon the Plan Sponsor's request and their expense, shall promptly forward to Plan Sponsor the subject records in its possession in the format identically maintained by Ameritas at the time the Agreement is discontinued. During the time in which Ameritas is to maintain benefit payment records, Ameritas shall be permitted, if it so desires, and unless otherwise prohibited by law, to destroy hard copies whenever the information has been transferred to microfiche or such other similar process which permits the retention of such information.

M. If it is determined that any payment has been made under this Agreement to an ineligible person, or if it is determined that more or less than the correct amount has been paid by Ameritas, Ameritas will make a diligent attempt to recover the overpayment or will adjust the underpayment in accordance with Ameritas' established claim practices. However, in no event shall such recovery or adjustment be performed in a manner violative of any state's Unfair Claims Practices Act. Ameritas shall not initiate court proceedings for any such recovery. In the event, however, that Ameritas is sued by any beneficiary seeking to recover an adjustment to an alleged underpayment, then the decision whether to defend such court suit shall be the responsibility of Plan Sponsor. Plan Sponsor may direct Ameritas to enter into a settlement or to forego the defense to any such action, provided, however, that Plan Sponsor shall ensure that Ameritas is fully reimbursed and indemnified for any and all payments made by reason of such decision by Plan Sponsor.

N. If the Plan includes PPO benefits, Ameritas shall arrange for those contracted dental providers comprising the Ameritas PPO Network to render services to those Covered Persons who seek such services from a member of the Ameritas PPO Network. Ameritas' foregoing obligation, when measured at an individual provider level, is subject to the provider's then-current patient load and ability to accept new patients. Ameritas represents and warrants that in exchange for

rendering services to the Covered Persons, each participating provider member of the Ameritas PPO Network agrees to accept the amount set forth in their respective fee schedule as payment in full for procedures listed on the fee schedules and further, that the participating providers have agreed to bill Covered Persons only for the cost of services not covered under the Plan.

Section III. Obligations of Plan Sponsor

Plan Sponsor or Plan Sponsor's subcontractor shall:

A. Promptly and diligently provide eligibility information for Covered Persons under the Plan, on or after the Effective Date of this Agreement, to Ameritas in a format mutually agreed upon by Plan Sponsor and Ameritas.

B. Provide benefit information, eligibility information and periodic (at least monthly) updates of additions, deletions and changes with regard to Covered Persons by an agreed upon medium.

C. Designate personnel with authority to answer questions relative to eligibility so that accurate eligibility information is available to Ameritas upon request.

D. Maintain and administer the Plan in compliance with ERISA or the PHSA, as applicable; provide discretionary authority and exercise control respecting Plan management and claims decisions.

Section IV. Banking Arrangements

During the term of this Agreement:

A. All benefit payments made by Ameritas on behalf of the Plan will be issued by Ameritas on checks payable through Ameritas' bank of choice.

B. Ameritas will send to Plan Sponsor, or, upon request and authorization, an entity designated by Plan Sponsor ("Designee"), the Dental Weekly Paid/Denied Claim Report and the Eye Care Monthly Paid/Denied Claim Report identified in Addendum D. Accompanying this report will be a cover letter setting forth the total amount paid as reflected by the report. Three (3) business days after sending, Plan Sponsor or Designee will pay or cause to be paid to Ameritas the amount listed in the letter in a mutually agreed upon format. Plan Sponsor will complete and provide all necessary authorizations to accommodate the payment.

C. Failure to reimburse Ameritas in accordance with the above will result in interest being charged on the unpaid amount from the date due until fully paid at a rate equal to the lower of a) ten percent (10%) per year or, b) the maximum rate allowable by applicable usury laws and may result in the discontinuance of the Agreement in accordance with Section VI.

Section V. Administrative Service Charge Schedule

A. Except as otherwise provided hereafter, the administrative service charge for each month of

this Agreement shall be as specified in Addendum B ("Administrative Service Charge"), both for the Initial Term of this Agreement and for any Subsequent Agreement Period unless adjusted by Ameritas in accordance with Section V(E) or otherwise agreed by the Parties. Initial Term and Subsequent Agreement Period shall be as defined in Section VI., below.

B. The Administrative Service Charge as applied and provided for in Addendum B, will start on the first day of the month falling on or after the date the applicable coverage is effective. The Administrative Service Charge for the applicable coverage will cease on the last day of the month falling on or after the date of termination of the applicable coverage. There will be no pro rata charges or credits for partial month.

C. Ameritas will refund unearned Administrative Service Charges to Plan Sponsor for up to three (3) months before the date Ameritas receives evidence that a refund is due.

D. Prior to the first (1st) day of each month of this Agreement, Ameritas will submit a report to Plan Sponsor, or, if applicable to Designee, identifying the Covered Person(s) and listing the Administrative Charges for the month. Remittance of the Administrative Service Charges shall be due by the first (1st) of the month and past due on the tenth (10th) of the month. Such report and remittance shall be subject to audit and adjustment, as necessary, by Ameritas within ninety (90) days of receipt.

E. The Administrative Service Charge may be adjusted by Ameritas at the start of any Subsequent Agreement Period following the Initial Term, provided Ameritas has given Plan Sponsor at least thirty (30) days advance written notice of its intent to adjust the Administrative Service Charge. Subsequent Agreement Period shall be as defined in Section VI., below. Should Ameritas fail to timely deliver any Administrative Service Charge change notice, the Administrative Service Charge contained in the notice shall still be effective but not until the first month following the month in which the advance notice period required hereunder ended. Upon the delivery of such Administrative Service Charge change notice, Addendum B attached hereto shall be deemed to be modified without any further action by the parties.

Section VI. Term and Termination

A. Term

1. Although executed on the dates shown below, this Agreement shall be effective as of 1/1/2025 (the "Effective Date") through 12/31/2027 (This time period shall be considered the "Initial Term").

2. This Agreement may be renewed for successive twelve (12) month periods beginning the first day following the expiration of the Initial Term and each anniversary of such date thereafter upon agreement of the parties. Such renewal periods shall be considered "Subsequent Agreement Periods."

B. Termination

1. Termination without cause. This Agreement may be terminated without cause by either

Party at the expiration of the Initial Term or any subsequent term with at least thirty (30) days written notice to the other Party in advance of such date. The Parties may also mutually agree in writing to terminate at any time.

2. Termination with Cause. Either Party has the right to terminate this Agreement upon at least 30 days' advance written notice of such termination to the other Party if the Party to whom such notice is given breaches any material provision of this Agreement. The Party claiming the right to terminate shall provide the facts underlying its claim of breach and cite the relevant sections of this Agreement that are claimed to have been breached. Remedy of such breach to the satisfaction of the other Party, within 30 days of the receipt of such notice, shall revive this Agreement for the remaining portion of its then-current term, subject to any other rights of termination contained in this Agreement.

C. Effect of Termination

1. Termination of this Agreement for whatever reason, shall not terminate the rights or liabilities of either Party arising out of a period prior to termination.

2. Ameritas will continue to process all claims received on or before the date the Agreement is terminated. Upon request, and with appropriate guarantees of funding and agreement to Administrative Service Charges from Plan Sponsor, Ameritas will, for a period of ninety (90) days subsequent to the date of termination of this Agreement, continue to process those standard claims containing expenses for services performed prior to the date of termination of this Agreement which claims are received during said ninety (90) day period. At the expiration of said ninety (90) day period, Ameritas will cease all claim processing in accordance with (3) hereof.

3. Plan Sponsor agrees to reimburse Ameritas in the same manner as provided for in accordance with Section IV. B., for benefit payments made subsequent to the date of termination until all payments made by Ameritas have been reimbursed by Plan Sponsor.

Section VII. General Provisions

A. Plan Administration

1. The Plan Sponsor is the fiduciary with respect to the management, and administration of the Plan and Ameritas does not insure or underwrite the liability of the Plan Sponsor under the Plan. Ameritas shall not have discretionary authority or control over plan management or disposition of assets of the Plan (including final claim decisions). In no event shall Ameritas be responsible for Plan Sponsor's compliance with the requirements of ERISA or PHSA if applicable. Ameritas shall not be responsible for complying with the provisions of any federal or state laws and regulations pertaining to the Plan and Plan administration (except as to its non-fiduciary administrative functions regarding processing claims and customer claims service). The Plan Sponsor has final complete discretion to construe or interpret the provisions of the Plan, to determine eligibility for benefits from the Plan, to determine the type and extent of benefits, to be provided by the Plan, and to make final claims decisions under the Plan. Plan Sponsor's decisions in such matters shall be controlling, binding, and final. By this Agreement, Plan Sponsor is delegating to Ameritas

such authority as is necessary to process or otherwise resolve undisputed claims, eligibility questions, or other matters governed by this Agreement, but the Plan Sponsor reserves ultimate authority with respect to those and all other aspects of the Plan.

2. Ameritas shall have no responsibility to provide Summary Plan Descriptions or other disclosures required under the PHSA; comply with COBRA or state continuation of coverage requirements; or to comply with HIPAA portability requirements. If such obligations exist, they shall be the sole responsibility of Plan Sponsor and not the responsibility of Ameritas.

B. Indemnification

1. General Indemnity. Subject to the limitations on liability contained in Section VII.B.2, below, each Party ("Indemnitor") shall indemnify and hold the other Party harmless from and against any and all claims, suits, liabilities, obligations, damages and expenses (including reasonable attorneys' fees and expenses of litigation) arising out of either Indemnitor's (or Indemnitor's agent, employee, subcontractor, or Designee) performance or failure to perform in accordance with the terms of this Agreement or any negligence or willful misconduct of any kind on the part of Indemnitor. Ameritas or Plan Sponsor, as applicable, shall reasonably cooperate with the indemnifying Party in connection with the indemnifying Party's obligations under this section.

2. Limitation of Liability. Except for breach by either Party of Sections VII. C. or D., below, neither Party shall be liable to the other for any indirect, special, incidental, exemplary, reliance, punitive or consequential damages arising out of or related to this agreement, even if advised of the possibility thereof.

3. Survival. The provisions of this Section VII. B. shall survive the expiration or termination of the Agreement.

C. Proprietary Interest

Plan Sponsor acknowledges that the claims paying, administration and eligibility systems employed by Ameritas and, if applicable, the Ameritas PPO Network and the listing of the dental providers participating therein, have been developed by Ameritas and that Ameritas has a proprietary interest therein. Plan Sponsor further agrees that at no time shall Plan Sponsor or any of its employees use such other than for the intended purposes of this Agreement.

D. Confidentiality and Privacy

Except as otherwise provided in this Agreement, all information communicated to one Party by the other Party, whether before or after the Effective Date of this Agreement, was and shall be, to the extent permitted by law, received in confidence and shall be used only for purposes of this Agreement. No such information, including without limitation the provisions of this Agreement, shall be disclosed by the recipient Party to other persons including its own employees, except as may be necessary by reason of legal, accounting, regulatory or administrative requirements under this Agreement. The Parties further agree to comply with all applicable laws respecting privacy and security, including HIPAA, and agree to abide by the HIPAA Business Associate Addendum, which is incorporated herein and attached hereto

as Addendum E. The provisions of such Business Associate Addendum shall control as to all matters falling within the scope of such Business Associate Addendum.

E. Examination of Records

Each Party shall have the right to examine any records of the other relating to the other Party's obligations under this Agreement provided, however, such examination shall take place on a regular working day in a manner agreed to between the Parties and in a manner designed to protect the confidentiality of an individual's medical information. The cost of any such examination shall be borne by the Party requesting the examination.

F. Entire Agreement, Amendments, May be signed in Counterparts, Notices

This Agreement and attached Addendums, shall constitute the entire agreement between the Parties and all prior oral agreements shall be merged into this written Agreement. This Agreement may be amended from time to time by written agreement between the Parties. The Parties may execute this Agreement in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The Parties may provide notice to each other as follows:

In the case of Ameritas:

Ameritas Life Insurance Corp.
5900 O Street
P.O. Box 81889
Lincoln, Nebraska 68501-1889
Attn: Group Department

In the case of Plan Sponsor:

NEVADA COUNTY
950 MAIDU AVE STE 260
NEVADA CITY, NV 95959
ATTN:

Plan Sponsor and Ameritas have caused this Agreement to be executed on the dates set forth below.

AMERITAS LIFE INSURANCE CORP.	**NEVADA COUNTY**
By: _____	By: _____
Bruce E. Mieth, Ph.D.	Print: _____
Senior Vice President – Group Operations	Title: _____
Date:	Date: _____

Addendum A

Plan Booklet

[See attached]

ADDENDUM A

GROUP DENTAL PLAN

NEVADA COUNTY

Plan Number: 10-302140

Administered by:

Ameritas Life Insurance Corp.

Non-Insurance Products/Services

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

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

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

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

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	Eligible Employee Enrolled In The Dental Plan

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1, Type 2, Type 3, and Type 4 Procedures	$0

Benefit Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	100%
Type 3 Procedures	80%
Type 4 Procedures	50%

Maximum Amount - Each Benefit Period	$2,500

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Benefit Percentage	50%
Maximum Benefit During Lifetime	$2,500

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on December 31, 2024 and
b. on January 1, 2025 is both:

   i. covered under the plan, and

   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.

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

a. the normal benefit payable under the plan 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 9260.

MATERNITY DENTAL BENEFIT

Covered Members who meet the requirements for the ELIGIBLE CLASS FOR MEMBERS, found on the CONDITIONS FOR COVERAGE, page 9070, and who are pregnant at the time of receiving the procedure described below and who return a completed Maternity Benefit Disclosure form are eligible to receive this benefit. The Maternity Benefit Disclosure form may be obtained by contacting us or the Planholder.

For those Covered Members who satisfy the requirements listed above, Covered Expenses include one additional cleaning and/or exam for the corresponding Benefit Period. All plan provisions and limitations apply during this Benefit Period, including but not limited to: The Plan's Annual Maximum, Benefit Percentage, Deductibles, and services for which the patient would not be liable in the absence of coverage. Covered Expenses under this benefit include those cleaning and/or exam procedures listed in the Table of Dental Procedures.

DEFINITIONS

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

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for coverage by completing the eligibility period, if any; and

c. for whom the coverage has become effective.

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

DEPENDENT refers to:

a. a Member's spouse or Domestic Partner.

b. each child less than 26 years of age, for whom the Member, the Member's spouse, or the Member's Domestic Partner, is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

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

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while covered as a dependent under b. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the

child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Member's Dependent as:

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

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

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

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

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

LATE ENTRANT refers to any person:

a. whose Effective Date of coverage is more than 31 days from the date the person becomes eligible for coverage; or

b. who has elected to become covered again after canceling a fee contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is January 1, 2025. The effective date of coverage for a Member is shown in the Planholder's records.

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

CONDITIONS FOR COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Coverage is any eligible employee enrolled in the dental plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

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

ELIGIBLE CLASS FOR DEPENDENT COVERAGE. Each Member of the eligible class for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any eligible employee enrolled in the dental plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

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

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

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is required to contribute to the payment of coverage fees for his or her dependents.

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

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

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

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur on the first of the month falling on or first following the date of employment.

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

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

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

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

1. the date on which the Member qualifies for coverage, if the Member agrees to contribute on or before that date.

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

3. the date we accept the Member and/or Dependent for coverage when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

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

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

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

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group plan for dental expenses incurred by a Member. A Covered person has the freedom of choice to receive treatment from any Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan.

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

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

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

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

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

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

1. in the first 12 months that a person is covered if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. a. 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 covered person is covered under this plan. 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 person is covered on January 1, 2025. For those Members covered on January 1, 2025, see b.

    b. Limitation a. will be waived for those Insureds whose coverage was effective on January 1, 2025 and

        i. the person has the tooth extracted while covered under the prior contract: and

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

        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.

3. for appliances, restorations, or procedures to:

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

4. for any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this Plan terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

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

10. for charges which the Covered person is not liable or which would not have been made had no coverage been in force.

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

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

TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is covered, 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 dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Radiographic images, 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 Member.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

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

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC

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

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

OTHER XRAYS

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

PERIAPICAL: D0220, D0230

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

BITEWINGS

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

BITEWINGS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWINGS: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

TYPE 1 PROCEDURES

D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

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

PROPHYLAXIS: D1110, D1120

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

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

An additional D1110 may be allowed if service is received during pregnancy.

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

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

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

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

SEALANTS AND CARIES MEDICAMENTS

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

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per 2 year(s).

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

Benefits are considered for persons age 15 and under.

Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).

Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

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

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

Benefits are considered for persons age 13 and under.

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

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

LIMITED ORAL EVALUATION: D0140, D0170

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

Coverage is limited to 1 examination per biopsy/excision.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)
- D2330 Resin-based composite - one surface, anterior.
- D2331 Resin-based composite - two surfaces, anterior.
- D2332 Resin-based composite - three surfaces, anterior.
- D2335 Resin-based composite - four or more surfaces (anterior).
- D2391 Resin-based composite - one surface, posterior.
- D2392 Resin-based composite - two surfaces, posterior.
- D2393 Resin-based composite - three surfaces, posterior.
- D2394 Resin-based composite - four or more surfaces, posterior.
- D2410 Gold foil - one surface.
- D2420 Gold foil - two surfaces.
- D2430 Gold foil - three surfaces.
- D2990 Resin infiltration of incipient smooth surface lesions.

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

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

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

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.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.

TYPE 2 PROCEDURES

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, D2928, D2929, D2930, D2931, D2932, D2933, D2934

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

RECEMENT

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

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.
D2991 Application of hydroxyapatite regeneration medicament - per tooth.

ENDODONTICS MISCELLANEOUS

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

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

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

SURGICAL PERIODONTICS

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

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

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

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

TYPE 2 PROCEDURES

Coverage is limited to treatment of periodontal disease.

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.

ANTIMICROBIAL AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

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

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).
An additional D4355 may be allowed if service is received during pregnancy.

PERIODONTAL MAINTENANCE

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

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.
D1110, D1120, also contribute(s) to this limitation.
An additional D4910 may be allowed if service is received during pregnancy.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

NON-SURGICAL EXTRACTIONS

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

SURGICAL EXTRACTIONS

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

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

TYPE 2 PROCEDURES

D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7509 Marsupialization of odontogenic cyst.
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.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

PALLIATIVE

D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.

TYPE 2 PROCEDURES

D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

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 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.

THERAPEUTIC DRUG

D9610 Therapeutic parenteral drug, single administration.

D9612 Therapeutic parenteral drugs, two or more administrations, different medications.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.

D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

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

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

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

DESENSITIZATION: D9911

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

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

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

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
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, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
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.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.

TYPE 3 PROCEDURES

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

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

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

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

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

POST AND CORE

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

FIXED CROWN AND PARTIAL DENTURE REPAIR

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

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

IMPLANTS

D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim implant abutment placement.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
D6191 Semi-precision abutment-placement.
D6192 Semi-precision attachment-placement.

IMPLANT: D6010, D6040, D6050

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

D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

TYPE 3 PROCEDURES

Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES

D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6089 Accessing and retorquing loose implant screw - per screw.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Surgical removal of implant body.
D6105 Removal of implant body not requiring bone removal nor flap elevation.
D6190 Radiographic/surgical implant index, by report.
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.
D6198 Remove interim implant component.

IMPLANT SERVICES: D6080, D6081, D6089, D6090, D6091, D6095, D6096, D6100, D6105, D6190, D6197, D6198

Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period. Coverage for D6089, D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D6106 Guided tissue regeneration - resorbable barrier, per implant.
D6107 Guided tissue regeneration - non-resorbable barrier, per implant.
D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.
D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site.
D7957 Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.

BONE AUGMENTATION: D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956, D7957

Each quadrant is limited to 1 of any of these procedures per 5 year(s).
Coverage of D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956 and D7957 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

TYPE 4 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

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 retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
D5228 Immediate mandibular partial denture-flexible base(including any clasps, rests and teeth).
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
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 (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

TYPE 4 PROCEDURES

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D6010, D6040, D6050, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
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.

DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.
D5725 Rebase hybrid prosthesis.

DENTURE RELINES

D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
D5765 Soft liner for complete or partial removable denture-indirect.

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

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

TISSUE CONDITIONING

TYPE 4 PROCEDURES

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 crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
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 FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.
D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
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 and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
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.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.

TYPE 4 PROCEDURES

D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

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

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

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

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

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

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

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

TYPE 4 PROCEDURES

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

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the plan for orthodontic expenses incurred by a Member.

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 Benefit 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 Covered 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 a Member 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 covered under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

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

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

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

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

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

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

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

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

1. for a Program begun before the Member became covered under this section, unless the Member was covered for Orthodontic Expense Benefits under the prior carrier on December 31, 2024 and are both:

    a. member under this plan; and
    b. currently undergoing a Treatment Program on January 1, 2025.

2. in the first 12 months that a person is covered if the person is a Late Entrant.

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

4. if the Member's coverage under this section terminates.

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

6. for charges the Member is not legally required to pay or would not have been made had no coverage been in force.

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

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

9. to replace lost, missing, or stolen orthodontic appliances.

COORDINATION OF BENEFITS

This section applies if a covered person has dental coverage under more than one Plan definition below. All benefits provided under this plan are subject to this section.

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

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

DEFINITIONS. The following apply only to this provision of the plan.

1. "Plan" refers to the group plan and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide dental coverage.

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

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

1. Release any information with respect to your coverage and benefits under the plan; and

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

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

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

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

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

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

PAYMENT OF BENEFITS. All benefits will be paid to the Member unless otherwise agreed upon through your authorization or Provider contracts.

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

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

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

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

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

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

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

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

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

GROUP EYE CARE PLAN

NEVADA COUNTY

Plan Number: 10-302140

Administered by:

Ameritas Life Insurance Corp.

Non-Insurance Products/Services

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

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

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

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 2	Eligible Employee Enrolled In The Vision Plan

EYE CARE EXPENSE BENEFITS

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

Deductible Amount:	
When a Participating Provider is used:	
Exams - Each Benefit Period	$10
Contact Lens Fitting and Evaluation - Each Benefit Period	$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$0
When a Non-Participating Provider is used:	
Exams - Each Benefit Period	$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$0

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

DEFINITIONS

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

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for coverage by completing the eligibility period, if any; and

c. for whom the coverage has become effective.

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

DEPENDENT refers to:

a. a Member's spouse or Domestic Partner.

b. each child less than 26 years of age, for whom the Member, the Member's spouse, or the Member's Domestic Partner, is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

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

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while covered as a dependent under b. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the

child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Member's Dependent as:

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

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

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

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

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

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is January 1, 2025. The effective date of coverage for a Member is shown in the Planholder's records.

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

CONDITIONS FOR COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Coverage is any eligible employee enrolled in the vision plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

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

ELIGIBLE CLASS FOR DEPENDENT COVERAGE. Each Member of the eligible class for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any eligible employee enrolled in the vision plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

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

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

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is required to contribute to the payment of coverage fees for his or her dependents.

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

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

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

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur on the first of the month falling on or first following the date of employment.

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

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

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

1. the date on which the Member qualifies for coverage, if the Member agrees to contribute on or before that date.

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

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

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

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

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

EYE CARE EXPENSE BENEFITS

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

COVERED EXPENSES
Covered Expenses include the lesser of:

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

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

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

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

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

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

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

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

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

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

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

LIMITATIONS
This plan has the following limitation:

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

EXCLUSIONS
This plan does not cover:

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

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

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

Two pairs of glasses in lieu of Bifocals,

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

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

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

Contact Lens plans or service contracts,

Additional office visits associated with contact lens pathology,

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

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

SCHEDULE OF EYE CARE SERVICES

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

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 50.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 75.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $100.00
Lenticular	Once every 12 months	Covered in Full	Up to $125.00
Frames			
Single Frame%	Once every 12 months	Up to $300.00	Up to $ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to $120.00	Up to $105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

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

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

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

%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.

COORDINATION OF BENEFITS

This section applies if a covered person has eye care coverage under more than one Plan definition below. All benefits provided under this plan are subject to this section.

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

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

DEFINITIONS. The following apply only to this provision of the plan.

1. "Plan" refers to the group plan and any of the following plans, whether insured or uninsured, providing benefits for eye care services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide eye care coverage.

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

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

1. Release any information with respect to your coverage and benefits under the plan; and

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

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

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

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

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

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

PAYMENT OF BENEFITS. All benefits will be paid to the Member unless otherwise agreed upon through your authorization or Provider contracts.

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

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

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

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

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

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

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

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

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

Addendum B - Administrative Service Charges

Administrative Service Charges

The Administrative Service Charges from Effective Date through 12/31/2027

$7.75 per Covered Persons per month for Dental
$3.60 per Covered Persons per month for Eye Care

Fees shown above are based on the services outlined in Section II. Services to be Provided by Ameritas.

Addendum C - Intentionally Omitted

Addendum D - Summary of Reports

Weekly Reports
- Dental Paid/Denied Claims Report

Monthly Reports
- Fees List Bill
- Eye Care Paid/Denied Claims Report

Annual Reports
- Experience Detail Report
- Customer Reporting Package
  - Claim Payment Summary
  - Claim Payment Breakdown by Procedure Type
  - Claim Summary – PPO vs. Non-PPO
  - Claim Payment analysis by Procedure Group
  - Claim Payment analysis by Category within Procedure Group
  - Claims Savings Categories
  - Claims Savings Categories – PPO
  - Claims Savings Categories – Non-PPO
  - PPO Savings Illustration

Fees include this reporting package. Deviations from these reports and/or frequency will be priced accordingly.

ADDENDUM E
HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("BAA") supplements and is made a part of the Administrative Services Agreement ("Service Agreement") by and between Ameritas ("Business Associate") and the party identified in the Service Agreement above ("Covered Entity"). Covered Entity and Business Associate shall be collectively referred to herein as the ("Parties").

RECITALS

A. Covered Entity and Business Associate have entered or may enter into one or more services agreements (collectively the "Service Agreement") pursuant to which Business Associate is or will be providing those certain agreed upon services for and on behalf of Covered Entity, some of which may involve Business Associate's use, disclosure or creation of Protected Health Information.

B. Covered Entity and Business Associate intend to protect the privacy and provide for the security of Protected Health Information received, created, used, and disclosed to or by Business Associate pursuant to the Service Agreement in compliance with HIPAA and HITECH (each as defined below).

C. As part of the HIPAA and HITECH, the Standards for Privacy and the Standards for Security of Individually Identifiable Health Information codified at 45 CFR Parts 160, 162 and 164 require Covered Entity to enter into a contract with Business Associate that includes and imposes on Business Associate specific duties, obligations and requirements with respect to Business Associate's use, disclosure, creation and general handling of Protected Health Information, as set forth in, but not limited to, Title 45, §§ 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR") and as otherwise provided in this BAA.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the Parties agree as follows:

1) Definitions.

a) Specific Definitions.

i) "Breach" shall have the meaning given to such term under the Privacy Rule, at 45 CFR § 164.402.

ii) "Business Associate" shall have the meaning set forth above.

iii) "Compliance Date" shall mean, in each case, the date by which compliance with a particular provision is required under HITECH; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

iv) "Covered Entity" shall have the meaning set forth above.

v) "Data Aggregation" shall have the meaning given to such term under the Privacy Rule at

45 CFR § 164.501.

vi) "Designated Record Set" shall have the meaning given to such term under the Privacy Rule, at 45 CFR § 164.501.

vii) "Electronic Health Record" shall have the meaning given to such term in 42 USC 17921(5).

viii) "Electronic Media" has the meaning in CFR §160.103, which is:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable or transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet, leased lines, dialup lines, private networks, and the physical movement of removable or transportable electronic storage media. Certain transmissions, including paper, via facsimile, and via telephone, are not considered transmissions via electronic media because the information did not exist in electronic form before the transmission.

ix) "Electronic Protected Health Information" (or "EPHI") has the meaning of 45 CFR § 160.103 and is defined as protected health information contained in or transmitted on electronic media received from us or created or received on behalf of us.

x) "Health Care Operations" shall have the meaning given to such term under the Privacy Rule at 45 CFR 164.501.

xi) "HIPAA" shall mean the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d through 1320d-8, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

xii) "HITECH" shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act (a.k.a. the ''HITECH Act'') provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§17921-17954, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

xiii) "Individual" shall mean the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with the Privacy Rule.

xiv) "Privacy Rule" shall mean the standard for Privacy of Individually Identifiable Health Information codified at 45 CFR Parts 160 and 164.

xv) "Protected Health Information" ("PHI") has the meaning in 45 CFR § 164.304.

xvi) "Required by Law" shall mean a mandate contained in law that compels a covered entity to make a use or disclosure of PHI and that is enforceable in a court of law.

xvii) "Security Rule" shall mean the standard for Security of Individually Identifiable Health Information codified at 45 CFR Parts 160, 162 and 164.

xviii) "Security Incident" has the meaning in 45 CFR § 164.304, which is the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

xix) "Subcontractor" shall have the meaning given to such term at 45 CFR § 160.103 and includes any agent/agency relationships.

xx) "Unsecured Protected Health Information" (or "unsecured PHI") shall mean Protected Health Information has the meaning as set forth in 45 C.F.R. 164. 402.that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the regulations or guidance issued pursuant to 42 U.S.C. §§17932(h)(2).

xxi) "Unsuccessful Security Incident" shall mean, without limitation, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, disclosure, modification or destruction of PHI or intentional interference with system operations in an information system that contains PHI.

b) Catch-all Definition. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy Rule and Security Rule.

2) Obligations of Business Associate.

a) Permitted Uses. Business Associate shall not use PHI except for the purpose of performing Business Associate's obligations under the Service Agreement and as permitted or required by this BAA. Further, Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule if so used by Covered Entity. However, Business Associate may (i) use PHI for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate, and (ii) provide Data Aggregation services relating to the health care operations of Covered Entity if such services are provided by Business Associate to Covered Entity under the Service Agreement.

b) Permitted Disclosures. Business Associate shall not disclose PHI in any manner that would constitute a violation of HITECH and HIPAA (including without limitation the Privacy Rule) if disclosed by Covered Entity. However, Business Associate may disclose PHI in a manner permitted pursuant to the Service Agreement, for the proper management and administration of Business Associate; and as required by law. Additionally, Business Associate may disclose PHI in a manner allowed by law if Covered Entity specifically authorizes the disclosure. In no event shall Business Associate be permitted to receive remuneration, either directly or indirectly, in exchange for PHI, except as may be approved by Covered Entity in its sole discretion and then, only to the extent permitted by 42 U.S.C. § 17935(d). To the extent that Business Associate discloses PHI to a third party, Business Associate must prior to making any such disclosure obtain, (i) reasonable assurances from such third party that such PHI will be held confidential as provided pursuant to this BAA and only disclosed as required by law or

for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

c) Appropriate Safeguards.

i) Business Associate will comply with all applicable federal and states laws and regulations and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule and as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316;

ii) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate safeguards to protect it; and

iii) Business Associate will report to Covered Entity as soon as reasonably practicable (i) any use or disclosure of protected health information not provided for by this BAA of which it becomes aware in accordance with 45 C.F.R. § 164.504(e)(2)(ii)(C); and/or (ii) any security incident affecting EPHI of which Business Associate becomes aware in accordance with 45 C.F.R. § 164.314(a)(2)(C) provided, however, that the Parties acknowledge and agree that this Section constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of Unsuccessful Security Incidents for which no additional notice to Ameritas shall be required; and

iv) Business Associate agrees to promptly report to Covered Entity any Breach of which it becomes aware as soon as reasonably practicable following Business Associate's discovery of any Breach involving Covered Entity's unsecured PHI. The foregoing report shall include identification of each Individual whose PHI Business Associate reasonably believes to have been accessed, acquired, or disclosed during such Breach. As soon as possible thereafter, and to the extent known, Business Associate shall also provide Covered Entity with a description of (i) what happened, including the date of the Breach and the date of the discovery, (ii) the types of unsecured PHI involved in the Breach, (iii) any steps individuals should take to protect themselves from potential harm from the Breach, and (iv) what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

d) Restrictions on Disclosures. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within ten (10) business days.

e) Subcontractors. Business Associate shall ensure that any Subcontractor, to whom it provides PHI agree in writing to the same or substantially similar restrictions and conditions that apply to Business Associate with respect to such PHI. Business Associate will advise Covered Entity if any such Subcontractor breaches its agreement with Business Associate with respect to the disclosure or use of Covered Entity's Protected Health Information or EPHI.

f) Access to Protected Information. Business Associate shall make PHI maintained by Business Associate or its agents or subcontractors in Designated Record Sets available to Covered Entity for inspection and copying to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to 45 CFR Section 164.524.

g) Amendment of PHI. Upon receipt of a request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, Business Associate or its agents or subcontractors shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of PHI directly from Business Associate or its agents or subcontractors, Business Associate shall notify Covered Entity in writing within ten (10) days of the request. Any decision to deny the requested amendment of PHI maintained by Business Associate or its agents or subcontractors shall be the sole responsibility of Covered Entity.

h) Accounting Rights. Upon request for an accounting of disclosures of PHI from Covered Entity, Business Associate and its agents or subcontractors shall make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.528. As set forth in, and as limited by, 45 CFR section 164.528, Business Associate shall not provide an accounting to Covered Entity of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR Section 164.502; (ii) to individuals of PHI about them as set forth in 45 CFR 164.502; (iii) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR Section 164.510; (iv) for national security or intelligence purposes as set forth in 45 CFR Section 164.512(k)(2); or (v) to correctional institutions or law enforcement officials as set forth in 45 CFR Section 164.512(k)(5). Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the Privacy rule. In the event that the request for an accounting is delivered directly to Business Associate or its agents or subcontractors, Business Associate shall forward it to Covered Entity. It shall be Covered Entity's responsibility to prepare and deliver any such accounting requested. Business Associate shall not disclose any PHI except as set forth in Sections 2(b) of this BAA.

i) Governmental Access to Records. If requested, Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining Covered Entity's compliance with Privacy Rule in accordance with 45 CFR 164.504(e)(ii)(I).

j) Minimum Necessary. Business Associate (and its agents and subcontractors) shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure and consistent with Covered Entity's minimum necessary policies and procedures.

k) Data Ownership. Business Associate acknowledges that Business Associate has no ownership rights with respect to the PHI.

l) Retention of PHI. Upon termination of the Service Agreement for any reason, Business Associate shall return or destroy all PHI that Business Associate or its agents or subcontractors still maintain in any form and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall continue to extend the legally required protections of this BAA to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. If Business Associate elects to destroy the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

m) Electronic Health Record. In the event that Business Associate in connection with rendering the services under the Service Agreement uses or maintains an Electronic Health Record of PHI of or about an individual, the Business Associate will provide an electronic copy of such PHI in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date. Moreover, in the event that Business Associate uses or maintains an Electronic Health Record of PHI of or about an individual, then Business Associate shall make an accounting of disclosures of such PHI in accordance with the requirements for accounting of disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), as of its Compliance Date.

n) Business Associate will not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

o) Business Associate will not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

p) Pursuant to the Privacy Rule, made applicable to Business Associate by HITECH, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity.

q) Pursuant to the Security Rule, made applicable to Business Associate by HITECH, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity.

3) Obligations of Covered Entity.

a) Covered Entity shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate pursuant to this BAA, in accordance with the Covered Entity and requirements of the Privacy Rule, until such PHI is received by Business Associate.

b) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

c) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate’s use or disclosure of PHI.

d) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

4) Term and Termination.

   a) Term. This BAA shall be effective as of the effective date of the underlying Service Agreement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provision in this section.

   b) Material Breach. A breach by Business Associate of any provision of this BAA, as determined by Covered Entity, shall constitute a material breach of the Service Agreement and shall provide grounds for immediate termination of the Service Agreement by Covered Entity pursuant to the Service Agreement.

   c) Reasonable Steps to Cure Breach. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under the provisions of this BAA or another arrangement and does not terminate the Service Agreement pursuant to Section 4 (b), then Covered Entity shall take reasonable steps to cure such breach or end such violation, as applicable. If Covered Entity's efforts to cure such breach or end such violation are unsuccessful, Covered Entity shall either (i) terminate the Service Agreement, if feasible, or (ii) if termination of the Service Agreement is not feasible, Covered Entity shall report Business Associate's breach or violation to the Secretary of the Department of Health and Human Services.

   d) Judicial or Administrative Proceedings. Either party may terminate the Service Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, HITECH or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any requirement of HIPAA, HITECH or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5) Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with this BAA, HIPAA or HITECH will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

6) Certifications. To the extent Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligations pursuant to HIPAA and HITECH relating to certification of its security practices, Covered Entity or its authorized agents or contractors, may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, HITECH or this BAA.

7) Amendment to Comply with Law. The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this BAA may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the amendments and requirements of HIPAA (including without limitation the Privacy Rule), HITECH and other applicable laws relating to the security or confidentiality of PHI. The Parties understand and agree that Covered Entity must

receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all PHI. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the amendments and requirements of HIPAA (including without limitation the Privacy rule), HITECH or other applicable laws. Covered Entity may terminate the Service Agreement upon thirty (30) days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BAA when requested by Covered Entity pursuant to this Section or (ii) Business Associate does not enter into an amendment to this BAA providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the Covered Entity and requirements of HIPAA, including without limitation the Privacy Rule, and HITECH.

8) Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under the Service Agreement, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity, its directors, officers or employers based upon a claimed violation of HIPAA, including without limitation the Privacy Rule, HITECH or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

9) No Third-Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

10) Effect on Agreement. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Service Agreement shall remain in force and effect.

11) Indemnification. In addition to any indemnification obligations, which are a part of the Service Agreement, the Business Associate hereby indemnifies and agrees to hold the Covered Entity harmless against any and all claims, liabilities, obligations, costs or damage, including Civil Monetary Penalties, arising from a breach by the Business Associate of its obligations in connection with this BAA or HITECH, or HIPAA.

12) Interpretation. This BAA shall be interpreted as broadly as necessary to implement and comply with HIPAA and HITECH. The Parties agree that any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA and HITECH in light of any interpretation and/or guidance on HIPAA, the Privacy Regulation and/or the Security Regulation issued by HHS from time to time.

13) Counterparts; Facsimiles. This BAA may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

14) Disputes. If any controversy, dispute or claim arises between the Parties with respect to this BAA, the Parties shall make good faith efforts to resolve such matters informally.

Addendum F
INSURANCE REQUIREMENTS

Insurance. Ameritas ("Contractor") shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder and the results of that work by the Contractor, its agents, representatives, employees, or subcontractors. Coverage shall be at least as broad as:

(i) **Commercial General Liability** CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury, and personal & advertising injury with limits no less than **$2,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

(ii) **Automobile Liability** Insurance Services Office Form Number CA 00 01 covering any auto (Code 1), or if Contractor has no owned autos, hired, (Code 8) and non-owned autos (Code 9), with limit no less than **$1,000,000** per accident for bodily injury and property damage.

(iii) **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$1,000,000** per accident for bodily injury or disease.
CONTRACTOR AFFIRMS UNDER PENALTY OF PERJURY THEY ARE INDEPENDENT AND WITHOUT EMPLOYEES. CONTRACTOR AFFIRMS THEY CARRY HEALTH INSURANCE POLICY, HEALTHCARE SERVICE PLAN, OR DISABILITY INSURANCE COVERING CONTRACTOR FOR BODILY INJURY OR DISEASE. CONTRACTOR FURTHER AGREES TO WAIVE ALL RIGTHS TO WORKERS' COMPENSATION BENEFITS FOR ANY ACCIDENT FOR BODILY INJURY OR DISEASE. CONTRACTOR HEREBY GRANTS TO COUNTY A WAIVER OF ANY RIGHT TO SUBROGATION WHICH ANY INSURER OF SAID CONTRACTOR MAY ACQUIRE AGAINST THE COUNTY BY VIRTUE OF THE PAYMENT OF ANY LOSS UNDER SUCH INSURANCE.

(iv) **Professional Liability** (Errors and Omissions) Insurance appropriate to the Contractor's profession, with limit no less than **$2,000,000** per occurrence or claim, **$2,000,000** aggregate.

(v) **Cyber Liability** Insurance, with limit not less than **$2,000,000** per occurrence or claim, **$2,000,000** aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Contractor in this Contract and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.

If the Contractor maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or the higher limits maintained by the contractor. Any available insurance proceeds more

than the specified minimum limits of insurance and coverage shall be available to the County.

Other Insurance Provisions: The insurance policies are to contain, or be endorsed to contain, the following provisions:

(i) **Additional Insured Status: The County, its officers, employees, agents, and volunteers are to be covered as additional insureds** on the CGL policy with respect to liability arising out of the work or operations performed by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10 or if not available. through the addition of **both** CG 20 10, CG 20 25, CG 20 33, or CG 20 38; **and** CG 20 37 forms if later revisions used.)

(ii) **Primary Coverage** For any claims related to this contract, the **Contractor's insurance shall be primary** insurance primary coverage at least as broad as ISO CG 20 01 04 13 as respects the County, its officers, employees, agents, and volunteers. Any insurance or self-insurance maintained by the County, its officers, employees, agents, and volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

(iii) **Umbrella or Excess Policy:** The Contractor may use Umbrella or Excess Policies to provide the liability limits as required in this agreement. This form of insurance will be acceptable if all the Primary and Umbrella or Excess Policies shall provide all the insurance coverages herein required, including, but not limited to, primary and non-contributory, additional insured, Self-Insured Retentions (SIRs), indemnity, and defense requirements. Umbrella or Excess policies shall be provided on a true "following form" or broader coverage basis, with coverage at least as broad as provided on the underlying Commercial General Liability insurance. No insurance policies maintained by the Additional Insureds, whether primary or excess, and which also apply to a loss covered hereunder, shall be called upon to contribute to a loss until the Contractor's primary and excess liability policies are exhausted.

(iv) **Notice of Cancellation** This policy shall not be changed without first giving thirty (30) days prior written notice and ten (10) days prior written notice of cancellation for non-payment of premium to the County of Nevada.

(v) **Waiver of Subrogation** Contractor hereby grants to County a waiver of any right to subrogation which any insurer of said Contractor may acquire against the County by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether the County has received a waiver of subrogation endorsement from the insurer.

(vi) **Sole Proprietors** If Contractor is a Sole Proprietor and has no employees, they are not required to have Workers Compensation coverage. Contractor shall sign a statement attesting to this condition, and shall agree they have no rights, entitlements or claim against County for any type of employment benefits or workers' compensation or other programs afforded to County employees.

(vii) **Self-Insured Retentions** must be declared to and approved by the County. The County may require the Contractor to provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention. The Policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County. The CGL and any policies, including Excess liability policies, may not be subject to a self-insured retention (SIR) or deductible that exceeds **$25,000** unless approved in writing by the County. All deductibles and SIRs shall be the sole responsibility of the Contractor or subcontractor who procured

such insurance and shall not apply to the Indemnified Additional Insured Parties. County may deduct from any amounts otherwise due Contractor to fund the SIR/deductible. Policies shall NOT contain any self-insured retention (SIR) provision that limits the satisfaction of the SIR to the Named. The policy must also provide that Defense costs, including the Allocated Loss Adjustment Expenses, will satisfy the SIR or deductible. County reserves the right to obtain a copy of any policies and endorsements for verification.

(viii) **Acceptability of Insurers:** Insurance is to be placed with insurers authorized to conduct business in the state with a current A.M. Best's rating of no less than A: VII, unless otherwise acceptable to the County.

(ix) **Claims Made Policies** if any of the required policies provide coverage on a claims-made basis: ***(note – should be applicable only to professional liability)***

a. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
b. Insurance must be maintained, and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.
c. If the coverage is canceled or non-renewed, and not replaced with another **claims-made policy form with a Retroactive Date**, prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of **five (5)** years after completion of contract work.

(x) **Verification of Coverage** Contractor shall furnish the County with original Certificates of Insurance including all required amendatory endorsements (or copies of the applicable policy language effecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements to County before work begins. However, failure to obtain and provide verification of the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

(xi) **Subcontractors** Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Contractor shall ensure that County is an additional insured on insurance required from subcontractors. For CGL coverage subcontractors shall provide coverage with a format at least as broad as CG 20 38 04 13.

(xii) **Special Risks or Circumstances** County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

(xiii) **Premium Payments** The insurance companies shall have no recourse against the COUNTY and funding agencies, its officers, and employees or any of them for payment of any premiums or assessments under any policy issued by a mutual insurance company.

(xiv) **Material Breach** Failure of the Contractor to maintain the insurance required by this agreement, or to comply with any of the requirements of this section, shall constitute a material breach of the entire agreement.

(xv) **Certificate Holder** the Certificate Holder on insurance certificates and related documents should read as follows:

County of Nevada
950 Maidu Ave.
Nevada City, CA 95959

Upon initial award of a contract to your firm, you may be instructed to send the actual documents to a County contact person for preliminary compliance review.

Certificates which amend or alter the coverage during the term of the contract, including updated certificates due to policy renewal, should be sent directly to Contract Administrator

INFORMATION TECHNOLOGY SECURITY EXHIBIT

This Information Technology Security Exhibit ("Exhibit") supplements and is made a part of the Administrative Services Agreement ("Service Agreement" or "Agreement") by and between Ameritas Life Insurance Corp. ("Ameritas" or "Contractor") and Nevada County ("County of Nevada" or "County"). In the event of any inconsistency or conflict with the Agreement (including the Business Associate Agreement attached thereto), the Agreement shall prevail.

1. Notification of Data Security Incident

For purposes of this section, "Data Security Incident" is defined as successful unauthorized access to the Contractor's business and/or business systems by a third party, which said access exposes County data or systems to unauthorized access, disclosure, or misuse. Data Security Incident shall not include Unsuccessful Security Incident (as that term is defined in the Business Associate Agreement). In the event of a Data Security Incident, Contractor must notify County **in writing as soon as possible after Contractor determines a Data Security Incident has occurred**. Notice should be made to all parties referenced in the "Notices" section of the Agreement. Notice under this section must include, to the extent known at the time, the date of incident, Contractor's locations which were affected, and County services or data affected. Failure to notify under this section is a material breach, and County may immediately terminate the Agreement for failure to comply.

2. Data Location

Contractor will not transmit, store or process (other than remote access, as provided in the following sentence) any County data, outside the United States, without the prior written approval of County of Nevada, not to be unreasonably withheld. Process, as used in the preceding sentence, excludes remote system access from a location outside the United States to a system located within the United States, in accordance with generally accepted industry security standards, such as National Institute of Standards Technology (NIST).

3. Data Encryption

1. The Contractor shall encrypt all non-public County data in transit regardless of the transit mechanism.
2. The Contractor shall encrypt all non-public County data at rest.
3. Encryption algorithms shall be AES-128 or better.

4. Cybersecurity Awareness and Training

The County maintains a robust Cybersecurity Awareness and Training program intended to assist employees and contractors with maintaining current knowledge of changing cybersecurity threats and countermeasures. Any contractor that is assigned a County network account will be assigned User Awareness training and must complete it within the time period it is assigned. Training completion progress is monitored by sponsor departments and non-compliant users may have their account suspended or restricted.

The County conducts email Phish testing on a regular basis to expose account holders to the types of potential threats. Contractor will maintain a Cybersecurity Awareness and Training program for training staff at a minimum of once a year. Contractor will maintain records of the program for review by the County when requested.