Dental Certificate

Say Cheese Dental Network
Client Number – 6614 and 6615
Subclient Number – 1162, 6000, 6001 and 6002

Plan Name: $750 Comprehensive Plan

Benefit Year: January 1 through December 31

Deductible: None

Maximum Benefit: $750 total per Covered Person per Calendar Year on all services.

Introduction to Your Dental Certificate

What Is a Dental Certificate?

The *Dental Certificate* describes Covered Dental Care Services, subject to the terms, conditions, exclusions and limitations of the Policy.

This *Dental Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Say Cheese Dental Network. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Defined Terms*.

How Do You Contact Us?

Call us at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m. Throughout the document you will find statements that encourage you to contact us for more information.

Would You Like a Printed List of Dental Providers?

Call us at 800-378-5234 (TTY users may call 711), Monday–Friday from 8 a.m. to 8 p.m. and daily from 8 a.m. to 8 p.m. during the months of October 1, 2025, through March 31, 2026.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply.

- Your enrollment must be in accordance with the requirements of the Policy issued, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Defined Terms*.

Be Aware the Policy Does Not Pay for All Dental Care Services

The Policy does not pay for all dental care services. Benefits are limited to Covered Dental Care Services. The *Schedule of Covered Dental Care Services* will tell you the portion you must pay for Covered Dental Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Dental Provider. We do not make decisions about the kind of care you should or should not receive.

Choose Your Dental Provider

It is your responsibility to select the dental care professionals who will deliver your care. We arrange for Dental Providers and other dental care professionals and facilities to participate in Say Cheese Dental Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not guarantee the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

You are responsible for verifying the participation status of your Dental Provider, prior to receiving such Dental Care Services.

If you fail to verify whether your treating Dental Provider is in the Say Cheese Dental Network, and the failure results in non-compliance with our required procedures, Coverage of Benefits may be denied.

Your Cost Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Dental Care Services. These payments are due at the time of service or when billed by the Dental Provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Covered Dental Care Services*. You must also pay any amount that exceeds the Allowed Amount.

Cost of Excluded Services

You must pay the cost of all excluded services and items. Review the *Exclusions and Limitations* section to become familiar with the Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an Out-of-Network provider, you may be responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *How to File a Claim*.

Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

Benefits are available on the first day of coverage without a waiting period, provided all of the following conditions are met.

- The dental care service, including supplies or Pharmaceutical Products, is only a Covered Dental Care Service if it is Necessary. (See definitions of Necessary and Covered Dental Care Service in *Defined Terms*.)
- You receive Covered Dental Care Services while the Policy is in effect.
- You receive Covered Dental Care Services prior to the date that any of the individual termination conditions listed in *When Coverage Ends* occurs.
- The person who receives Covered Dental Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, or its symptoms does not mean that the procedure or treatment is a Covered Dental Care Service under the Policy.

This section describes Covered Dental Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Dental Care Services* for details about the following.

- The amount you must pay for these Covered Dental Care Services (including any Deductibles, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Dental Care Services (frequency and dollar limits on services and/or materials and waiting periods).

Please note that in listing services or examples, when we say, "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Pre-Treatment Estimate

If the charge for a Dental Care Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental X-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Care Service under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent

to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Treatment Estimates are not an agreement to pay for expenses. These estimates provide an advance overview of approximately what portion of the expenses are eligible for reimbursement under your Network Benefits and may indicate if any services are considered Exclusions based on your Network Benefits.

The Pre-Treatment Estimate is valid for 90 calendar days from the date we provide it to your Dental Provider. If you will not receive the services within the 90 calendar days, you or the Dental Provider must request another Pre-Treatment Estimate from us.

Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if either of the following is true.

- It is recommended or prescribed by a Physician or Dental Provider.
- It is the only available treatment for your condition.

The services, treatments, and materials listed in this section are not Covered Dental Care Services, except as may be specifically provided for in *Covered Dental Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Dental Care Service categories described in *Covered Dental Care Services*, those limits are stated in the corresponding Covered Dental Care Service category in the *Schedule of Covered Dental Care Services*. Limits may also apply to some Covered Dental Care Services that fall under more than one Covered Dental Care Service category. When this occurs, those limits are also stated in the *Schedule of Covered Dental Care Services* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Exclusions

Except as may be specifically provided in the *Schedule of Covered Dental Care Services* or through a Rider to the Policy, the following are not Covered Dental Care Services.

1. All taxes applicable to the services.
2. Appliances or services started before a person became eligible under this Plan.
3. Appliances, surgical procedures, and restorations for increasing vertical dimensions; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
4. Biological materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
5. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.

6. Charges for failure to keep a scheduled visit with the Dentist.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Chemical curettage.
9. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Say Cheese Dental Network.
10. Diagnostic photographs and cephalometric films.
11. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
12. General anesthesia and intravenous sedation for (a) surgical procedures unless medically necessary, or (b) restorative dentistry.
13. Implant/abutment supported interim fixed denture for edentulous arch.
14. Interim caries arresting medicament.
15. Lost, missing, or stolen appliances of any type.
16. Metal bases on removable prostheses.
17. Mounted cases analyses.
18. Myofunctional therapy.
19. Paste-type root canal fillings on permanent teeth.
20. Personalization or characterization of any appliance or service.
21. Posterior bridges in conjunction with partial dentures in the same arch sharing at least one posterior edentulous space in common.
22. Precision attachments and stress breakers.
23. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.
24. Preventive control programs (including oral hygiene instructions, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
25. Processing policies may otherwise exclude payments by Say Cheese Dental Network for services or supplies.
26. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
27. Replacement, repair, adjustments or relines of occlusal guards.
28. Replacement of complete dentures fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If the replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
29. Replacement, repair, relines or adjustments of occlusal guards.

30. Services associated with overdentures.
31. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
32. Services or supplies covered under a hospital, medical, surgical, or prescription drug program.
33. Services or supplies for which the patient is not legally obligated to pay, or for which no charges would be made in the absence of Say Cheese Dental Network coverage.
34. Services or supplies received due to an act of war, declared or undeclared or terrorism.
35. Services or supplies, that are investigational in nature, including services or supplies required to treat complications from investigational procedures, as determined by Say Cheese Dental Network.
36. Services or supplies, for correction of congenital or developmental malformations, as determined by Say Cheese Dental Network.
37. Services or supplies, for which no valid dental need can be demonstrated, as determined by Say Cheese Dental Network.
38. Services or supplies, which are specialized techniques, as determined by Say Cheese Dental Network.
39. Services related to the temporomandibular joint (TMG), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for temporomandibular joint.
40. Services rendered by a provider with the same legal residence as you or who is a part of your family, including but not limited to: spouse, brother, sister, parent or child.
41. Services rendered while covered under this Policy which were also covered by a prior carrier will be reviewed based on current Policy Coverage. Any Policy Exclusions and/or limitations will apply based on when the Covered Dental Care Service was originally rendered.
42. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
43. Surgical extractions of wisdom teeth.
44. Temporary crowns used for temporization during crown or bridge fabrication.
45. The replacement of teeth beyond the normal complement of teeth.
46. Treatment other than by a Dentist, except for services performed by a licensed dental professional or dental hygienist, as determined by Say Cheese Dental Network, under the scope of his or her license as permitted by applicable state law.

47. Treatment of benign cysts, neoplasms, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excisions.

Say Cheese Dental Network does not reimburse for the following services or supplies when provided by an In-Network Dental Provider, and you may not be balance billed. You may incur charges if any of the services listed below were provided by an Out-of-Network Dental Provider.

1. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
2. A prophylaxis when done on the same day as periodontal maintenance or scaling and root planning.
3. A pulp cap, when done with a sedative filling or any other restoration. A temporary filling or sedative, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as a completed root canal treatment.
4. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
5. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
6. Acid etching, cavity liners, cement bases, and bases or temporary fillings.
7. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
8. Any substructure when done for inlays, onlays, and veneers.
9. Charges for fees of overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
10. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Full mouth debridement when done on the same day as a comprehensive evaluation, or when done within 30 days of scaling and root planing.
13. Gingivectomy as an aid to the placement of a restoration.
14. Infection control.
15. Local anesthesia.

16. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
17. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Say Cheese Dental Network.
18. Periodontal charting.
19. Pins and preformed posts, when done with core buildups for crowns, inlays, or onlays.
20. Post-operative X-rays, when done following any complicated service or procedure.
21. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planning or other periodontal treatment.
22. Processing policies that may otherwise exclude payment by Say Cheese Dental Network for services or supplies.
23. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
24. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant services without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planning, periodontal surgery or debridement of a peri-implant defect.
27. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
28. Services or supplies, as determined by Say Cheese Dental Network, which are not provided in accordance with generally accepted standards of dental practice.
29. Temporary, interim, or provisional crowns.
30. The completion of forms or submission of claims.
31. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or a reline or rebase of a denture.

When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Dental Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any dental care services received after that date.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below.

- **The Entire Policy Ends**
  Your coverage ends on the date the Policy ends.
- **You Are No Longer Eligible**
  Your coverage ends on the date you are no longer eligible to be a Subscriber. Please refer to *Defined Terms* for definitions of the terms "Covered Person" and "Subscriber".
- **We Receive Notice to End Coverage**
  Your coverage ends on the date we receive the required notice from you to end your coverage, or on the date requested in the notice, if later.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

How to File a Claim

How Are Covered Dental Care Services from In-Network Dental Providers Paid?

We pay In-Network Dental Providers directly for your Covered Dental Care Services. If an In-Network Dental Provider bills you for any Covered Dental Care Service, please contact us. However, you are required to meet any applicable deductible and to pay any required Copayments and Coinsurance to In-Network Dental Providers. You will also be responsible for any charges that are not covered by the Policy to your Dental Provider.

How Are Covered Dental Care Services from an Out-of-Network Provider Paid?

When you receive Covered Dental Care Services from an Out-of-Network provider, you may be responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that dental care service will be denied or reduced, as determined by us.

This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information.

- The Subscriber's name and address.
- The patient's name and date of birth.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider(s) including a complete dental chart showing extractions, fillings or other Dental Care Services rendered before the charge was incurred for the claim.
- Radiographs, lab, or hospital reports, as applicable.
- Casts, molds, or study models, as applicable.
- An itemized bill which includes the CDT codes or a description of each charge.
- The date dental disease began.

The above information should be filed with us at:
MEMBER REIMBURSEMENT CLAIMS
PO BOX 644
MILWAUKEE WI 53201

If you would like to use a claim form, you may access a form on the internet at **saycheesedentalnetwork.com** or call us at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m. and a claim form will be provided to you.

Payment of Benefits

When you complete the Out-of-Network Member Reimbursement Form, the reimbursement will be sent directly to you. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other Dental Providers.

Coordination of Benefits

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below governs the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Defined Terms

Allowed Amounts – Allowed Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are determined as stated below.

A. For In-Network Benefits, when Covered Dental Care Services are received from In-Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with that Dental Provider.
B. For Out-of-Network Benefits, when Covered Dental Care Services are received from Out-of-Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with an In-Network Dental Provider in the same geographic area.

Annual Deductible – the total of the Allowed Amount you must pay for Covered Dental Care Services in a calendar year before we will begin paying for In-Network or Out-of-Network Benefits in that calendar year. It does not include any amount that exceeds Allowed Amounts. The Schedule of Covered Dental Care Services will tell you if your plan is subject to an Annual Deductible.

Benefits – your right to payment for Covered Dental Care Services that are available under the Policy.

Calendar Year – each successive period of 12 months starting on January 1 and ending December 31, when accumulators for applicable deductibles and plan maximums are calculated.

CDT Codes – mean the Current Dental Terminology for the current Code on Dental Procedures and Nomenclature (the Code). The Code has been designated as the national standard for reporting dental care services by the Federal Government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) and is currently recognized by third party payors nationwide.

Clinical Review – is the process where Say Cheese Dental Network reviews dental documentation, such as patient records, X-rays, and treatment plans, to evaluate and determine if the care provided aligns with clinical guidelines, dental practice standards and dental policies.

Coinsurance – the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Dental Care Services.

Congenital Anomaly – a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment – the charge, stated as a set dollar amount, that you are required to pay for certain Covered Dental Care Services.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function.

Covered Dental Care Service(s) or Dental Procedures – dental care services, including supplies or materials, which we determine to be all of the following.

- Necessary.
- Treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.
- Described as a Covered Dental Care Service in this *Dental Certificate* under *Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *Dental Certificate* under *Exclusions and Limitations*.

Covered Person – a person who is enrolled in a plan that offers Say Cheese Dental Network benefits.

Dental Provider – any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Care Services, perform dental surgery or administer anesthetics for dental surgery.

Emergency – a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Experimental or Investigational Service(s) – medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following.

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Foreign Services – services provided outside the U.S. and U.S. territories.

Initial Enrollment Period – the first period of time when Covered Persons may enroll themselves under the Policy.

In-Network Benefit – the description of how Benefits are paid for Covered Dental Care Services received by In-Network Dental Providers that participate in the Say Cheese Dental Network.

In-Network Dental Provider – when used to describe a provider of dental care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Dental Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Dental Care Services, but not all Covered Dental Care Services, or to be an In-Network Dental Provider for only some of our products. In this case, the provider will be a Network provider for the Covered Dental Care Services and products included in the participation agreement and an Out-of-Network provider for other Covered Dental Care Services and products. The participation status of providers will change from time to time.

Maximum Benefit – the maximum amount paid for Covered Dental Care Services during a calendar year for you under the Policy. The Maximum Benefit is stated in The Schedule of Covered Dental Care Services.

Natural Tooth – sound natural teeth are defined as teeth that are free of any pathological, functional or structural disorders at the time of injury and not having had any restorative treatment including, but not limited to fillings, root canals, crowns, caps and orthodontia in place at the time of trauma.

Necessary – Dental Care Services and supplies which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate; and

A. needed to meet your basic dental needs; and
B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service; and
C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us; and

D. consistent with the diagnosis of the condition; and
E. required for reasons other than the convenience of you or your Dental Provider; and
F. demonstrated through prevailing peer-reviewed dental literature to be either:
   1. safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or
   2. safe with promising efficacy:
      a. for treating a life-threatening dental disease or condition; and
      b. in a clinically controlled research setting; and
      c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this *Dental Certificate.* The definition of Necessary used in this *Dental Certificate* relates only to Coverage and differs from the way in which a Dental Provider engaged in the practice of dentistry may define Necessary.

Network Benefits – the description of how Benefits are paid for Covered Dental Care Services provided by Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Out-of-Network Benefits – the description of how Benefits are paid for Covered Dental Care Services received by providers that do not participate in the Say Cheese Dental Network, i.e. (Out-of-Network providers). The *Schedule of Covered Dental Care Services* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Network Member Reimbursement Form – is the form used when a member paid for services received from an Out-of-Network Provider, and is requesting reimbursement from Say Cheese Dental Network.

Out-of-Network Dental Provider – any provider that does not participate in the Say Cheese Dental Network.

Physician – any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy – the entire agreement issued to the Subscriber that includes all of the following.

- Policy
- Application
- Riders
- Amendments

These documents make up the entire agreement.

Policy Charge – the sum of the Premiums for all Covered Persons enrolled under the Policy.

Premium – the periodic fee required for each Subscriber in accordance with the terms of the Policy.

Pre-Service Request – are requests that require Clinical Review or Benefit confirmation prior to receiving dental care. These services will have an asterisk (*) next to the ADA Dental Code.

Pre-Treatment Estimate – an estimation of the cost for planned services.

Procedure in Progress – all treatment for Covered Dental Care Services that results from a recommendation and an exam by a Dental Provider. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Rider – any attached written description of additional Covered Dental Care Services not described in this *Dental Certificate*. Covered Dental Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Say Cheese Dental Network – is a network of Dental Providers that have a participation agreement to provide Covered Dental Care Services at the In-Network benefit.

Schedule of Covered Dental Care Services – the Schedule of Covered Dental Care Services describes the Covered Dental Services and any applicable limitations to those services, such as applicable waiting periods, maximum benefits, and member cost share. If a specific service is not listed in the Schedule of Covered Dental Care Services**, it is not covered under your plan.**

Subscriber – a Covered Person who is properly enrolled under the Policy. The Subscriber is the person on whose behalf the Policy is issued.

Usual and Customary – Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services. If a Dental Provider routinely waives Copayments and/or the applicable deductible for benefits, Dental Care Services for which the Copayments and/or the applicable deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies/

- As shown in the most recent edition of the *Current Dental Terminology*, a publication of the *American Dental Association*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate sources of determination accepted by us.

Schedule of Covered Dental Care Services

How Do You Access Benefits?

The Schedule of Covered Dental Care Services: (1) describes the Covered Dental Care Services and any applicable limitations to those services; (2) outlines the Copayment and/or Coinsurance that you are required to pay and the applicable Waiting Periods for each Covered Dental Care Service; and (3) describes the applicable Deductible and any Maximum Benefits that may apply.

If a specific service is not listed in the Schedule of Covered Dental Care Services, **it is not covered under your plan.**

You can choose to receive In-Network Benefits or Out-of-Network Benefits.

In-Network Dental Providers

We have arranged with certain Dental Providers to participate in Say Cheese Dental Network. These In-Network Dental Providers have agreed to discount their charges for Covered Dental Care Services and supplies.

If In-Network Dental Providers are used, the amount of Covered expenses for which you are responsible will generally be less than the amount owed if Out-of-Network Dental Providers had been used.

Directory of Say Cheese Dental Network Providers

A Directory of Say Cheese Dental Network Providers may be accessed online at **saycheesedentalnetwork.com**. You can also call customer service to determine which Dental Providers participate in the Say Cheese Dental Network at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

In-Network and Out-of-Network Benefits

This Schedule of Covered Dental Care Services describes both benefit levels available under the Policy.

In-Network Benefits

Dental Care Services must be provided by an In-Network Dental Provider to be receive In-Network Benefits.

The only exception is if you need emergency care, and you are out of your service area or are unable to contact your general Dental Provider. In this situation, emergency care will be covered as an In-Network Benefit, and you will not be responsible for greater out-of-pocket expenses than if you had received services from a Say Cheese Dental Network Provider. You must submit appropriate reports and X-rays for review.

When Dental Care Services are received from an Out-of-Network Dental Provider as a result of an Emergency, the Coinsurance will be the In-Network Coinsurance.

Enrolling for Coverage under the Policy does not guarantee Dental Care Services by a particular Say Cheese Dental Network Provider on the list of Dental Providers. **The list of Network Dental Providers is subject to change.** When a Dental Provider on the list no longer has a contract with us, you must choose among remaining Network Dental Providers.

You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services. **If you fail to verify whether your treating Dental Provider is an In-Network Dental Provider, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.**

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, appropriate Waiting Period, satisfaction of any applicable deductible, and payment of the Coinsurance specified for any service shown in this *Schedule of Covered Dental Care Services* and generally require you to pay less to the In-Network Dental Provider than Out-of- Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits

When Network Coinsurance is charged as a percentage of Allowed Amounts, the amount you pay for Dental Care Services from an In-Network Dental Provider is determined as a percentage of the negotiated contract fee between us and the Dental Provider rather than a percentage of the Dental Provider's billed charge. Our negotiated rate with the Dental Provider is ordinarily lower than the Dental Provider's billed charge.

An In-Network Dental Provider cannot charge you or us for any service or supply that is not Necessary as determined by us. **If you agree to receive a service or supply that is not Necessary, the In-Network Dental Provider may charge you. These charges will not be considered Covered Dental Care Services and will not be payable by us.**

Out-of-Network Benefits
Out-of-Network Benefits apply when you obtain Dental Care Services from Out-of-Network Dental Providers.

Before you are eligible for Coverage of Dental Care Services obtained from Out-of-Network Dental Providers, you must meet the requirements for payment of the applicable deductible and appropriate Waiting Period stated below. Generally, you are required to pay more than In-Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

We will reimburse an Out-of-Network Dental Provider for a Covered Dental Care Service up to an amount equal to the contracted fee for the same Covered Dental Care Service received from a similarly situated In-Network Dental Provider. The actual charge made by an Out-of-Network Dental Provider for a Covered Dental Care Service may exceed the contracted fee. As a result, you may be responsible for paying an Out-of-Network Dental Provider more than the contracted rate for a Covered Dental Care Service. In addition, when you receive Covered Dental Care Services from an Out-of-Network Dental Provider, you need to submit a claim with us to be reimbursed for a percentage of the Allowed Amounts.

Schedule of Covered Dental Care Services

In-Network Benefits: The percentage of the **allowed** amounts covered by Say Cheese Dental Network.

Out-of-Network Benefits: The percentage of the **allowed** amounts covered by Say Cheese Dental Network.

You must also pay the difference between the Out-of-Network Provider-charged amount and the Say Cheese Dental Network payment.

An asterisk (*) represents the dental services that require Clinical Review with Say Cheese Dental Network.

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D0100-D0999: Diagnostic Services				
D0120	Periodic oral evaluation – established patient	100%	20%	Twice per calendar year
D0140	Limited oral evaluation – problem focused	100%	20%	Twice per calendar year.
D0150	Comprehensive oral evaluation – new or established patient	100%	20%	Once every 36 months
D0160	Detailed and extensive oral evaluation – problem focused, by report	100%	20%	Once every 36 months
D0180	Comprehensive periodontal evaluation – new or established patient	100%	20%	Once per calendar year
D0190	Screening of a patient	100%	80%	Once per calendar year
D0210	Intraoral – complete series of radiographic images	100%	20%	Once every five-year period

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D0220, D0230	Intraoral – periapical first, and each additional radiographic image	100%	20%	Covered dental care service
D0240	Intraoral-occlusal radiographic image	100%	20%	Twice per calendar year
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	100%	20%	Twice per calendar year
D0270	Bitewing – single radiographic image (X-ray)	100%	20%	Covered dental care service
D0272, D0273, D0274, D0277	Bitewing radiographic image (X-rays), 2-8 images	100%	20%	Once per calendar year
D0330	Panoramic radiographic image	100%	20%	Once every five-year period
D0419	Assessment of salivary flow, by measurement	100%	20%	Once every three-year period
D0460	Pulp vitality tests	100%	20%	One per day
D0999*	Unspecified diagnostic procedure, by report	100%	20%	One per day
D1000-D1999: Preventive				
D1110	Prophylaxis – adult	100%	20%	Twice per calendar year
D1206, D1208	Topical application of fluoride	100%	20%	Once per calendar year
D1999*	Unspecified preventive procedure, by report	100%	20%	One per day

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D2000-D2999: Restorative				
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	Amalgam and resin-based composite restoration, anterior and posterior	50%	20%	One every two-year period
D2390*	Resin-based composite crown, anterior	50%	20%	One every five-year period
D2542* D2543* D2544*	Onlay – metallic; multiple surfaces	50%	20%	One every five-year period
D2642* D2643* D2644* D2662* D2663* D2664*	Onlay – porcelain/ceramic or resin based; multiple surfaces	50%	20%	One every five-year period
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*, D2783*	Crown – resin-based composite or porcelain/ceramic	50%	20%	One every five-year period
D2780*, D2781*, D2782*	Crown – 3/ 4 cast	50%	20%	One every five-year period

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D2790*, D2791*, D2792*, D2794*	Crown – full cast	50%	20%	One every five-year period
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	50%	20%	One every 24 months
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	50%	20%	One every 24 months
D2920	Re-cement or re-bond crown	50%	20%	One every 24 months
D2921	Reattachment of tooth fragment, incisal edge or cusp	50%	20%	One every 24 months
D2928, D2929, D2930, D2931, D2932, D2933, D2934	Prefabricated crown	50%	20%	One every 24 months
D2940	Protective restoration	50%	20%	One per tooth, per lifetime
D2941	Interim therapeutic restoration – primary dentition	50%	20%	One per tooth, per lifetime
D2950*	Core buildup, including any pins when required	50%	20%	One every five-year period
D2951	Pin retention – per tooth, in addition to restoration	50%	20%	One per tooth, per lifetime
D2952*, D2954*	Post and core in addition to crown	50%	20%	One every five-year period
D2955	Post removal	50%	20%	One per tooth, per lifetime

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D2971	Additional procedures to construct new crown under existing partial denture framework	50%	20%	One every five-year period
D2980, D2981, D2982, D2983	Repair necessitated by restorative material failure	50%	20%	One every 24 months
D2999*	Unspecified restorative procedure, by report	50%	20%	One per day
D3000-D3999: Endodontics				
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	50%	20%	One per tooth, per lifetime
D3221	Pulpal debridment, primary or permanent teeth	50%	20%	One per tooth, per lifetime
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	50%	20%	One per tooth, per lifetime
D3230, D3240	Pulpal therapy (resorbable filling) – anterior or posterior primary tooth (excluding final restoration)	50%	20%	One per tooth, per lifetime
D3310, D3320, D3330	Endodontic therapy; anterior, premolar or molar tooth, (excluding final restoration)	50%	20%	One per tooth, per lifetime
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	20%	One per tooth, per lifetime
D3333	Internal root repair of perforation defects	50%	20%	One per tooth, per lifetime

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D3346*, D3347*, D3348*	Retreatment of previous root canal therapy; anterior, premolar or molar	50%	20%	One per tooth, per lifetime
D3351, D3352, D3353	Apexification/recalcification, initial, interim and final visit (apical closure/calcific repair of perforations, root resorption, root canal, pulp space, disinfection etc.)	50%	20%	One per tooth, per lifetime
D3410, D3421, D3425, D3426	Apicoectomy, anterior, premolar or molar or each additional root	50%	20%	One per tooth, per lifetime
D3430	Retrograde filling – per root	50%	20%	One per tooth, per lifetime
D3450*	Root amputation – per root	50%	20%	One per tooth, per lifetime
D3471, D3472, D3473	Surgical repair of root resorption, anterior, premolar or molar	50%	20%	One per tooth, per lifetime
D3501, D3502, D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption; anterior, premolar or molar	50%	20%	One per tooth, per lifetime
D3920*	Hemisection (including any root removal), not including root canal therapy	50%	20%	One per tooth, per lifetime
D3921	Decoronation or submergence of an erupted tooth	50%	20%	One per tooth, per lifetime
D3999*	Unspecified endodontic procedure, by report	50%	20%	One per day
D4000-D4999: Periodontics				
D4210, D4211	Gingivectomy or gingivoplasty	50%	20%	Once every 36 months
D4240, D4241	Gingival flap procedure, including root planing	50%	20%	Once every 36 months

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D4245	Apically positioned flap	50%	20%	Once every 36 months
D4249*	Clinical crown lengthening - hard tissue	50%	20%	One per tooth, per lifetime
D4260*, D4261*	Osseous surgery (including elevation of a full thickness flap and closure)	50%	20%	Once every 36 months
D4263*, D4264*	Bone replacement graft – retained natural tooth	50%	20%	One every 36 months
D4265*	Biologic materials to aid in soft and osseous tissue regeneration	50%	20%	One every 36 months
D4266*, D4267*	Guided tissue regeneration	50%	20%	One every 36 months
D4268*	Surgical revision procedure, per tooth	50%	20%	One every 36 months
D4270*	Pedicle soft tissue graft procedure	50%	20%	One every 36 months
D4273*, D4277*, D4278*	Free soft tissue graft procedure (including recipient and donor surgical sites)	50%	20%	One every 36 months
D4274*	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	50%	20%	One every 36 months
D4275*	Non-autogenous connective tissue graft (including recipient site and donor materials) first tooth, implant, or edentulous tooth position in graft	50%	20%	One every 36 months
D4276*, D4283*, D4285*	Connective tissue graft (including recipient site and donor material)	50%	20%	One every 36 months

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D4341, D4342	Periodontal scaling and root planing	50%	20%	Once every 24 months
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50%	20%	Twice per calendar year
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	50%	20%	Once every 36 months
D4910	Periodontal maintenance	50%	20%	Twice per calendar year
D4999*	Unspecified periodontal procedure, by report	50%	20%	One per day
D5000-D5899: Prosthodontics				
D5110, D5120	Complete/immediate denture; maxillary or mandibular	50%	20%	One every five-year period
D5130, D5140	Immediate denture, maxillary and mandibular	50%	20%	One per tooth, per lifetime
D5211, D5212, D5213, D5214	Partial denture; maxillary or mandibular – resin base (including retentive/clasping materials, rests, and teeth)	50%	20%	Once every five-year period
D5221, D5222, D5223, D5224	Immediate partial denture; maxillary or mandibular – resin base (including any retentive/clasping materials, rests, and teeth)	50%	20%	Once every five-year period
D5225, D5226, D5227, D5228	Maxillary or mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	50%	20%	Once every five-year period

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D5282, D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary and mandibular	50%	20%	Once every five-year period
D5284	Removable unilateral partial denture – one-piece flexible base (including retentive/clasping materials, rests, and teeth) per quadrant	50%	20%	One per quadrant, per five-year period
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) per quadrant	50%	20%	One per quadrant, per five-year period
D5410, D5411, D5421, D5422	Adjust complete/partial denture; maxillary or mandibular	50%	20%	Twice per calendar year
D5511, D5512, D5611, D5612, D5621, D5622, D5630	Repair broken complete or partial denture; maxillary or mandibular	50%	20%	Twice per calendar year
D5520	Replace missing or broken teeth – complete denture (each tooth)	50%	20%	Twice per calendar year
D5640	Replace broken teeth – per tooth	50%	20%	Twice per calendar year
D5650	Add tooth to existing partial denture	50%	20%	One per tooth, per lifetime
D5660	Add clasp to existing partial denture – per tooth	50%	20%	One per tooth, per lifetime

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D5670, D5671	Replace all teeth and acrylic on cast metal framework	50%	20%	Twice per calendar year
D5710, D5711, D5720, D5721	Replace missing or broken teeth – complete denture (each tooth).	50%	20%	Once per calendar year
D5725	Rebase hybrid prosthesis	50%	20%	Once per calendar year
D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Reline complete or partial denture; maxillary or mandibular	50%	20%	Once per calendar year
D5765	Soft liner for complete or partial removable denture	50%	20%	Once per calendar year
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth); maxillary	50%	20%	Once every five-year period
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth); mandibular	50%	20%	Once every five-year period
D5850	Tissue conditioning; maxillary	50%	20%	Once every five-year period
D5851	Tissue conditioning; mandibular	50%	20%	Once per calendar year
D5899*	Unspecified removable prosthodontic procedure, by report	50%	20%	Once per lifetime
D5931*	Obturator prosthesis, surgical	50%	20%	One per tooth, per lifetime

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D5999*	Unspecified maxillofacial prosthesis, by report	50%	20%	One per day
D6200-D6999: Prosthodontics				
D6205*, D6245*	Pontic – indirect resin-based composite or porcelain/ceramic	50%	20%	One every five-year period
D6210*, D6211*, D6212*, D6214*	Pontic	50%	20%	One every five-year period
D6240*, D6241*, D6242*, D6243*	Pontic – porcelain fused	50%	20%	One every five-year period
D6250*, D6251*, D6252*	Pontic – resin based	50%	20%	One every five-year period
D6545*	Retainer – cast metal for resin bonded fixed prosthesis	50%	20%	One every five-year period
D6548*	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	50%	20%	One every five-year period
D6549*	Resin retainer – for resin bonded fixed prosthesis	50%	20%	One every five-year period
D6600*, D6601*	Retainer inlay – porcelain/ceramic; multiple surfaces	50%	20%	One every five-year period
D6602*, D6603*	Retainer inlay – cast high noble metal; multiple surfaces	50%	20%	One every five-year period
D6604*, D6605*	Retainer inlay – cast predominantly base metal; multiple surfaces	50%	20%	One every five-year period
D6606*, D6607*	Retainer inlay – cast noble metal; multiple surfaces	50%	20%	One every five-year period
D6608*, D6609*	Retainer onlay – porcelain/ceramic; multiple surfaces	50%	20%	One every five-year period

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D6610*, D6611*	Retainer onlay – cast high noble metal; multiple surfaces	50%	20%	One every five-year period
D6612*, D6613*	Retainer onlay – cast predominantly base metal; multiple surfaces	50%	20%	One every five-year period
D6614*, D6615*	Retainer onlay – cast noble metal; multiple surfaces	50%	20%	One every five-year period
D6624*	Retainer inlay – titanium	50%	20%	One every five-year period
D6634*	Retainer onlay – titanium	50%	20%	One every five-year period
D6710*	Retainer crown – indirect resin-based composite	50%	20%	One every five-year period
D6720*, D6721*, D6722*	Retainer crown – resin	50%	20%	One every five-year period
D6740*	Retainer crown – porcelain/ceramic	50%	20%	One every five-year period
D6750*, D6751*, D6752*, D6753*	Retainer crown – porcelain fused	50%	20%	One every five-year period
D6780*, D6781*, D6782*, D6784*	Retainer crown – 3/4 cast	50%	20%	One every five-year period
D6783*	Retainer crown – 3/4 porcelain/ceramic	50%	20%	One every five-year period
D6790*, D6791*, D6792*, D6794*	Retainer crown – full cast	50%	20%	One every five-year period
D6930	Re-cement or re-bond fixed partial denture	50%	20%	One time per calendar year

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D6980*	Fixed partial denture repair, necessitated by restorative material failure	50%	20%	Once every 24 months
D6999*	Unspecified fixed prosthodontic procedure, by report	50%	20%	One per day
D7000-D7999: Oral and Maxillofacial Surgery				
D7111	Extraction, coronal remnants – primary tooth	50%	20%	One per tooth, per lifetime
D7140	Extraction, erupted tooth or exposed root (elevation and or forceps removal)	50%	20%	One per tooth, per lifetime
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	50%	20%	One per tooth, per lifetime
D7220*, D7230*, D7240*	Removal of impacted tooth, soft tissue, partially bony or completely bony	50%	20%	One per tooth, per lifetime
D7241*	Removal of impacted tooth – completely bony, with unusual surgical complications	50%	20%	One per tooth, per lifetime
D7250	Removal of residual tooth roots (cutting procedure)	50%	20%	One per tooth, per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	20%	One per tooth, per lifetime
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	20%	One per tooth, per lifetime
D7280	Exposure of an unerupted tooth	50%	20%	One per tooth, per lifetime
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	50%	20%	One per tooth, per lifetime

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D7283	Placement of device to facilitate eruption of impacted tooth	50%	20%	One per tooth, per lifetime
D7286	Incisional biopsy of oral soft tissue	50%	20%	One per tooth per day
D7290	Surgical repositioning of teeth	50%	20%	One per tooth, per lifetime
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	50%	20%	One per tooth, per lifetime
D7310, D7311	Alveoloplasty in conjunction with extractions – per quadrant	50%	20%	One per quadrant, per lifetime
D7320, D7321	Alveoloplasty not in conjunction with extractions – per quadrant	50%	20%	One per quadrant, per lifetime
D7510	Incision and drainage of abscess – intraoral soft tissue	50%	20%	One per tooth per day
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	50%	20%	One per tooth per day
D7910	Suture of recent small wounds up to 5 cm	50%	20%	Covered dental care service
D7970	Excision of hyperplastic tissue – per arch	50%	20%	Once every 36 months
D7971	Excision of pericoronal gingiva	50%	20%	Once every 36 months
D7999*	Unspecified oral surgery procedure, by report	50%	20%	One per day
D9000-D9999: Adjunctive General Services				
D9110	Palliative (emergency) treatment of dental pain – minor procedure	50%	20%	Twice per calendar year

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D9120	Fixed partial denture sectioning	50%	20%	Once every five-year period
D9222*, D9223*	Deep sedation/general anesthesia – first 15 minutes and/or each subsequent 15-minute increment	50%	20%	One per code per day. Additional based on medical necessity.
D9224*, D9225*	Administration of general anesthesia with advanced airway – first 15-minute increment, or any portion thereof	50%	20%	One per code per day. Additional based on medical necessity.
D9239*, D9243*	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes and/or each subsequent 15-minute increment	50%	20%	Covered dental care service
D9244*	In-office administration of minimal sedation – single drug – enteral	50%	20%	One per code per day. Additional based on medical necessity.
D9245*	Administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof	50%	20%	One per code per day. Additional based on medical necessity.
D9246* D9247*	Administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof	50%	20%	One per code per day. Additional based on medical necessity.

ADA Dental Code	Benefit Description	In-Network Benefits	Out-of-Network Benefits	Benefit Limitation
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	50%	20%	Twice per calendar year
D9410	House/extended care facility call	50%	20%	One per day
D9420	Hospital or ambulatory surgical center call	50%	20%	One per day
D9440	Office visit – after regularly scheduled hours	50%	20%	Twice per calendar year
D9930*	Treatment of complications (post- surgical) – unusual circumstances, by report	50%	20%	Twice per calendar year
D9944*, D9946*	Occlusal guard - hard appliance; full or partial arch	50%	20%	Once every five-year period
D9951	Occlusal adjustment – limited	50%	20%	Three every five-year period
D9952	Occlusal adjustment – complete	50%	20%	Once every five-year period
D9999*	Unspecified adjunctive procedure, by report	50%	20%	One per day

Covered Dental Care Services are subject to satisfaction of any applicable Deductibles, Maximum Benefits and payment of any Coinsurance as stated below.

Cost Share: Deductibles and Benefit Maximums

Deductible: None

Maximum Benefit: $750 total per Covered Person per Calendar Year on all services.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after dental care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require Clinical Review or Benefit confirmation prior to receiving dental care. These services will have an asterisk (*) next to the ADA Dental Code.

How to Request an Appeal

If you disagree with a pre-service request for benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal at:

APPEALS
PO BOX 361
MILWAUKEE WI 53201

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Dental Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental care professional with experience in the field, who was not involved in the prior determination. We may consult with or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for

Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows.

- For appeals of pre-service requests for Benefits as identified above, the appeal will take place, and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for benefits.
- For appeals of post-service claims as identified above, the appeal will take place, and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Questions, Complaints and Grievances

The following terms apply to this section.

A "complaint" is your expression of dissatisfaction with us or any In-Network Dental Provider.

An "expedited grievance" is a grievance where any of the following applies.

- The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum control.
- In the opinion of a Physician with knowledge of your condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- A Physician with knowledge of your condition determines that the grievance should be treated as an expedited grievance.

"Grievance" means any dissatisfaction with our administration, that is expressed in writing to us, by you or on your behalf that includes any of the following.

- Provision of services.
- Determination to reform or rescind a policy.
- Claims practices.

To resolve a question, complaint, or grievance, just follow these steps.

What if You Have a Question?

Contact Customer Service at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

What if You Have a Complaint?

Contact Customer Service at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, they can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Grievance Process

Each time we deny a claim or Benefit or begin disenrollment proceedings; we will notify you of your right to file a grievance.

We will acknowledge a grievance in writing, within five business days of its receipt and resolve the grievance within 30 calendar days of its receipt. If we are unable to resolve the grievance within that time, we will extend the time period by an additional 30 calendar days.

You or an authorized representative have the right to appear in person before the grievance committee to present written or oral information. We will notify you, in writing, of the time and place of the meeting at least seven calendar days before the meeting.

Following a review of your grievance, you will receive a written notification of the committee's decision, along with the titles of the people on the grievance committee.

What to Do if Your Grievance Requires Immediate Action

In situations where the normal duration of the grievance process could have adverse effects on you, a grievance will not need to be submitted in writing. Instead, you or your Physician should contact us as soon as possible. We will resolve the grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we will notify you of our decision by the end of the next business day following the receipt of the required information.

The expedited grievance process for urgent situations does not apply to procedures that we do not consider urgent situations.

What to Do if You Disagree with Our Decision

You may resolve your problem by taking the steps outlined above in the grievance process. You may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the OFFICE OF THE COMMISSIONER OF INSURANCE at its website at **http://oci.wi.gov/** or by contacting:

Office of the Commissioner of Insurance Complaints Department
PO Box 7873
Madison, WI 53707-7873

or you can call 800-236-8517 (outside of Madison) or 608-266-0103 in Madison or email them at **complaints@ociwi.state.us** and request a complaint form.

Please note that our decision is based only on whether or not Benefits are available under the Policy. We do not determine whether the pending Dental Care Service is necessary or appropriate. That decision is between you and your Dental Provider.