SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

P.O. Box 15645 • Las Vegas, Nevada 89114-5645

SHL Dental PPO – Individual Adult Only Coverage Agreement of Coverage

This Agreement of Coverage contains a Deductible.

This Agreement of Coverage ("AOC") describes your dental plan.

Sierra Health and Life Insurance Company, Inc. ("SHL"), a UnitedHealthcare Company, and the Subscriber have agreed to all of the terms of this AOC. It is part of the contract between SHL and the Subscriber. It may be terminated by SHL or the Subscriber with written notice.

This AOC and your attached Benefit Schedule tell you about your benefits, rights and duties as an SHL Insured. They also tell you about SHL's duties to you.

Your application form, Attachment A Benefit Schedule, this AOC and any amendments, Riders and endorsements to it are all part of your SHL membership package. Please read them carefully and keep them in a safe place. Please carefully review your AOC.

Words that are capitalized are defined in Section 12 - Glossary.

NOTICE: If upon examination of this Agreement of Coverage you are not satisfied, for any reason, you may return it within ten (10) days of its delivery, and request a full refund of the premium paid.

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The Department of Business and Industry

State of Nevada

NEVADA DIVISION OF INSURANCE

Telephone Numbers for Consumers of Healthcare

Hours of operation for the Division:

Monday through Friday from 8 a.m. until 5 p.m., Pacific Standard Time (PST)
The Division is closed during state holidays.

Contact information for the Division:

Carson City Office:
Phone: (775) 687-0700
Fax: (775) 687-0787
1818 East College Pkwy., Suite 103
Carson City, NV 89706

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
2501 East Sahara Ave., Suite 302
Las Vegas, NV 89104

The Division also provides a toll-free number for consumers residing outside of the above areas:

1-800-992-0900 Please listen to the greeting and select the appropriate prompt.

If you have any questions regarding your health care coverage, please contact SHL's Member Services Department at the following:

Address:

Sierra Health and Life Insurance Company, Inc.
Attn: Member Services Department
P.O. Box 15645
Las Vegas, NV 89114-5645

Phone:

1-800-888-2264

(Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time)

Agreement of Coverage

SECTION 1. Eligibility, Enrollment and Effective Date

Subscribers and Eligible Family Members who meet the following criteria are eligible for dental care coverage under this Plan.

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an Individual must:

- Meet the guidelines established in the SHL Individual PPO Enrollment Application.
- Complete and submit to SHL such applications, or forms that SHL may reasonably request.
- An adult age 19 and above.

Dependent. To be eligible to enroll as a Dependent, an individual must be one of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A registered Domestic Partner.
- An adult child age 19 and above (A child by birth. Adopted child. Stepchild).

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under the limiting age of 26.
- A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.
- A Dependent includes a Dependent child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below:

  a. The child must be covered as a Dependent under this Plan before reaching the limiting age, and proof of incapacity and dependency must be given to SHL by the Subscriber within thirty-one (31) days of the child reaching the limiting age; or

  b. The handicap started before the child reached the limiting age, but the Subscriber was covered by another health insurance carrier that covered the child as a handicapped Dependent prior to the Subscriber applying for coverage with SHL.

SHL may require proof of continuing incapacity and dependency, but not more often than once a year after the first two (2) years beyond the date when the child reaches the limiting age.

Evidence of any Court Order needed to prove eligibility must be given to SHL.

1.2 Who Is Not Eligible

The following individuals are not eligible for coverage:

- A foster child of the applicant or Subscriber.
- A child placed in the applicant's or Subscriber's home other than for adoption.
- A grandchild of the applicant or Subscriber.
- Any other individual not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give SHL written notice within thirty-one (31) days of changes which affect his Dependents' eligibility under this Plan. Changes include:

- Reaching the limiting age.
- Death.
- Divorce.

If the Subscriber fails to give notice which would have resulted in termination of coverage, SHL shall have the right to terminate coverage.

A Dependent's coverage terminates on the same day as the Subscriber.

1.4 Application

Eligible Individuals and Eligible Family Members must make application to SHL in order to have coverage under this Plan.

1. **Newly Eligible Family Members.** Any individual becoming a newly Eligible Family Member may apply for coverage under SHL by submitting to SHL the Application Form (or Membership Change Form) within thirty-one (31) days of the date on which the individual becomes eligible. An individual may become a newly Eligible Family Member as the result of:
   - A change in the Subscriber's marital or domestic partnership status.
   - Loss of eligibility under other dental coverage.

2. **Right to Deny Application.** SHL can deny membership to any person who:
   - At application, does not meet eligibility guidelines.
   - Fails to make a premium payment.

3. **Right to Deny Application for Renewal.** As a condition of renewal under this Plan, SHL may terminate a Subscriber and/or Dependent(s) who committed fraud upon SHL or misrepresented a material fact which affected his coverage under this Plan.

1.5 Effective Date of Coverage

Before coverage can become effective, SHL must receive and accept premium payments and an SHL Individual PPO Application Form for the person applying to be an Insured.

1. When the Enrollment Application Form is received, approved and applicable premium payments have been accepted by SHL the Effective Date is as follows:

   - Applications received will be reviewed for an effective date of the 1st of the month following the date the application is received.

2. If a court has ordered Subscriber to cover his or her legal spouse that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber makes application for the Dependent and pays any required premium. A copy of the court order must be given to SHL.

Subscriber must give SHL a copy of the certified marriage certificate or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

SHL may terminate coverage under this Plan at the times shown for any one (1) or more of the following reasons:

2.1 Termination by SHL

- If a Subscriber fails to make premium payments within thirty-one (31) days of the premium due date, coverage will be terminated on the first (1st) day of the month for which a premium was due and not received by SHL.
- With thirty (30) days written notice, if the Insured allows his or any other Insured's SHL Identification (ID) card to be used by any other person, or uses another person's card. The Insured will be liable to SHL for all costs incurred as a result of the misuse of the Insured's SHL ID card.
- Failure to maintain eligibility requirements as set forth in Section 1.
- If the Insured performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, SHL has the right to rescind coverage and declare coverage under the Plan null and void as of the original Effective Date of Coverage and refund any applicable premium. Thirty (30) days written notice shall be provided to the Insured prior to any rescission of coverage. The Insured has the right to appeal any such rescission.
- Except as specifically provided in Section 1.3, on the last day of the calendar month in which an Insured no longer meets the requirements of Section 1
- If the Insured fails to give written notice within thirty-one (31) days of the loss of eligibility, SHL will terminate coverage retroactively and refund any corresponding premium.
- When information provided to SHL in the application form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage. SHL shall have the right to retroactively increase past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by SHL within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to date.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under the Plan by written notice to SHL. Such termination is effective on the last day of the month in which the notice is received by SHL unless coverage is terminated prior to such date by SHL.

2.3 Reinstatement

Any Individual PPO Plan, which has been terminated in any manner, may be reinstated by SHL at its sole discretion.

2.4 Effect of Termination

No benefits will be paid under this Plan by SHL for services provided after termination of an Insured's coverage under this Plan. You will be responsible for payment of dental services and supplies incurred after the Effective Date of the termination of this Plan.

SECTION 3. Managed Care Program

This section tells you about SHL's Managed Care Program and which Covered Services require Predetermination.

3.1 Managed Care Program

SHL's Managed Care Program, using the services of professional dental peer review committees, Utilization Review Committees, and/or the Dental Director, determines whether services and supplies are Medically Necessary. The Managed Care Program helps direct care to the most appropriate setting to provide dental care in a cost-effective manner.

3.2 Managed Care Program Requirements

SHL's Managed Care Program requires the Insured, Plan Providers and SHL to work together.

- All Plan Providers have agreed to participate in SHL's Managed Care Program. Plan Providers have agreed to accept SHL's Reimbursement Schedule amount as payment in full for Covered Services, less the Insured's payment of any applicable Copayment, Deductible or Coinsurance amount, whereas Non-Plan Providers have not. In no event will SHL pay more than the maximum payment allowance established in the SHL Reimbursement Schedule.
- It is the Insured's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of SHL's Managed Care Program.
- Benefits payable for expenses incurred in connection with Covered Services which are not certified by SHL's Managed Care Program will be reduced to 50% of what the Insured would have received if the services had been certified.

3.3 Managed Care Process

The Dental Director and/or SHL's Utilization Review Committee will review proposed services and supplies to be received by an Insured to determine:

- If the services are Medically Necessary and/or appropriate.
- The appropriateness of the proposed setting.
- The required duration of treatment or admission.

The final decision as to whether any care should be received is between the Insured and the Provider. If SHL denies a request by an Insured and/or Provider, the Insured or his Authorized Representative may appeal the denial to the Grievance Review Committee (see the Appeals Procedures Section).

3.4 Services Requiring for Predetermination

Type III Covered Services require Predetermination and review through SHL's Managed Care Program.

3.5 Independent Dental Review; Appeals Rights

In the event SHL requires an Insured to undergo an Independent Dental Evaluation for any final determination of dental benefits or care, only a Dentist who is certified to practice in the same field of dentistry as the primary treating Dentist or who is formally educated in that field will conduct the evaluation. The Independent Dental Evaluation will include a dental examination of the Insured, and a personal review of all x-rays and reports prepared by the primary treating Dentist. A certified copy of all reports of findings will be sent to the primary treating Dentist and the Insured within ten (10) working days after the evaluation. If the Insured disagrees with the findings of the evaluation, he must submit an appeal to SHL for binding arbitration within thirty (30) days after he receives the finding of the Independent Dental evaluation.

3.6 Appeals Rights

All decisions of SHL's Managed Care Program may be appealed by the Insured or his Authorized Representative through the Appeals Procedures. If an imminent and serious threat to the health of the Insured exists, the appeal will be directed to SHL's Dental Director.

SECTION 4. Obtaining Covered Services

This section tells you under what conditions services are available under this Plan and your obligations as an Insured. You should also carefully review the Exclusions and Limitations Sections (Section 8.) prior to obtaining any dental care services.

4.1 Availability of Covered Services

Insureds are entitled to receive the Covered Services set forth in Section 6 herein and the Attachment A Benefit Schedule subject to all terms and conditions of this Certificate, and payment of required premium. These Covered Services are available only if and to the extent that they are:

(a) Prescribed by a duly licensed Provider; and;
(b) Medically Necessary as defined in this Certificate.

4.2 Provider Selection

Subject to all conditions, exclusions and limitations, if the Insured uses the services of a Provider who is a licensed Practitioner in the state in which he is practicing and who is operating within the scope of his license, then such services shall be treated as though they had been performed by a Dentist.

SECTION 5. Covered Services

This section tells you what services are covered under this Plan. Only services and supplies, which meet SHL's definition of Medically Necessary, will be considered to be Covered Services. The Attachment A Benefit Schedule shows applicable Copayments and benefit limitations for Covered Services. All Covered Services are subject to SHL's Managed Care Program.

5.1 Availability of Covered Services

Insureds are entitled to receive benefit payments for the Covered Services set forth in Attachment A, Benefit Schedule upon payment of the applicable premium, subject to all terms, conditions, and definitions in the Certificate

5.2 Alternate Benefit Provision

If a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition as determined by SHL's Managed Care Program and the alternate treatment will produce a professionally satisfactory result, then the maximum EDE to be considered for payment will be the less expensive treatment.

5.3 Pre-operative Dental X-rays

In order to determine if a procedure is a Covered Service, SHL's Managed Care Program may review pre-operative dental x-rays. If the x-rays are not provided, SHL's Managed Care Program will make a determination as to which procedures would provide professionally adequate restoration, replacement or treatment. If pre-operative dental x-rays are subsequently provided to SHL's Managed Care Program, and it is determined that additional procures are Medically Necessary and are Covered Services as defined in this Evidence of Coverage, the Managed Care Program will authorize such additional procedures.

5.4 Expenses Incurred

SHL has established the following guidelines for determining when an expense is considered to have been incurred for benefit payment determinations:

a) for an appliance or change to an appliance, at the time the impression is made;
b) for a crown, bridge or gold restoration, at the time the tooth is prepared and the impression is taken;
c) for root canal therapy, at the time the pulp chamber is opened;
d) for all other Covered Services, at the time the service is rendered or a supply furnished.

5.5 Dental Telemedicine

Covered Services received through a Dental Telemedicine Provider do not require Prior Authorization unless the Covered Service would require Prior Authorization if provided in person. The Insured does not have to establish a relationship with a Dental Telemedicine Provider to receive services.
SHL does not require the Dental Provider delivering Telemedicine Services to demonstrate the necessity to provide services through Dental Telemedicine or to receive additional certifications or licenses to provide Dental Telemedicine Services.

SHL will not refuse to provide coverage because of the distant site from which the contracted Dental Telemedicine Provider provides Covered Services or the originating site at which the Insured receives Dental Telemedicine Covered Services. SHL will not require Covered Services to be provided through Dental Telemedicine as a condition of coverage.

SECTION 6. Waiting Period

Some plans may have a waiting period requirement which must be satisfied prior to receiving any benefits for certain Covered Services. Please refer to your Attachment A, benefit Schedule to determine if you must be covered under this Plan for a specific period of time prior to receiving benefits for certain Covered Services.

SECTION 7. Exclusions and Limitations

This section tells you what services or supplies are excluded or limited under this Plan.

7.1 Covered Services will not include and no benefits will be payable for expenses incurred:

a. For any treatment, including veneers and bondings, which is for cosmetic purposes or to correct congenital or developmental malformations, Replacement of fillings for reasons other than decay or fractures.

b. For replacement of restorations due to material allergies.

c. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five (5) years of the date of placement, replacement will covered if determined to be Medically Necessary by SHL's Managed Care Program. If a replacement is required within five (5) years of the date of placement because of an Accidental Injury sustained while the Insured is covered under this Plan, it will be a Covered Services.

d. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one (1) or more natural teeth while the Insured is coved under this Plan. The extraction of a third molar (wisdom tooth) will not qualify as an exception to the above limitation. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

   Under the following circumstances, the limitation set forth in this subparagraph 8.1(d) will be waived for persons insured on the Effective Date of this Certificate:

   1) The person was insured under the prior contract on the date it was replaced by this Certificate; and
   2) The person:
      a. Had a tooth extracted while insured under the prior policy within six (6) months from the termination date of that policy; and
      b. Has a prosthetic appliance or fixed bridge installed to replace the extraction while insured under this Plan, but such extraction and installation must take place within six(6) months of the date on which all waiting periods have been satisfied; and
   3) The prosthetic appliance or fixed bridge in subparagraph (d) 2b above must be an initial placement. If it is not, the provisions of subparagraph 7.1(d) will apply.

e. For any procedure begun before the Insured was covered under this Plan.

f. For any procedure begun after the Insured's coverage under this Plan terminates.

g. To replace lost or stolen dentures, crowns, bridgework or other appliances.

h. For appliances, restorations or procedures to:

1) alter vertical dimension;

2) restore or maintain occlusion;

3) splint or replace tooth structure lost as a result of abrasion or attrition; or

4) treat disturbances of the termporomandibular joint (TMJ) or mysfascial pain dysfunction (MPD).

i. For implants or implant-related procedures (i.e. periodontal or oral surgery related to or to enable the placement or removal of implants, crown, bridge or appliance considered as the restoration required to complete an implant treatment plan).

j. For any procedure which not shown in the Covered Services set forth in Attachment A, Benefit Schedule.

k. For periodontal charting (to be included in examination or prophylaxis).

l. For education or training in and supplies used for, dietary or nutritional counseling, personal oral hygiene, decay control, periodontal disease treatment or dental plaque control.

m. For the completion of claim forms, missed appointments or OSHA requirements and standards required for Provider compliance.

n. For subgingival curettage, scaling and root planing and periodontal surgery unless the presence of periodontal disease is confirmed by periodontal charting or x-rays.

o. For treatment (including excision and biopsy) of neoplasms, lesions, cysts, tumors or malignancies.

p. For oral surgery including:

1) requiring the setting of fractures or dislocations;

2) treatment of traumatic wounds; and

3) ridge extension, augmentation or bone graft.

q. For behavioral management or nitrous oxide for an Insured.

r. For treatment required because of Injury to sound natural teeth when such charges are covered under any applicable health benefit plan.

s. Because of an injury arising out of, or in the course of, work for profit.

t. By an Insured because of an Illness for which he or she is eligible for benefits under any Workers' Compensation act or similar laws, or due to Occupational Injury of Illness.

u. For charges for which the insured is not liable or which would not have been made had no insurance been in force.

v. For services which are not recommended by a Dentist or which are not required for necessary dental care and treatment.

w. Because of war or any act of war, declared or not.

x. By an Insured if payment is not legal where the insured is living when expense are incurred.

SECTION 8. Premium Payments, Grace Period and Changes in Premium Rates

This section tells you when premium payments are due, what happens when payments are not received and when premium rates can change.

8.1 Monthly Payments

The Premium Due Date is the first (1st) day of the calendar month. On or before the Premium Due Date, the Subscriber will remit to SHL, on behalf of the Subscriber and his covered Dependents the premium amount specified by SHL.

8.2 Grace Period

Only Insureds for whom premium payment is actually received by SHL shall be entitled to Covered Services hereunder and then only for the period for which such payment is received. SHL shall not be liable for any dental care services incurred by any Insured beyond the period for which the premium payment has been paid. SHL shall be entitled to receive reimbursement from the Subscriber for any claims paid by SHL for services provided after the date of termination.

8.3 Changes in Premium Payments

SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber sixty (60) days prior written notice.

SECTION 9. General Provisions

9.1 Relationship of Parties

The relationship between SHL and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of SHL, nor is SHL, or any employee of SHL, an employee or agent of a Provider. SHL shall not be liable for any claims or demands on account of damages arising out of, or in any manner connected with, any injury suffered by an Insured while receiving care from any Plan Provider. SHL is not bound by statements or promises made by its Plan Providers.

9.2 Authority to Change the Form or Content of this AOC

No agent or employee of SHL is authorized to change the form or content of this AOC or waive any of its provisions. Such changes can be made only through an amendment authorized and signed by an officer of SHL.

9.3 Identification Card

Cards issued by SHL to Insureds pursuant to this Plan are for identification only. Possession of an SHL identification card confers no right to services or other benefits under this Plan. To be entitled to such services or benefits the holder of the card must, in fact, be an Insured on whose behalf all applicable premiums under this Plan have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this AOC will be liable for the actual cost of such services or benefits.

9.4 Notice

Any notice under this Plan may be given by United States mail, first class, postage prepaid, addressed as follows:

Sierra Health and Life Insurance Co., Inc.
P. O. Box 15645
Las Vegas, Nevada 89114-5645

Notice to an Insured will be sent to the last address known to SHL for the Insured.

9.5 Interpretations of the AOC

The laws of the state of issue shall be applied to interpretations of the Plan.

9.6 Modifications

By issuance of the Plan and the Agreement, the coverage available under this Plan becomes available to Insureds who are eligible under Section 1. However, the Plan shall be subject to amendment, modification or termination in accordance with any provision hereof or by mutual agreement between SHL and the Insured. This AOC will automatically be modified to conform with any applicable State and Federal law requirements. By electing dental coverage through SHL or accepting any benefits under the Plan, all Insureds legally capable of contracting, and the legal representatives of all Insureds incapable of contracting, agree to all terms, conditions, and provisions hereof.

9.7 Policies and Procedures

SHL may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan with which Insureds shall comply.

These policies and procedures are maintained by SHL at its offices. Such policies and procedures may have bearing on whether a dental service and/or supply is covered.

9.8 Choice of Facility of Provider

Nothing contained in the AOC shall be deemed to restrict an Insured in exercising full freedom of choice in the selection of a Dental Provider for dental care.

9.9 Overpayments

SHL has the right to correct payments for dental care services made in error. Dental providers, and/or Insureds have the responsibility to return any overpayments or incorrect payments to SHL. SHL has the right to offset any such overpayment against any future payments.

9.10 Cost Containment Features

The AOC contains a number of cost containment provisions including, but not limited to:
(a) Second and Third Opinions/Consultations;
(b) Preventive dental care benefits;
(c) Plan Provider benefit incentives as described in Attachment A Benefit schedule; and
(d) SHL's Managed Care Program.

9.11 Entire Agreement

This AOC, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, Insured Identification Card, and all other applications received by SHL constitutes the entire agreement between the Insured and SHL and as of its Effective Date, replaces all other agreements between the parties. For the duration of time an Insured's coverage is continuously effective under SHL, regardless of the occurrence of any specific Plan or product changes during such time, all benefits paid by SHL under any and all such Plans on behalf of such Insured shall accumulate towards any applicable lifetime or other maximum benefit amounts as stated in the Insured's most current Plan Attachment A Benefit Schedule to the AOC.

9.12 Contestability

No statement made by an Insured for the purpose of effecting any coverage or any increase in coverage under the Plan for such Insured will be used in contesting the validity of the coverage with respect to which such statement was made after such coverage or increase in coverage has been in force prior to the contest for a period of two (2) consecutive years unless the statement is contained in a written instrument signed by the Insured.

9.13 Availability of Providers

SHL does not guarantee the continued availability of any specific Plan Provider or the availability of Plan Providers in all specialty fields.

9.14 Legal Proceedings

No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of the AOC. No such action shall be brought at any time unless brought within the time allowed by the laws of the jurisdiction of issue.

If the laws of the jurisdiction of issue do not designate the maximum length of time in which such action may be brought, no action may be brought after three (3) years from the time within which proof of loss is required by the AOC.

9.15 Gender References

Whenever a masculine pronoun is used in this AOC, it also includes the feminine pronoun.

9.16 Authorized Representative

An Insured may elect to designate an "Authorized Representative" to act on their behalf to pursue a Claim for Benefits or the appeal of an Adverse Benefit Determination. The term Insured also includes the Insured's Authorized Representative, where applicable and appropriate.

To designate an Authorized Representative, written notice, signed and dated by the Insured, is required. The notice must include the full name of the Authorized Representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to:

Sierra Health and Life Insurance Co., Inc.
Attn: Customer Response and
Resolution Department
P.O. Box 15645
Las Vegas, Nevada 89114 5645

Any correspondence from SHL regarding the specified Claim for Benefits or appeal will be provided to both the Insured and his Authorized Representative.

In case of an Urgent Care Claim, a dental care professional with knowledge of the Insured's dental condition shall be permitted to act as an Authorized Representative of the Insured without designation by the Insured.

9.17 Failure to Obtain Predetermination for Type III services

If an Insured fails to follow the Plan's procedures for requesting Predetermination for Type III services, the Insured shall be notified of the failure and the proper procedures to be followed in order to obtain Predetermination. The Insured notification of correct Predetermination procedures from the Plan shall be provided as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the Plan's receipt of the Insured's original request. Notification by SHL may be oral unless specifically requested in writing by the Insured.

9.18 Timing of Notification of Benefit Determination

Concurrent Care Decision: If SHL has approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, SHL will notify the Insured at a time sufficiently in advance of the reduction or termination to allow the Insured to appeal and obtain a determination before the benefit is reduced or terminated. Subject to the paragraph below, such request may be treated as a new Claim for Benefits and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim as appropriate. Provided, however, any appeal of such a determination must be made within a reasonable time and may not be afforded the full one-hundred eighty (180) day period as described in the Appeals Procedures section.

Any request by an Insured to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim shall be decided as soon as possible. SHL shall notify the Insured within twenty-four (24) hours after receipt of the Claim for Benefits by the Plan, provided that the request is received at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments. If the request is not made at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments, the request will be treated as an Urgent Care Claim.

9.19 Notification of an Adverse Benefit Determination

If you receive an Adverse Benefit Determination, you will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claim for Benefits to be approved, modified or reversed, and an explanation of why such material or information is necessary;
- A description of the review procedures and the time limits applicable to such procedures;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Insured's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

SECTION 10. Claims Provisions

This Section tells you how and when to file a claim under the Plan.

10.1 Notice and Proof of Claim

Written notice of each Illness or Injury for which benefits are claimed should be given to SHL within twenty (20) days of the date any dental care services are received. Failure to furnish notice within twenty (20) days will not invalidate or reduce any claim if it is shown that notice was provided as soon as was reasonably possible.

SHL, upon receipt of such notice, will furnish to the Insured within fifteen (15) days forms for filing the proof of claim. If such forms are not furnished within fifteen (15) days, the Insured shall be deemed to have complied with the requirements of this Plan as to proof of loss upon submitting, within fifteen (15) days, written proof covering the occurrence, the character and the extent of the loss for which the claim is being made.

SHL agrees to:
(a) Provide claim forms to the Insured for submitting claims to SHL;
(b) Receive claims and claims documentation;
(c) Correspond with Insureds and Providers of services if additional information is deemed by SHL to be necessary to complete the processing of claims;
(d) Determine the amount of benefits payable under the Plan; and
(e) Pay the amount of benefits determined to be payable under the Plan.

When seeking reimbursement from SHL for expenses incurred in connection with services received, the Insured must complete a claim form and submit it to the SHL Claims Department with copies of all of the dental records, bills and/or receipts from the Provider. Additional claim forms can be obtained by contacting the Member Services Department at 1-800-888-2264.

If the Insured receives a bill for Covered Services, the Insured may request that SHL pay the Provider directly by sending the bill, with copies of all dental records and a signed completed claim form to the SHL Claims Department.

SHL shall approve or deny a claim within thirty (30) days after receipt of the claim. If the claim is approved, the claim shall be paid within thirty (30) days from the date it was approved.

If the approved claim is not paid within that thirty (30) day period, SHL shall pay interest on the claim at the rate set forth by applicable Nevada law. The interest will be calculated from thirty (30) days after the date on which the claim is approved until the date upon which the claim is paid.

SHL may request additional information to determine whether to approve or deny the claim. SHL shall notify the Provider of its request for additional information within twenty (20) days after receipt of the claim. SHL will notify the Provider of the dental care services of all the specific reasons for the delay in approving or denying the claim. SHL shall approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, SHL shall pay the claim within thirty (30) days after it receives the additional information. If the approved claim is not paid within that time period, SHL shall pay interest on the claim in the manner set forth above.

If SHL denies the claim, notice to the Insured will include the reasons for the rejection and the Insureds right to file an Informal Appeal as set forth in the Appeals Procedures section of this AOC.

10.2 Timely Filing Requirement

All claims must be submitted to SHL within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If the Insured authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed directly to the Insured if direct payment to the Provider is not authorized. The Insured will receive an explanation of how the payment was determined.

10.3 Late Claims Exclusion

No payment shall be made under the Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by SHL within twelve (12) months after the date Covered Services were provided. In no event will SHL pay more than SHL's Eligible Dental Expense for such services.

10.4 Examination

SHL will have the right and opportunity at its own expense to examine the person of any individual whose Illness or Injury is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and in the case of death, to make an autopsy where not prohibited by law.

SECTION 11. Appeals Procedures

The SHL Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration or you wish to appeal an Adverse Benefit Determination. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Insured with the appropriate information.

Concerns about dental services are best handled at the dental service site level before being brought to SHL. If an Insured contacts SHL regarding an issue related to the dental service site and has not attempted to work with the site staff, the Insured may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.

Please see the Glossary Terms Section herein for a description of the terms used in this section.

The following Appeals Procedures will be followed if the dental service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits. All Appeals will be adjudicated in a manner designed to ensure independence and impartiality on the part of the persons making the decision.

Formal Appeal: An appeal of an Adverse Benefit Determination filed either orally or in writing which SHL's Customer Response and Resolution Department investigates. If a Formal Appeal is resolved to the satisfaction of the Insured, the appeal is closed. The Formal Appeal is **mandatory** if the Insured is not satisfied with the initial determination and the Insured wishes to appeal such determination.

Member Services Representative: An employee of SHL that is assigned to assist the Insured or the Insured's Authorized Representative in appealing an Adverse Benefit Determination.

11.1 Formal Appeal

A Formal Appeal must be submitted orally or in writing to SHL's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

A Formal Appeal shall contain at least the following information:

- The Insured's name (or name of Insured and Insured's Authorized Representative), address, and telephone number;
- The Insured's SHL Membership number ; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Insured feels that the Adverse Benefit Determination was wrong.

Additionally, the Insured may submit any supporting dental records, Dentist's letters, or other information that explains why SHL should approve the Claim for Benefits. The Insured can request the assistance of a Member Services Representative at any time during this process.

The Formal Appeals should be sent or faxed to the following:
Sierra Health and Life Insurance Co., Inc.
Attn: Customer Response and Resolution Department
PO Box 14865
Las Vegas, NV 89114 Fax: 1-702-266-8813

SHL will investigate the appeal. When the investigation is complete, the Insured will be informed in writing of the resolution within thirty (30) days of receipt of the request for the Formal Appeal. This period may be extended one (1) time by SHL for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of SHL and SHL notifies the Insured prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which SHL expects to render a decision. If the extension is necessary due to a failure of the Insured to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Insured shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

If the Formal Appeal results in an Adverse Benefit Determination, the Insured will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Insured's Claim for Benefits;

- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Insured's request; and

Limited extensions may be required if additional information is required in order for SHL to reach a resolution.

11.2 Expedited Appeal

The Insured can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that involves an Urgent Care Claim if the Insured or his Dentist believe that the health of the Insured could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim) or for Pre-Service Claims that are not Urgent Care Claims. Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to SHL. If the initial notification was oral, SHL shall provide a written or electronic explanation to the Insured within three (3) days of the oral notification.

If insufficient information is received, SHL shall notify the Insured as soon as possible, but no later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. The Insured will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. SHL shall notify the Insured of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- SHL's receipt of the specified information, or
- The end of the period afforded the Insured to provide the specified information.

If the Insured's Dentist requests an Expedited Appeal, or supports an Insured's request for an Expedited Appeal, and indicates that waiting for a routine appeal could seriously harm the health of the Insured or subject the Insured to unmanageable severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim for Benefits, SHL will automatically grant an Expedited Appeal.

If a request for an Expedited Appeal is submitted without support of the Insured's Physician, SHL shall decide whether the Insured's health requires an Expedited Appeal. If an Expedited Appeal is not granted, SHL will provide a decision within thirty (30) days, subject to the routine appeals process for Pre-Service Claims.

11.3 Office for Consumer Health Assistance

- (702) 486-3587 in Las Vegas area
  1-888-333-1597 outside of Las Vegas area (toll-free)

SECTION 12. Glossary

12.1 **"Accidental Injury"** means a bodily injury which can be seen or felt by a Dentist or which shows up on an x-ray or other diagnostic imaging device. The bodily injury must have been caused by an accident. Accidental Injury does not mean bodily injury caused by routine body movements such as stooping, twisting, bending or chewing.

12.2 "**Adverse Benefit Determination**" means a rescission of coverage; a decision by SHL to deny, reduce, terminate, fail to provide, or make payment for a benefit, including a denial, reduction termination, or failure to provide, or make a payment for a benefit that is based on: an individual's eligibility; a determination that a benefit is not a Covered Service; or other limitation on an otherwise Covered Service; or a determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate.

An Adverse Benefit Determination is final if the Insured has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

12.3 "**Authorized Representative**" means a person designated by the Insured to act on his behalf in pursuing a Claim for Benefits, to file an appeal of an Adverse Benefit Determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a dental care professional with knowledge of the Insured's dental condition is seeking to act on the Insured's behalf as his Authorized Representative.

12.4 "**Benefit Schedule**" means the brief summary of benefits, limitations and Copayments, Deductibles and Coinsurance amount given to the Subscriber by SHL. It is Attachment A to this Certificate.

12.5 "**Calendar Year**" means January 1 through December 31 of the same year.

12.6 **"Agreement of Coverage"** or **"AOC"** means this document, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, Insured Identification Card, and all other applications received by SHL.

12.7 "**Claim for Benefits**" means a request for a Plan benefit or benefits made by an Insured in accordance with the Plan's Appeals Procedures, including any Pre-Service Claims (requests for Prior Authorization) and Post-Service Claims (requests for benefit payment).

12.8 **"Coinsurance"** means the percentage of the charges billed or the percentage of eligible Dental Expenses, whichever is less, that an Insured must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Insured directly to the Provider who bills for the Covered Services. (See Attachment A Benefit Schedule.)

12.9 "**Copayment**" or **"Cost-share"** means the amount the Insured pays when a Covered Service is received.

12.10 "**Covered Services**" means the dental services, supplies and accommodations for which SHL pays benefits under this Plan.

12.11 **"Deductible"** means the portion of Eligible Dental Expenses billed by Providers each Calendar Year that an Insured must pay, either in the aggregate or for a particular service, before SHL will make any benefit payments for Covered Services. (See Attachment A Benefit Schedule.)

12.12 "**Dependent**" means an Eligible Family Member of the Subscriber's family who:

- meets the eligibility requirements of the Plan as set forth in Section 1 of this Certificate;
- is enrolled under this Plan; and
- for whom premiums have been received and accepted by SHL.

12.13 "**Effective Date**" means the initial date on which Insureds are covered for services under the SHL Plan provided any applicable premiums have been received and accepted by SHL.

12.14 **"Eligible Dental Expenses" ("EDE")** means the maximum amount SHL will pay for a particular Covered Service as determined by SHL in accordance with the SHL Reimbursement Schedule.

12.15 "**Eligible Family Member**" means a member of the Subscriber's family that is or becomes eligible to enroll for coverage under this Plan as a Dependent.

12.16 "**Emergency Dental Services**" means Covered Services provided after the sudden onset of a dental condition with symptoms severe enough to cause a prudent person to believe that lack of immediate dental attention could result in serious:

- jeopardy to his health;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

12.17 "**Enrollment Date**" means the first day of coverage under this Plan. If an individual receiving benefits under the employer's Dental Benefit Plan changes benefit packages, or if the employer changes Dental Benefit Plan carriers, the individual's Enrollment Date does not change.

12.18 "**Expedited Appeal**" means if an Insured appeals a decision regarding a denied request for Prior Authorization (Pre-Service Claim) for an Urgent Care Claim, the Insured or Insured's Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

12.19 **"Final Adverse Benefit Determination"** means the upholding of an Adverse Benefit Determination at the conclusion of the internal appeals process or an Adverse Benefit Determination in which the internal appeals process has been deemed exhausted.

12.20 **"Dental Benefit Plan"** means a policy, contract, certificate or agreement offered by a carrier or similar agreement offered by an employer or other legal entity, to provide for, arrange for payment of, pay for or reimburse any of the costs of dental care services.

12.21 "**Illness**" means an abnormal state of health resulting from disease, sickness or malfunction of the body; or a congenital malformation, which causes functional impairment.

12.22 "**Independent Dental Review**" means an independent evaluation of the dental care of an Insured that must include a physical examination of the Insured unless he is deceased, and a personal review of all x-rays and reports by a certified Dentist who is formally educated in the applicable dental field.

12.23 "**Injury**" means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

12.24 "**Insured**" means a person who meets the eligibility requirements of Section 1. who has enrolled under this Plan and for whom premiums have been received and accepted by SHL.

12.25 "**Managed Care Program**" means the process that determines Medical Necessity and directs care to the most appropriate setting to provide quality care in a cost-effective manner, including Prior Authorization of certain services.

12.26 "**Medically Necessary**" means a dental service or supply needed to improve a specific dental condition or to preserve the Insured's dental health and which, as determined by SHL is:

- consistent with the diagnosis and treatment of the Insured's Illness or Injury;
- the most appropriate level of service which can be safely provided to the Insured; and
- not solely for the convenience of the Insured, the Provider(s) or Insured's Dentist.

In determining whether a service or supply is Medically Necessary, SHL may give consideration to any or all of the following:

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by SHL.

Services and accommodations will not automatically be considered Medically Necessary simply because they were prescribed by a Dentist.

12.27 **"Non-Plan Provider"** means a Provider who does not have an independent contractor agreement with SHL.

12.28 "**Placed (or Placement) for Adoption**" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person ends upon the termination of such legal obligation.

12.29 "**Plan**" means this Certificate of Coverage (COC), including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, the Insured Identification Card, and all other applications received by SHL.

12.30 "**Plan Dentist**" means a Dentist who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds. A Plan Provider's agreement with SHL may terminate, and an Insured will be required to select another Plan Provider.

12.31 "**Plan Provider**" means a Provider who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds. A Plan Provider's agreement with SHL may terminate, and an Insured receiving care from that Provider may be required to select another Plan Provider.

12.32 "**Post-Service Claim**" means any Claim for Benefits under a Dental Benefit Plan regarding payment of benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

12.33 "**Practitioner**" means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.

12.34 **"Predetermination"** means a written report prepared by a Dentist of Practitioner and reviewed and approved by SHL's Dental Director describing the recommended treatment for any dental disease, defect, Injury or other condition as a result of a Dentist's or

Practitioner's examination of an Insured and includes review of the recommended treatment by the Managed Care Program to determine whether the recommended services are Medically Necessary.

12.35 "**Pre-Service Claim**" means any Claim for Benefits under a Dental Benefit Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

12.36 **"Provider"** means a:

- dentist,
- other person or organization licensed by the state where his practice is located to provide dental services, supplies, and accommodations acting within the scope of his license.

12.37 "**Referral**" means a recommendation for an Insured to receive a service or care from another Provider or facility.

12.38 "**Retrospective**" or "**Retrospectively**" means a review of an event after it has taken place.

12.39 "**Rider**" means a provision added to the Agreement or the Certificate to expand benefits or coverage.

12.40 "**SHL Reimbursement Schedule**" means the schedule showing the amount SHL will pay Eligible Dental Expenses (EDE) to Providers. EDE will be applicable to Non-Plan Providers including Non-Plan Facilities. SHL Reimbursement Schedule is based on:

- the amount most consistently paid to the Provider; or
- the amount paid to other Providers with the same or similar qualifications; or
- the relative value and worth of the service compared to other services which SHL determines to be similar in complexity and nature with reference to other industry and governmental sources, examples of these sources include published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar services within the geographic market, a gap methodology, or Eligible Dental Expense could be based on a percentage of the provider's billed charge.

For Non-Plan Provider Emergency Services, SHL will pay the greater of:

- the amount we have negotiated with Plan Providers for the Emergency Services received (and if there is more than one amount, the median of the amounts); or
- 100% of the Eligible Dental Expense for Emergency Services provided by a Non-Plan Provider under your Plan; or
- the amount that would be paid for the Emergency Services under Medicare.

12.41 "**Subscriber**" means an Insured who meets the eligibility requirements of this Certificate and who has enrolled under this Plan, and for whom premiums have been received and accepted by SHL.

12.42 "**Urgent Care Claim**" means a Claim for Benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the Insured's life, health or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits that, in the opinion of a physician with knowledge of the Insured's dental conditions, would subject the Insured to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for Prior Authorization of an Urgent Care service was denied, the Insured could request an Expedited Appeal for the Urgent Care Claim.

12.43 "**Urgent Care Facility**" means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

12.44 "**Urgently Needed Services**" means Covered Services needed to prevent a serious deterioration in an Insured's health. While not as immediate as Emergency Services, these services cannot be delayed until the Insured can see a Plan Provider.

12.45 "**Waiting Period**" means the period of time that must pass before coverage for an Eligible Enrollee can become effective.

SIERRA HEALTH AND LIFE
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SHL Dental PPO Plan 27 – Individual Adult Only Coverage

Attachment A Benefit Schedule

Please read the definition of Eligible Dental Expenses ("EDE") and SHL Reimbursement Schedule in the Certificate. When accessing a Non-Plan Dentist, you are responsible for any charges over EDE. There is no Calendar Year Deductible (CYD) for Type I Services and the CYD for Type II/ Type III Services is combined. The CYD for Plan Dentist Type II/Type III Services is $50 of EDE per Insured and $150 of EDE per Family. The CYD for Non Plan Dentist Type II/Type III Services is $50 of EDE per Insured and $150 of EDE per Family. Further, the stated CYD maximum amounts are separate for each tier of benefits and do not accumulate to one another. The Calendar Year plan maximum benefit for Tier II/Tier III Plan and Non-Plan Services is a combined limit of $1,500 per Insured.

Type III Covered Services Waiting Period: You will not be eligible to receive any benefits for Type III Covered Services until you have been covered under this Agreement for 12 consecutive months. For Insured's who meet the following two requirements, Waiting Period Credit will be allowed for the amount of time an Insured had continuous coverage under the Insured's previous UHC affiliated dental plan. First, the previous plan had been in force at least twelve (12) consecutive months immediately prior to the Effective Date of this plan. And, second, this Agreement was issued within sixty (60) days after the date the previous dental plan was discontinued. Credit will be applied only for those Insureds covered under the prior dental plan as of the Effective Date of this Agreement.

Predetermination: Predetermination is recommended for all Type III services. Please see Section 3 of your Dental Agreement for additional information about Predetermination.

Deductible Credit: Dental Expenses incurred by an individual on or after January 1st of the Calendar Year in which this Agreement becomes effective, will apply to the current Calendar Year Deductible for this plan if: 1) proof is furnished to SHL that such dental expenses were covered under the dental insurance policy in force immediately prior to the Effective Date of this Agreement; and 2) such expense would have been considered Covered Services under this Agreement had this Agreement been in force at the time expenses were incurred.

Benefit Schedule

Covered Services and Limitations		Plan Dentist Benefits	Non-Plan Dentist Benefits
Type I Services: Diagnostic and Preventive			
Type I	Routine Evaluation (exams limited to twice (2) per Calendar Year)	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Limited to Oral Evaluation – problem-focused/emergency	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Detailed and Extensive Oral Evaluation – problem-focused (exam limited to specialist only, i.e. periodontal Exam)	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Intraoral Radiograph – Complete Series or Panoramic Survey – Film (limited to one or the other, once every three (3) Calendar Year	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Intraoral or Extraoral Radiographs	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Bitewing Radiographs – (limited to twice (2) per Calendar Year)	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Oral/facial images, Pulp Vitality Tests and Diagnostic Casts	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Prophylaxis, Adult (limited to twice (2) per Calendar Year)	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type I	Recementation of Space Maintainer	Insured pays 0% of EDE.	Insured pays 20% of EDE.
Type II Services: Restorative (Includes local anesthesia and routine postoperative care)			
Type II	Restoration/Amalgam – per tooth (anterior & posterior teeth)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Restoration/Composite – per tooth (anterior & posterior teeth)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Recementation of Inlay, Crown or Bridge	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Sedative Filling	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Pin Retention – per tooth, in addition to restoration	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Post Removal (not in conjunction with endodontic therapy)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.

Covered Services and Limitations		Plan Dentist Benefits	Non-Plan Dentist Benefits
Type II Services: Endodontics			
Type II	Pulp Cap - excluding final restoration	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Therapeutic Pulpotomy, excluding final restoration	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Pulpal Therapy, per primary tooth	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Root Canal Therapy - initial or re-treatment, per tooth - *Note: Root Canals include intra-operative radiographs; excludes final restoration.*	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Retrograde Filling – per root	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Root Amputation – per root	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Hemisection (including root removal) not including root canal therapy	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II Services: Periodontics			
Type II	Gingivectomy or Gingivoplasty – per quadrant	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Gingivectomy or Gingivoplasty – per tooth	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Gingival Curettage, surgical – per quadrant	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Gingival Flap Procedure (including Root Planing) – per quadrant	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Clinical Crown Lengthening	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Osseous Surgery – (including flap entry and closure)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Free Soft Tissue Graft Procedure (including donor site surgery)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Periodontal Scaling.Root Planing – per quadrant (limited to once (1) per quadrant per Calendar Year)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Full Mouth Debridement (limited to once in three (3) Calendar Years)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Periodontal Maintenance Procedure – following Active Therapy (limited to once in any three (3) month period)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.

Benefit Schedule

Covered Services and Limitations		Plan Dentist Benefits	Non-Plan Dentist Benefits
Type II Services: Oral Surgery (includes local anesthesia and routine postoperative care)			
Type II	Simple Extraction – per tooth	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Surgical Extraction – per tooth	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Alveoloplasty – per quadrant	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Removal of Exostosis – per site	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Incision and Drainage of Abscess	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Frenulectomy	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II Services: Adjunctive General Services			
Type II	Excision of hyperplastic tissue – per arch	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Sectioning of a bridge, to enable extraction of an abutment tooth	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Adjustment to Denture of Partial, per appliance, per visit	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Repair to Denture of Partial Denture, per repair, per appliance	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Palliative (Emergency) treatment of dental pain – minor procedures	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	General Anesthesia or Intravenous Sedation when administered by the dentist in the office (when in connection with a surgical extraction or surgical procedure, or when Medically Necessary)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Professional Consultation (diagnostic service provided by dentist other than dentist providing treatment)	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Office Visit after Regularly Scheduled Office Hours	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Therapeutic Drug Injection	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Other Drugs and/or Medicaments, by report	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Application of Desensitizing Medicaments	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.
Type II	Treatment of Complication (post-surgical), unusual circumstances	After CYD, Insured pays 20% of EDE.	After CYD, Insured pays 40% of EDE.

Covered Services and Limitations		Plan Dentist Benefits	Non-Plan Dentist Benefits
Type III Services: Prosthodontics – Removable (includes local anesthesia and routine postoperative care) **(Subject to 12 month waiting period)**			
Type III	Denture or Partial Denture, per appliance	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Rebase Denture of Partial Denture (limited to once (1) per three (3) Calendar years, per appliance)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Reline Denture or Partial Denture, chairside process (limited to twice (2) per Calendar Year, per appliance)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Reline Denture or Partial Denture, laboratory process (limited to twice (2) per Calendar Year, per appliance)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Interim Partial Denture, replacing anterior teeth (temporary stayplate/flipper)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Tissue Conditioning (limited to twice (2) per Calendar Year per appliance)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Note: Adjustments are included in the cost of full and immediate dentures, partial dentures, relines and tissues conditionings within the first six (6) months after installation. Relines are allowed twice in a Calendar Year. Precision attachments, overdentures, specialized techniques and characterizations are considered optional and the additional expense shall be borne by the insured. All partials included conventional clasps and rests.			
Type III Services: Restorative and Prosthodontics – Fixed (includes local anesthesia and routine postoperative care) **(Subject to 12 month waiting period)**			
Type III	Inlay or Onlay each	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Crown – per tooth	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Core Buildup, including pins	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Post and Core, in addition to crown	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Temporary Crown, fractured tooth	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Crown or Bridge Repair (by report)	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Pontic – per tooth	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Retainer (inlay/onlay) – per tooth	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.
Type III	Retainer (crown/abutment) – per tooth	After CYD, Insured pays 50% of EDE.	After CYD, Insured pays 50% of EDE.

Note: Refer to the Agreement of Coverage for limitations, exclusions, Managed Care requirements and additional information about the covered services.