



A STOCK COMPANY  
LINCOLN, NEBRASKA

**CERTIFICATE  
GROUP DENTAL INSURANCE**

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**The Policyholder**      **DEAN HEALTH PLAN INC. FOR THE BENEFIT OF STATE OF WISCONSIN  
EMPLOYEE TRUST FUND BENEFICIARIES**

**Policy Number**      **10-350558**      **Insured Person**

**Plan Effective Date**      **January 1, 2008**      **Certificate Effective Date**  
**Refer to Exceptions on 9070.**

**Plan Change Effective Date**      **January 1, 2012**

**Class Number 1**

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

**The determination of covered expenses and the amount of benefits payable for those services are based on a specific methodology as defined within the certificate. The eligible amount of the benefit determined on this methodology may be less than the provider's billed charge.**

*JoAnn M Martin*

President



**GRIEVANCE PROCEDURES**  
**In Accordance with Chapter 632.83 of the Wisconsin Insurance Code and Ins. 18 of the Wisconsin Administrative Code**

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. Also, you always have the right to contact the Wisconsin Commissioner of Insurance if you have a question or concern regarding your coverage under this contract. The Wisconsin Department may be contacted:

In Writing:                                   Office of the Commissioner of Insurance  
  Complaints Department  
  P.O. Box 7873  
  Madison, WI 53707 7873

Consumer Hotline:                       1 800 236 8517

You also have the right to ask your insurer to review its decisions involving your requests for service or your requests to have your claims paid.

**A.       Definitions**

"Complaint" means any expression of dissatisfaction expressed to the insurer by the insured, or an authorized representative, about an insurer or the providers with whom the insurer has a direct or indirect contact.

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

"Expedited Grievance" means a grievance where any of the following applies:

- (a)   The duration of the standard resolution process will result in serious jeopardy to the life or health of the Insured or the ability of the Insured to regain maximum function.
  
- (b)   In the opinion of a provider with knowledge of the insured's condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
  
- (c)   A provider with knowledge of the insured's condition determines that the grievance shall be treated as an expedited grievance.

"Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an Insured.

**B.       Eligibility**

A grievance concerning any matter may be submitted by a covered person to the following area:

Name:                                       Quality Control  
Address:                                   P.O. Box 82657  
  Lincoln, Nebraska 68501-2657  
Phone:                                       1-877-897-4328 (Toll-Free)  
Fax:   1-402-309-2579

**C.       Deadlines Applicable to the Grievance Review Process**

Your insurer will send a written acknowledgment that they have received your grievance within 5 business days of receipt of a grievance.

Your insurer has 30 calendar days to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your treating provider.

This time period may be extended an additional 30 days if the time frame cannot be reasonably met due to the insurer's inability to obtain necessary information from a person or entity not affiliated with or under contract with the insurer. A written notice will be sent to the person filing the grievance requesting such extension. The notice shall explain the reasons for the delay and the time period that a resolution may be expected.

#### **D. Grievance Committee**

The grievance committee reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. The Covered Person has the right to appear in person before the grievance committee to present oral or written information and to question those people responsible for making the determination which resulted in the grievance. The insurer will inform the Covered Person in writing of the time and place of the meeting at least 7 calendar days before the meeting. The insurer shall provide reasonable accommodations to allow the Covered Person to participate in the meeting. It is the Covered Person's option as to whether or not to attend the meeting.

#### **E. Expedited Grievances**

Those situations meeting the definition of an "expedited grievance" shall be resolved as expeditiously as the Covered Person's health condition requires but not more than 72 hours after receipt of the grievance.

#### **F. Decision**

##### **a. Denial upheld**

If the decision is adverse to the covered person, you will receive a written notice of that decision. The written decision will be signed by on member of the grievance committee and will contain:

1. The names, titles and qualifying credentials of the person or persons participating in the grievance review process (the grievance committee).
2. A statement of the reviewer's understanding of the covered person's grievance and all pertinent facts.
3. The reviewer's decision in clear terms and the basis for the decision.
4. A reference to the evidence or documentation used as the basis for the decision.
5. The covered person's right to contact the Commissioner's Office at the Wisconsin Department of Insurance to request assistance.
6. Information on your rights to an administrative review through the Department of Employee Trust Funds.

##### **b. Denial reversed**

If your insurer agrees that a benefit should have been provided, or that your claim should have been

paid, your insurer must authorize the benefit or pay the claim.



## TABLE OF CONTENTS

<b>Name of Provision</b>	<b>Page Number</b>
Schedule of Benefits	Begins on 9040
Benefit Information, including Co-Payment, Coinsurance, & Maximums	
Definitions	
Late Entrant, Dependent	9060
Conditions for Insurance	9070
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods,	
Missing Tooth Clause, Cosmetic Clause, Late Entrant	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Orthodontic Expense Benefits	9260
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	



**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

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

**DENTAL EXPENSE BENEFITS**

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

Co-Payment:

When a Participating Provider is used: Type 1 and Type 2 Procedures	\$0
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When a Non-Participating Provider is used: Combined Type 1 and Type 2 Procedures - Each Visit	\$40
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	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	100%*	100%*
Type 2 Procedures	80%*	80%*

When a Non-Participating Provider is used: Maximum Amount - Each Benefit Period	\$1,000
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When a Participating Provider is used: Maximum Amount - Each Benefit Period	\$1,500
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**ORTHODONTIC EXPENSE BENEFITS**

Deductible Amount - Once per lifetime	\$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	\$1,750

\* The Coinsurance Percentage is a shared responsibility between the covered person and the Company. The level We will pay toward the expenses incurred for services is shown above. The Coinsurance Percentage is applied after the allowance is considered as defined in the 9219, DENTAL EXPENSE BENEFITS section.

Please Note: This Certificate limits covered expenses, received from a Non-Participating Provider, only in the counties listed below, to a Maximum Allowable Benefit. If you see a Non-Participating Provider in the counties listed below, charges will be paid up to our Maximum Allowable Benefit. If there is a difference between the amount we pay and the amount that the provider bills, you will be responsible for that amount.

Counties

Brown, Dane, Eau Claire, Green, Kenosha, La Crosse, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sauk, Sheboygan, Washington, Waukesha, and Winnebago



## DEFINITIONS

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

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

**INSURED** refers to a person:

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

**DOMESTIC PARTNER** means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

- Each individual is at least 18 years old and otherwise competent to enter into a contract.
- Neither individual is married to, or in a domestic partnership with, another individual.
- The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
- The two individuals consider themselves to be members of each other's immediate family.
- The two individuals agree to be responsible for each other's basic living expenses.
- The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
  - Only one of the individuals has legal ownership of the residence.
  - One or both of the individuals have one or more additional residences not shared with the other individual.
  - One of the individuals leaves the common residence with the intent to return.

**CHILD.** Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent and as defined in Uniform Benefits.

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

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

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

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

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

## **CONDITIONS FOR INSURANCE COVERAGE**

Conditions for Insurance Coverage are defined in Uniform Benefits.



## DENTAL EXPENSE BENEFITS

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

**PARTICIPATING AND NON PARTICIPATING PROVIDERS.** A Participating Provider is a Provider who has entered into an agreement to provide at a specific fee ("MAC") services to Insureds. A Participating Provider is also referred to as a "Participating Provider" or 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 a "Non-Participating Provider" or 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.

**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 Co-Payment, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

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

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

**DENTAL EMERGENCY.** Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

**BENEFITS FOR DENTAL EMERGENCIES.** Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply. In no event will the Covered Person be liable for any more out-of-pocket expenses whether they see a Non-Participating Provider or a Participating Provider for services rendered in connection with a Dental Emergency.

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to one of the following:

1. the actual charge of the Provider.
2. the Maximum Allowable Charge ("MAC") as determined by us.
3. the Maximum Allowable Benefit ("MAB") as determined by us, in the counties specified previously.

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.

MAB - The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. These allowances are an option for policyholders who want to offer their insured members affordable yet comprehensive coverage. The MAB 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 x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after the insured person's insurance under this contract terminates.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
11. because of war or any act of war, declared or not.



## TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.



## **TYPE 1 PROCEDURES**

**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Actual Charge or Maximum Allowable  
Benefit as specified previously  
BENEFIT PERIOD - Calendar Year  
For Additional Limitations - See Limitations**

### **ROUTINE ORAL EVALUATION**

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

**COMPREHENSIVE EVALUATION: D0150, D0180**

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

**ROUTINE EVALUATION: D0120, D0145**

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

### **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.

### **COMPLETE SERIES OR PANORAMIC FILM**

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

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

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

### **OTHER XRAYS**

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

**PERIAPICAL FILMS: D0220, D0230**

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

### **BITEWING FILMS**

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

**BITEWING FILMS: D0270, D0272, D0273, D0274**

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

**VERTICAL BITEWING FILM: D0277**

## TYPE 1 PROCEDURES

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

### PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
  - D1120 Prophylaxis - child.
  - D1203 Topical application of fluoride - child.
  - D1204 Topical application of fluoride - adult.
  - D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.
- FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

### PROPHYLAXIS: D1110, D1120

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

### SPACE MAINTAINERS

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

### SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

### PERIODONTAL MAINTENANCE

- D4910 Periodontal maintenance.

### PERIODONTAL MAINTENANCE: D4910

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

## TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Actual Charge or Maximum Allowable

Benefit as specified previously

BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

### SEALANT

D1351 Sealant - per tooth.

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

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 1 lifetime.
- Benefits are considered for persons age 14 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

### AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

### RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

### STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2930 Prefabricated stainless steel crown - primary tooth.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2930, D2934

- Replacement is limited to 1 of any of these procedures per 3 year(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

### ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.

D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.

## TYPE 2 PROCEDURES

### PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

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

## **TYPE 1 PROCEDURES**

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

**ROUTINE EVALUATION: D0120, D0145**

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

### **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.

### **COMPLETE SERIES OR PANORAMIC FILM**

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

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

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

### **OTHER XRAYS**

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

**PERIAPICAL FILMS: D0220, D0230**

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

### **BITEWING FILMS**

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

**BITEWING FILMS: D0270, D0272, D0273, D0274**

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

**VERTICAL BITEWING FILM: D0277**

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

## TYPE 1 PROCEDURES

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

### PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1203 Topical application of fluoride - child.
- D1204 Topical application of fluoride - adult.
- D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

#### FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

#### PROPHYLAXIS: D1110, D1120

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

### SPACE MAINTAINERS

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

#### SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

### PERIODONTAL MAINTENANCE

- D4910 Periodontal maintenance.

#### PERIODONTAL MAINTENANCE: D4910

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

**TYPE 2 PROCEDURES**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**BENEFIT PERIOD - Calendar Year**  
**For Additional Limitations - See Limitations**

**SEALANT**

D1351 Sealant - per tooth.

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

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 1 lifetime.
- Benefits are considered for persons age 14 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

**AMALGAM RESTORATIONS (FILLINGS)**

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

**RESIN RESTORATIONS (FILLINGS)**

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

**STAINLESS STEEL CROWN (PREFABRICATED CROWN)**

D2930 Prefabricated stainless steel crown - primary tooth.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2930, D2934

- Replacement is limited to 1 of any of these procedures per 3 year(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

**ENDODONTICS MISCELLANEOUS**

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.

D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.

**PALLIATIVE**

## TYPE 2 PROCEDURES

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

PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-LOCAL/NITROUS

D9215 Local anesthesia in conjunction with operative or surgical procedures.

D9230 Inhalation of nitrous oxide/analgesia, anxiolysis.

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

## ORTHODONTIC EXPENSE BENEFITS

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

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

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

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

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

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

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

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

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

- a. monthly of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by monthly periods over the length of the Program. However, the first payment will be 25 percent of the total allowed Covered Expense. The last monthly 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 on or after the Insured's 19 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in the first 12 months that a person is insured if the person is a Late Entrant.
4. in any month of a Program if the Insured was not covered under this section for the entire month.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. for repair or replacement of orthodontic appliances.

## COORDINATION OF BENEFITS

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

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:
  - a. Any group or blanket insurance policy.
  - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
  - c. Any labor/management, 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 Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

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

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

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

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

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

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

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

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

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

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

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



## GENERAL PROVISIONS

**NOTICE OF CLAIM.** 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 Policyholder's name, Insured's name, and policy 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 date of the loss for which claim is made. If it was not reasonably possible 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:

1. as soon as is reasonably possible; and
2. within one year after the 90 day period.

**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 Insured unless otherwise agreed upon through your authorization or provider contracts.

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

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

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

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

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

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

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

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

## **NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES**

We are required by law to maintain the privacy of our insured members' and their dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be provided to you directly or to your group's Plan Sponsor (usually your employer) by regular mail or e-mail with instructions to deliver a paper copy to each certificate holder.

**THIS NOTICE DESCRIBES OUR PRACTICES REGARDING YOUR PROTECTED HEALTH INFORMATION MAINTAINED BY THE GROUP DENTAL LINE OF BUSINESS WITHIN THE UNIFI COMPANIES.**

**THIS NOTICE MORE PARTICULARLY DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **Contact Information**

All of the entities affiliated under the common control of the UNIFI Mutual Holding Company that pay for the cost of healthcare, including Ameritas Life Insurance Corp. and First Ameritas Life Insurance Corp. of New York, are required by federal law to maintain the privacy of your protected health information and to provide notice of the legal duties and privacy practices with respect to your protected health information. This Notice fulfills the "Notice" requirements of the Final Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about any part of this Notice of Protected Health Information Privacy Practices or desire to have further information concerning the information practices at the UNIFI Companies, please direct your inquiries to: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at [privacy@ameritas.com](mailto:privacy@ameritas.com).

**THIS NOTICE IS PUBLISHED AND BECOMES EFFECTIVE: APRIL 14, 2003**

### **OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION**

We understand that information about you and your family is personal and we are committed to protecting your privacy and the security of your protected health information. This Notice explains the ways in which we use and disclose protected health information about you and your covered dependents and details certain obligations we have in connection with such use and disclosure. It also describes your rights with regard to your protected health information. **We are required by both law and internal policy to: make sure that protected health information that identifies you and/or your covered dependents is kept private; give you notice of our legal duties and privacy practices and your rights with respect to your protected health information; and follow the practices outlined in this Notice.**

### **WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE**

The Protected Health Information Privacy Practices described in this Notice have been adopted and implemented by all of the divisions and associates who work directly or indirectly with your protected health information within the following UNIFI Companies: Ameritas Life Insurance Corp.; and First Ameritas Life Insurance Corp. of New York. All of the associates who need access to your protected health information in order to service your products and administer your claims have received proper training about how to protect your privacy, secure your protected health information and adhere to our Privacy of Protected Health Information Policies, Practices and Procedures.

In order to keep costs of your coverage down and provide you with the best customer service, we may contract with outside carriers and/or vendors, known as "business associates," to assist us with the administration of your policy. For example, we may contract with third party administrators who process claims and collect premium payments; or paper-shredding companies who destroy records when they are no longer needed. Because these business associates need access to your protected health information in order to fulfill their obligations to us, we **require** them to agree in writing to keep **your protected health information confidential** in the same manner that we do as described in this Notice.

## **TYPES OF PROTECTED HEALTH INFORMATION WE MAY HAVE AND HOW WE OBTAIN IT**

**Protected Health Information is: Any information that identifies you that we obtain from you or others that relates to your past, present or future healthcare including the payment for such healthcare.**

In the regular course of business we receive protected health information about you in order to provide you with our products and services. Some of this protected health information comes directly from you. For example, when you purchase one of our health insurance products for you and your family, you provide us with information about you and your covered dependents such as name, address, phone number, social security number, etc. Some of the protected health information we obtain about you comes from your provider. For example, as you and your covered dependents utilize your coverage, your healthcare provider sends us information about services and treatments performed so that we can process and pay your claims. All of this information we receive about you and your covered dependents is necessary in order for us to provide you and your covered dependents with quality health insurance products and to comply with legal requirements.

## **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following categories describe different ways we may use and disclose your protected health information without your authorization. For each category of uses and disclosures, we will explain what we mean and give an example. Not every use or disclosure in a category will be listed. All of the ways we are permitted to use and disclose information will fall within one of the identified categories.

**For Payment: We may use and disclose protected health information about you and your covered dependents in order to verify your coverage to your provider, process payment for claims filed under your policy or coordinate benefits with another carrier.** For example, we may need to disclose your protected health information to a provider whom you have seen or are planning to see in order to pre-approve that a particular treatment you are seeking is covered under your plan. It is also necessary for us to use the information received from your medical provider concerning the services rendered to you so the health plan can pay the provider or reimburse you for the cost of the treatment under the terms of your plan. Finally, when you have more than one insurance policy that covers some of the same procedures as your plan with us, it may be necessary for us to exchange payment information with the carrier of your other insurance plan in order to coordinate the payment of your claim with that other carrier.

**For Health Care Operations: We may use and disclose protected health information about you and your covered dependents as necessary to operate your health insurance plan and promote quality service.** For example, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management.

**Business Associates: We may disclose protected health information to other persons or organizations, known as business associates, who provide services on our behalf under contract.** However, in order to assure the protection of your private information, we require our business associates to adhere to our Privacy Policies concerning the use and disclosure of your protected health information and appropriately safeguard the information we disclose to them. We prohibit our business associates from using and disclosing any of your protected health information in any manner except for the purpose intended by the contract. Business associates are expressly prohibited from using your protected health information to create any marketing target lists.

**Plan Sponsors:** We may disclose your protected health information to your plan sponsor (usually your employer). It is our policy not to disclose your protected health information to your Plan's sponsor. There may be exceptional occasions that your Plan Sponsor requests protected health information. We will only disclose your protected health information to your Plan Sponsor if we have your authorization to do so, or if the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

**Public policy uses and disclosures of your protected health information**

**We may use and disclose your protected health information for public policy purposes. For example:**

**As Required By Law:** We will disclose protected health information about you or your covered dependent when required to do so by federal, state or local law. For example, we may be required by law to disclose certain protected health information about you pursuant to a court order or subpoena served upon us.

**About Victims of Abuse, Neglect or Domestic Violence:** For example, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Workers' Compensation:** We may release your protected health information for workers' compensation or similar programs that provide benefits to you for work-related injuries or illness but only in a manner consistent with applicable laws.

**Public Health:** We may have an occasion to disclose protected health information about you or your covered dependent for public health activities to a public health authority that is permitted by law to collect or receive the information. A public health activity would be, for example, an activity conducted by a public health authority in the furtherance of preventing or controlling disease, injury or disability; reporting births, deaths or reactions to medications; or notifying people of recalls of products they may be using.

## **AUTHORIZED USES AND DISCLOSURES**

**From time to time you may request that we disclose your protected health information to other individuals or entities.** For example, you may request that we disclose your claims history to an attorney that you have hired to assist you in a civil matter. **Likewise, we may ask your permission to use or disclose your protected health information.** Any disclosures, such as these that do not fit into one of the categories in the previous section require us to obtain your written authorization prior to making such disclosure. In the event that you do provide us with written authorization to use or disclose your information, you may revoke such authorization at any time by writing to the Privacy Officer at the address indicated in the "Contact" section of this Notice below.

## **YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION**

You have the following rights regarding protected health information that we maintain about you. All requests must be made in writing.

**Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice. You have a right to receive this Notice because you are insured by a health plan offered by Ameritas Life Insurance Corp. or First Ameritas Life Insurance Corp. of New York. You may ask us to give you a copy of this Notice at any time and we will comply. Even if you have agreed to receive this Notice electronically, you are entitled to a paper copy of this Notice if you so request.

**Your Right to an Accounting of Disclosures:** You have the right to request a listing of any disclosures of your protected health information that we have made that are required by law. This listing would exclude disclosures we made to you, or pursuant to your authorization or request, or for payment of your claims as described above, or for health care operations as described above. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically, fax etc.). The first accounting of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists during that same 12-month period. In the event that you may incur a charge, we will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

**Your Right to Request an Amendment:** You have the right to request an amendment to the protected health information that we maintain about you if you believe that our information is incorrect or incomplete. You maintain the right to request an amendment for as long as the information is kept by or for the UNIFI Companies. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: 1) was not created by us; 2) is not part of the medical information kept by or for a UNIFI Company; 3) is not part of the information which you would be permitted to inspect and copy under the law; or 4) is accurate and complete.

**Your Right to Request a Restriction:** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for, payment or health plan operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for care, like a family member or friend. We are not required to agree to your request. If we do agree to a requested restriction, we will comply with your request unless the information is needed to facilitate emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

**Your Right to Request Confidential Communications:** You have the right to request that we communicate with you about payment for your medical matters in an alternative means (such as by fax) or at an alternative location (such as to your office). To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Your Rights to Inspect and Copy:** You have the right to inspect and copy protected health information that we maintain about you that may be used to make decisions about payment for your care. To inspect this protected health information you may contact the Privacy Officer. To obtain copies of such protected health information, you must submit your request in writing as indicated below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your protected health information, in most situations you may request that the denial be reviewed by a licensed health care professional who did not take part in the decision to deny access. We will comply with the outcome of the review.

**Your Right to Make Complaints:** If you believe that your privacy rights have been violated you may make a complaint to the UNIFI Companies Privacy Office or to the Secretary of Health and Human Resources as follows:

UNIFI Privacy Office  
Attn. HIPAA Privacy  
P.O. Box 81889  
Lincoln, NE 68510

Secretary, Health and Human Services, Office of Civil Rights  
United States Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building  
Washington D.C. 20201

Any complaint you file will not cause you to suffer retaliation from our company. We will promptly investigate your complaint as soon as we receive it. When we have completed our investigation, we will notify you of our findings. If the investigation reveals that your privacy rights have indeed been violated, we will immediately take the appropriate measures to correct the violation pursuant to our Privacy Practices and Procedures.

### **Individual Rights Contact**

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form.

### **Effective Date**

This Notice will become effective as of April 14, 2003.

