COMPANION LIFE INSURANCE COMPANY
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

Policy Number:	907-14-01769	**Certificate Effective Date:**	
Certificateholder:		**Policyholder:**	County of Anson Corporation
Policy Anniversary Date:	January 01		

This Certificate is issued to the Certificateholder and subject to the laws of the jurisdiction within which the Policy has been issued.

In consideration of the application made by the Policyholder, the applications of the Certificateholders and receipt of any and all premiums when due, the Company agrees to provide the coverage described herein subject to all provisions of the Policy and any amendments added to the Policy.

The Policy may be amended or cancelled without the consent of the Insured.

This Certificate replaces all certificates previously issued to the Insured under the Policy.

The Policy shall renew on each Policy Anniversary Date unless terminated in accordance with the Termination of Insurance provision. The Entire Contract provision of the Policy determines all rights and benefits of persons who are insured hereunder.

Important Cancellation Information – Please Read The Provision Entitled "Termination of Insurance" Found On Page 10.

ANY DENTAL CARE INSURANCE BENEFITS PAYABLE UNDER THE POLICY DESCRIBED HEREIN MAY BE COMBINED WITH THE BENEFITS PAYABLE UNDER OTHER PLANS OR PROGRAMS SO THAT THE TOTAL REIMBURSEMENT FOR ALLOWABLE EXPENSES DOES NOT EXCEED THE ACTUAL EXPENSES INCURRED. SEE THE COORDINATION OF BENEFITS PROVISION FOR DETAILED INFORMATION.

In witness whereto, Companion Life Insurance Company has caused this Certificate to be signed and shall take effect on the Certificate Effective Date specified above.

Signed for by the Company

Andy Folsom
President

GROUP DENTAL INSURANCE CERTIFICATE
OPTIONALLY RENEWABLE AS
DESCRIBED WITHIN*Please read your Certificate carefully. This is a PPO Certificate.*

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Us.

For service or questions about the Policy, please address any inquiries to Companion Life, P.O. Box 1535 Dubuque, IA 52004-1535, call 1-877-676-5789 or via website www.companionlife.com.

SECTION 1 - TABLE OF CONTENTS

SECTION

SECTION 2 - SCHEDULE OF BENEFITS

NOTICE: Your actual expenses for covered services may exceed the stated Coinsurance because actual Provider charges may not be used to determine the Company's and Insured Individual's pay obligations.

Classes Eligible for Insurance	All Active Employees	
Persons Covered	Eligible Employees and Dependents	
Employees Contributions	Voluntary	
Eligibility Waiting Period	1 day	
Prior Insurance Credit	Yes	
Recommended Predetermination of Benefits Amount Applicable to All Classes of Service	$300	
	PPO	**Non PPO**
Maximum Calendar Year Benefit Applicable to Each Insured Individual for Covered Services Other than Orthodontia Preventive Services does not count toward Maximum Year Benefit	$1,000	$1,000
Maximum Applicable to Each Insured Individual for Implant Services	N/A	N/A
Annual Calendar Year Deductible Amount Applicable to Each Insured Individual for Covered Services Other Than Orthodontia	$50	$50
Family Deductible – Number of Insured Individuals	3	3
Deductible Waived for Class I Services	Yes	Yes
Benefit Waiting Period for Class II Services	None	None
Benefit Waiting Period for Class III Services	None	None
Orthodontic Services	Yes	
Lifetime Deductible Amount Applicable to Each Dependent Child for Orthodontic Services	N/A	N/A
Lifetime Maximum Applicable to Each Dependent Child for Orthodontic Services	$1,000	$1,000
Benefit Waiting Period for Orthodontic Services	None	None
Takeover Credit for Orthodontic Services	Yes	

Percentage of Covered Dental Expenses Payable:
Covered Expenses in excess of the Deductible will be paid by Companion Life up to the Maximum Calendar Year Benefit or Othodontic Lifetime Maximum, as applicable, at the benefit rates shown below:

		In-Network	Out-of-Network
Class I	Preventive Services	100%	100%
Class II	Basic Services	80%	80%
Class III	Major Services	50%	50%
Class IV	Orthodontic Services	50%	50%

If an Insured Individual is unable to receive a Covered Expense from a Participating Provider without unreasonable travel or delay, please contact Us for assistance. We will either:
1. help the Insured Individual find a Participating Provider within a reasonable distance who can see the Insured Individual within a reasonable time frame; or
pay for the Covered Expense from a Non-Participating Provider at the In-Network benefit rate shown above.

Takeover Provisions

Preferred Takeover – The Benefit Waiting Period will be waived under the Policy if the Employees were covered under the Policyholder's prior plan for similar benefits. Benefit Waiting Periods are waived for all current Employees. All Benefit Waiting Periods will continue to apply to future Employees. The current dental plan must have been in effect continuously for at least 12 months prior to the Effective Date of the Policy and the Employees must have been insured by the Policyholder's prior plan on its date of termination. Takeover applies to Class III (Major) and Class IV (Orthodontics) procedures.

SECTION 3 - DEFINITIONS

ACTIVE EMPLOYEE means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. The Employee must work the number of hours as defined in the Eligibility provision.

ACTIVE SERVICE means the performance in the customary manner by an Active Employee of all the regular duties of their employment with their Employer at one of the Employer's business establishments or at some location to which the Employer's business requires the Employee to travel.

ACTIVELY AT WORK means a day, which is one of the Employee's scheduled workdays if they are performing, in the usual way, all of the regular duties of their job. The Employee will be deemed to be Actively at Work on a day, which is not one of the Employee's scheduled workdays only if the Employee was Actively at Work on the preceding scheduled workday.

ADMINISTRATOR means an organization or entity that processes all or certain administrative functions for the Company.

ALLOWABLE CHARGE means the benefits according to a fee schedule that the Company and the Participating Provider have agreed upon. The Insured is responsible only for any Deductible amounts, the Coinsurance, and amounts in excess of any applicable maximum benefits.

For services rendered by a Non-Participating Provider, the Allowable Charge is the amount, determined by the Company, as developed from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is updated periodically; and (c) is collected on the basis of current codes and descriptions developed and maintained by recognized authorities.

BENEFIT WAITING PERIOD is a period of continuous coverage for an Insured Individual under the Policy, starting on their most recent Effective Date, during which expenses incurred for certain types of services are not covered. The lengths of all Benefit Waiting Periods, and the type of service to which they apply, are shown in the Schedule of Benefits and list of Covered Dental Expense Procedures.

CALENDAR YEAR means the 12 month period commencing on January 1st of a year and ending on December 31st of the same year.

CERTIFICATE means a document that describes the benefits provided to the Insured by the Policy.

CERTIFICATEHOLDER means the Employee who is eligible for benefits provided by the Policyholder's policy and who has been provided a Certificate of insurance.

COINSURANCE means the percentage of Covered Expenses that the Insured will pay once any Deductible is satisfied.

COMPANY is Companion Life Insurance Company. Our home office mailing address is P.O. Box 100102, Columbia, SC 29202-3102.

COVERED EXPENSES means services or treatment which are performed, prescribed, directed, or authorized by a Provider. To be considered Covered Expenses, services must be:

1) within the scope of the license of the Provider performing the service; and
2) incurred while coverage under this Certificate is in force; and
3) not specifically excluded or limited by the Certificate; and
4) listed as a covered procedure in the list of Covered Dental Expense Procedures.

DEDUCTIBLE means the amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. This Deductible must be met during each Calendar Year.

DENTIST means a person who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

DEPENDENT means:

1) an Insured's Spouse; or
2) each Insured's Dependent Child under 26 years of age; and
3) each child over 26 who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually following the child's attainment of the limiting age.

DEPENDENT CHILD means: (a) the Insured's natural child from moment of birth; (b) the Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order; (c) any foster child from the moment of placement in the foster home, for which the Insured has assumed legal obligation to support the foster child; (d) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or (e) any child for whom We have notice, pursuant to a medical support order, that the Insured must provide support in the form of dental insurance from the date of such notice. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of dental insurance.

EFFECTIVE DATE means the first date coverage under the Policy becomes effective. The Effective Date is on the Policy cover page. The Effective Date for an Insured is shown on the Certificate. All insurance will begin at 12:01 A.M. standard time, at the Policyholder's address on the Effective Date. It will end at 12:01 A.M., standard time, at the Policyholder's address on the termination date.

ELIGIBILITY WAITING PERIOD means a period of continuous Active Service with an Employer that an Employee must serve in order to qualify for coverage under the Policy. The length of any Eligibility Waiting Period is shown on the Schedule of Benefits.

EMERGENCY SERVICES means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department. Emergency Services will be covered at the in-network rate.

EMPLOYEE means a person permanently employed by the Employer for wages or salary and working for the Employer on a regular basis.

EMPLOYER means the business organization listed on the Schedule of Benefits which provides dental insurance available through the Policy to its eligible Employees and has executed an application for dental insurance acceptable to Us.

FAMILY means an Insured and his or her Dependents.

FAMILY DEDUCTIBLE is met when the number of Insured Individuals as shown on the Schedule of Benefits separately meets the Deductible shown on the Schedule of Benefits. Once the Family Deductible is met, no additional Deductible will be required for other Insured Individuals for the remainder of the Calendar Year.

FAMILY MEMBER means anyone related to an Insured Individual by blood, marriage, or adoption.

INSURED means a person who is an eligible Employee, who has qualified for insurance by completing the Eligibility Waiting Period, if any; as shown on the Schedule of Benefits and for whom coverage under the Policy has become effective.

INSURED INDIVIDUAL means the Insured and any Dependent covered under the Policy.

LATE ENTRANT means an Insured Individual whose Effective Date of Insurance is more than 31 days from the date the person qualifies for insurance, or who has elected to become insured again after the premium contribution is stopped for reasons other than loss of eligibility for insurance.

MAXIMUM CALENDAR YEAR BENEFIT means the maximum amount the Company will pay on behalf of any Insured Individual per Calendar Year.

MEDICALLY NECESSARY means services needed to treat, correct, or ameliorate a medical defect or condition as part of an essential part of an overall treatment plan developed by both the Physician and the Provider in consultation with each other. Establishment of medical necessity requires documentation to support the severe handicapping malocclusion and the presence of a qualifying medical condition.

NON-PARTICIPATING PROVIDER means a Provider who has not agreed to provide services as a Participating Provider. The Insured Individual must pay the Non-Participating Provider the full cost at the time the covered service is provided and

file a claim with the Company or its Administrator. The Company or its Administrator will reimburse the Insured Individual for the out-of-network benefits as shown in the Schedule of Benefits.

PARTICIPATING PROVIDER means a Provider who agrees to provide services at a discounted fee pursuant to a written agreement. The Insured Individual must pay at the time the covered service is provided any balance remaining after the benefits provided shown in the Schedule of Benefits. Benefits will be paid to the Participating Provider who will file a claim with the Company.

PHYSICIAN means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for sickness or injury causing the expenses or loss for which claim is made.

POLICY means the contract of insurance made by the Company and the Policyholder.

POLICY ANNIVERSARY DATE means the date established and agreed to by the Policyholder and Us from which Policy months, years, and anniversaries are computed.

POLICYHOLDER means the Employer named on the face page of the Policy and Certificate to which the Policy is issued. The term Policyholder will also include those subsidiaries, divisions, and affiliates listed in the Policy.

PREVIOUS POLICY means the policy issued to the Policyholder by the previous insurer that is replaced by this coverage on the Policy Effective Date.

PROVIDER means a healthcare professional who is professionally licensed by the appropriate state agency and who provides services within the scope of that license. A Provider's services are not covered if the Provider resides in the Insured's home or is a Family Member.

SCHEDULE OF BENEFITS means the document showing the eligible class, the amounts of insurance, and other relevant information about the plan of insurance applied for by the Employer under the Policy. It is made a part of the Policy for the purposes of defining coverage under the Policy.

SPOUSE means a lawfully recognized partner of the Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Insured and shares financial obligations and can provide legal proof of marriage. Spouse also includes the Insured's domestic partner or civil union partner as defined by state law. The Insured must provide the Policyholder and Company with proof of such legal domestic partnership or legal civil union partnership required by state law or the Company including as applicable, but not limited to, a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

YOU, YOUR, YOURS means the Insured.

WE, US, and OUR means Companion Life Insurance Company or its Administrator.

SECTION 4 - ELIGIBILITY AND ENROLLMENT

Eligible Employee means You

1) are an Active Employee working 37.5 hours or more per week who is a legal resident or citizen of the U.S.; and
2) qualify as an eligible Employee as shown in the Schedule of Benefits.

Eligible Dependents include

1) an Insured's Spouse; and/or
2) each Insured's Dependent Child under 26 years of age.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

No one can be insured as a Dependent of more than one eligible Employee.

No one on active duty in the armed forces of any country can be insured as a Dependent.

No one can be insured as a Dependent if eligible for insurance as an eligible Employee.

If both the eligible Employee and Spouse are eligible Employees of the Policyholder, only one of them may insure the Dependent Child for dental care expenses.

Dependents acquired after coverage is effective

If additional premium is required, all Dependents except for newborn children will be covered from the date they meet the definition of Dependent if written request and payment of any required premium is submitted within 31 days. Newborn children will be covered from the moment of birth for a period of 31 days. To continue coverage beyond 31 days, written request and payment of any required premium must be submitted within such 31-day period. If additional premium is not required, written notice is not required to be provided, but We recommend providing written notice to prevent delays in the payment of claims.

Eligibility Waiting Period

Employees are eligible under this Certificate after completing the Eligibility Waiting Period as described on the Schedule of Benefits, if any, as established by the Policyholder.

An Insured whose eligibility terminates and is established again within 12 month(s) will not have to complete a new Eligibility Waiting Period before becoming eligible for coverage.

If We receive an eligible Employee's enrollment more than the 31 days after completing any Eligibility Waiting Period, they will be considered a Late Entrant. An additional Benefit Waiting Period as shown on the Schedule of Benefits may apply to Late Entrants.

Enrollment if a Section 125 Plan

If the Policy is provided as part of the Employer's Section 125 Plan, each eligible Employee has the option under the Section 125 Plan of participating or not participating in the Policy. If an eligible Employee does not elect to participate when initially eligible, the eligible Employee may elect to participate at a subsequent election period. This election period will be held each year and those who elect to participate in the Policy at that time will have their insurance become effective on January 01. An eligible Employee who elects to participate during the election period who did not elect to participate when initially eligible will be considered a Late Entrant and is subject to the waiting periods associated with the Policy. Eligible Employees may change their election option only during the election period, except for a change in family status. Family status changes would be marriage, divorce, birth of a child, death of a Spouse/ child, or termination of employment of a Spouse.

Eligible Employee Effective Date

The Effective Date for an eligible Employee covered by the Policy, subject to payment of the required premium and satisfaction of the waiting period, will be the later of:

1) the Effective Date of the Policy if We receive the eligible Employee request for coverage prior to the Effective Date; or
2) 1st day of the month after We receive the eligible Employee request for coverage if that date is after the date they have met the qualifications of an eligible Employee.

Eligible Employees must be Actively at Work on the Effective Date for coverage, or any increase in coverage to take effect. If not, the coverage or increase in coverage will take effect when the eligible Employee returns to work and meets the definition of Actively at Work.

Benefit Classification Change

If an Insured's status changes so they become an eligible Employee of a different class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect on the 1st of the month.

Eligible Dependent Effective Date

The Effective Date for each eligible Dependent covered by the Policy except for newborn children will be the first day of the month after:

1) the Company's acceptance of the signed request for coverage that includes Dependent coverage; and
2) receipt of the first premium.

However, if on such date the coverage for the eligible Employee has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Effective Date for such eligible Employee.

The Effective Date for each eligible Dependent who is a newborn child covered by the Policy will be the date of birth and will continue for a period of 31 days. Coverage will continue to be effective beyond 31 days provided written request and payment of any required premium is submitted within such 31-day period.

SECTION 5 - TERMINATION/NONRENEWAL/CONTINUATION

Termination of Insurance

The Insured's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

1) the date the Policy terminates;
2) the date the Policy is amended or changed to exclude coverage for the class of eligible individuals to which the Insured belongs;
3) the date that the Insured ceases to be a member of the classes for whom insurance is provided;
4) the end of the period for which any required contribution is made, or as negotiated by Us and the Policyholder;
5) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

The Dependent's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

1) the date the Policy terminates;
2) the date the Insured's coverage terminates;
3) the date We are notified to terminate the Dependent's coverage;
4) the date that the Dependent ceases to qualify as an eligible Dependent;
5) the end of the period for which any required contribution is made, or as negotiated by Us and the Policyholder;
6) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

Continuation of Coverage

The Policyholder may, but is not required to, consider Employees as eligible Employees and continue insurance even though they are:

1) temporarily laid-off and the Policyholder expects to call them back to work;
2) put on approved leave of absence; or
3) unable to work because of injury or sickness.

The Policyholder must treat all Insureds the same for purposes of continuing insurance. If insurance is so continued, it will end on the earliest of:

1) the date the Policyholder notifies the Company that the Insured is no longer a member of an eligible class; or
2) the date that ends the period for which the Policyholder last paid the premium for the Insured and their Dependents.

Any Insured Individual has the right to continue their coverage for a limited time after it would otherwise terminate. Below explains certain instances when an Insured Individual's coverage may be continued. Please contact the Policyholder's benefits Administrator for additional information. If insurance is continued, it must be according to a plan which does not allow individual selection.

COBRA Continuation Rights

If coverage for an Insured Individual ends, they may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, amended (COBRA). For more information, contact the Policyholder's benefits Administrator. The following groups are not subject to this regulation:

1) groups of less than 20 Employees; or
2) certain church plans.

Death or Divorce – For Dependents Only

The Insured's Spouse may continue coverage under the Policy if the Insured dies or the marriage is dissolved provided the Spouse makes an election to continue coverage within 90 days of such occurrence and premium is paid within 90 days of notification of continuation. Coverage may include any Dependent Child whose insurance would end at the same time.

Coverage will terminate under continuation due to death or divorce on the earliest of:

1) the last day of the period for which the premium is paid;
2) the date coverage would normally stop under the terms of the Policy, except coverage must not be changed or stopped during the first 90 days of continuation unless coverage is changed or stopped for all Employees covered under the Policy;
3) the date the Spouse becomes insured under another group health plan;
4) the date the Spouse remarries;
5) the date coverage has been continued for 3 years, for Spouse under age 65 when continuation started;
6) the date the Spouse or Dependent Child is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act; or

7) the date the Policy terminates.

SECTION 6 - BENEFITS/COVERAGE

The Company will pay the percentage payable as shown on the Schedule of Benefits for charges incurred during each Calendar Year after the Deductible, if any, has been met for all services listed in the Covered Dental Expense Procedures when Covered Expenses are incurred.

If an Insured Individual transfers from the care of one Provider to another Provider during the course of treatment, or if more than one Provider renders services, benefits are not payable for more than the amount that would have been covered if one Provider rendered the service or services.

The Company may request pre-operative dental x-rays to determine liability for procedures submitted. If x-rays are not provided, We will decide on the benefits for the procedure that would result in a professionally adequate restoration, replacement, or treatment.

Unless We agree otherwise, Covered Expenses will include only charges for services listed in the Covered Dental Expense Procedures. If a non-listed procedure is accepted, We will determine the amount payable from a list of procedures of comparable nature.

Predetermination of Benefits
Predetermination of dental benefits is a service available through the Policy. This benefit review in advance of treatment enables an Insured Individual and their Provider to see what services are covered by the Policy. Ask Your Provider to submit a predetermination request. The Company will then provide a Predetermination of Benefits and payable amounts.

Please note the service is not designed to be used for emergency treatments or routine preventive services such as exams, x-rays, or cleaning.

Deductible
The Deductible, if applicable, is the amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. The Deductible must be met from Covered Expenses incurred during each timeframe as outlined in the Schedule of Benefits and from the types of covered dental expenses to which it applies. The Deductible applies separately to the Covered Expenses incurred by each Insured Individual.

Family Deductible
The Family Deductible, if any, is met when the number of Insured Individuals as shown on the Schedule of Benefits separately meets the Deductible shown on the Schedule of Benefits. Once the Family Deductible is met, no additional Deductible will be required for other Insured Individuals for the remainder of the Calendar Year.

Benefit Waiting Period
The Company will not pay for, and Covered Expenses do not include, charges incurred by an Insured Individual before the Benefit Waiting Period, if any, is satisfied.

Alternative Procedures
If two or more procedures are adequate and appropriate treatment to correct a certain condition, the amount of the Covered Expense will be the allowance for the least expensive procedure. The Insured Individual may be responsible for the difference.

We may ask that pre-operative dental x-rays to be given to Us to decide if We are liable for the procedures submitted for consideration. If the x-rays are not given, We will decide the procedures which would provide professionally adequate restoration, replacement, or treatment. If We then receive the pre-operative dental x-rays and decide that different procedures are more appropriate, We will make adjustments that We deem are proper.

Start Date for Procedures
For a denture, partial denture, or other appliance or a change to any appliance, other than a fixed bridge, the procedure starts at the time the impression is made. For a fixed bridge or a crown, inlay, onlay, or other precious or semiprecious metal restoration, the procedure starts at the time the tooth or teeth are prepared. For root canal therapy, the procedure starts at the time the pulp chamber is opened. For any other procedure requiring more than one session to complete, the procedure starts at the time of the first session. For any procedure requiring only one session to complete, the procedure starts at the time the service is rendered or the supply is furnished.

Incurred Date for Expenses

For a denture, partial denture, implant, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration whether the item is new, replacement, repaired, or modified, the expense is incurred at the time of final placement of the item. For root canal therapy, the expense is incurred at the time the root canal is completed. Implant services include the accompanying crown and the expense is incurred on final placement of the prosthetic. For any other procedure requiring more than one session to complete, the expense is incurred at the time the last session is completed. For any procedure requiring only one session to complete the expense is incurred at the time the service is rendered or the supply is furnished.

COVERED DENTAL EXPENSE PROCEDURES

The following is a complete list of the dental procedures for which benefits are payable under this section. No benefits are payable for a procedure that is not listed.

Proc. No. **Description of Service**

Class I – Preventive Services

D0120 – Periodic oral evaluation
D0140 – Limited oral evaluation – problem focused
D0145 – Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 – Comprehensive oral evaluation
D0160 – Detailed and extensive oral evaluation – problem focused, by report
D0170 – Re-evaluation – limited, problem focused (established patient; not post op visit)
D0210 – Intraoral – comprehensive series of radiographic images (including any bitewings)
D0220 – Intraoral – periapical first film
D0230 – Intraoral – periapical each additional film
D0240 – Intraoral – occlusal film
D0250 – Extraoral – first film
D0270 – Bitewing – single film
D0272 – Bitewings – two films
D0273 – Bitewings – three films
D0274 – Bitewings – four films
D0277 – Vertical bitewings – 7 to 8 films
D0330 – Panoramic film
D0350 – Oral/facial photographic images
D0396 – 3D printing of 3D dental surface scan
D0460 – Pulp vitality test
D0470 – Diagnostic models
D1110 – Prophylaxis – adult
D1120 – Prophylaxis – child
D1206 – Topical fluoride varnish (under age 19)
D1208 – Topical application of fluoride (prophylaxis not included)
D1351 – Sealant – per tooth – unrestored permanent molars (under age 19)
D1510 – Space maintainer – fixed – unilateral
D1516 – Space maintainer – fixed – bilateral, maxillary
D1517 – Space maintainer – fixed – bilateral, mandibular
D1520 – Space maintainer – removable – unilateral
D1525 – Space maintainer – removable – bilateral
D1526 – Space maintainer – removable – bilateral, maxillary
D1527 – Space maintainer – removable – bilateral, mandibular
D1551 – Re-cement or re-bond bilateral space maintainer – maxillary
D1552 – Re-cement or re-bond bilateral space maintainer – mandibular
D1557 – Removal of fixed bilateral space maintainer – maxillary
D1558 – Removal of fixed bilateral space maintainer – mandibular
D1575 – Distal shoe space maintainer – fixed – unilateral, per quadrant
D9110 – Palliative treatment of dental pain – per visit
D9310 – Consultations

Class II – Basic Services

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
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)
D2390 – Resin-based composite crown, anterior
D2391 – Resin-based composite – one surface, posterior
D2392 – Resin-based composite – two surfaces, primary or permanent
D2393 – Resin-based composite – three surfaces, primary or permanent
D2394 – Resin-based composite – four surfaces, primary or permanent
D2940 – Placement of interim direct restoration
D2410 – Gold foil – one surface
D2420 – Gold foil – two surfaces
D2430 – Gold foil – three surfaces
D3110 – Anterior (excluding final restoration)
D3120 – Bicuspid (excluding final restoration)
D3220 – Therapeutic pulpotomy premolar (excluding final restoration)
D3221 – Pulpal debridement
D3222 – Partial pulpotomy for apexogenesis (permanent tooth with incomplete root development)
D3230 – Pulpal therapy (resorbable filling – anterior, primary tooth (excludes final restoration)
D3240 – Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D3310 – Endodontic therapy – anterior tooth (excluding final restoration)
D3320 – Endodontic therapy – premolar (excluding final restoration)
D3330 – Endodontic therapy – molar (excluding final restoration)
D3331 – Treatment of root canal obstruction – non–surgical access
D3332 – Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth
D3333 – Internal root repair of perforation defects
D3346 – Retreatment of previous root canal therapy – anterior
D3347 – Retreatment of previous root canal therapy – bicuspid
D3348 – Retreatment of previous root canal therapy – molar
D3351 – Apexification/recalcification – initial visit (apical closure/calcific repair or perforations, root resorptions)
D3352 – Apexification/recalcification – interim visit (apical closure/calcific repair or perforations, root resorptions)
D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair or perforations, root resorptions, etc.)
D3355 – Pulpal regeneration – initial visit
D3356 – Pulpal regeneration – interim medication replacement
D3357 – Pulpal regeneration – completion of treatment
D3410 – Apicoectomy/periradicular surgery – anterior
D3421 – Apicoectomy/periradicular surgery – premolar (first root)
D3425 – Apicoectomy/periradicular surgery – molar (first root)
D3426 – Apicoectomy/periradicular surgery – (each additional root)
D3428 – Bone graft in conjunction with periradicular surgery – per tooth, single site
D3429 – Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site
D3430 – Retrograde filling – per root
D3432 – Guided tissue regeneration – resorbable barrier, per site, in conjunction with periradicular surgery
D3450 – Root amputation – per root
D3460 – Endodontic endosseous implant

D3470 – Intentional re-implantation (including necessary splinting)
D3471 – Surgical repair of root resorption – anterior
D3472 – Surgical repair or root resorption – premolar
D3473 – Surgical repair of root resorption – molar
D3501 – Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502 – Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503 – Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3920 – Hemisection (including any root removal), not including root canal therapy
D3921 – Decoronation or submergence of an erupted tooth
D0180 – Comprehensive periodontal evaluation - new or established patient
D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4212 – Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240 – Gingival flap procedure – four or more teeth
D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth or bounded teeth spaces per quadrant
D4245 – Apically positioned flap
D4249 – Clinical crown lengthening – hard tissue
D4260 – Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant
D4261 – Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant
D4263 – Bone replacement graft – retained natural tooth – first site in quadrant
D4264 – Bone replacement graft – retained natural tooth – each additional site in quadrant
D4265 – Biologic materials to aid in soft and osseous tissue regeneration, per site
D4266 – Guided tissue regeneration, natural teeth – resorbable barrier, per site
D4267 – Guided tissue regeneration, natural teeth – non-resorbable barrier, per site
D4268 – Surgical revision procedure, per tooth
D4270 – Pedicle soft tissue graft procedure
D4273 – Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft site.
D4274 – Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)
D4275 – Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft site.
D4276 – Combined connective tissue and pedicle graft, per tooth
D4277 – Free soft tissue graft (including recipient and donor surgical sites) – first tooth, implant, or edentulous tooth position in graft
D4278 – Free soft tissue graft (including recipient and donor surgical sites) – each additional contiguous tooth, implant, or edentulous tooth position in graft additional teeth
D4286 – Removal of non-resorbable barrier
D4322 – Splint – intra-coronal natural teeth or prosthetic crowns
D4323 – Splint – extra-coronal natural teeth or prosthetic crowns
D4341 – Periodontal scaling and root planing – four or more teeth per quadrant.
D4342 – Periodontal scaling and root planing – one to three teeth, per quadrant.
D4346 – Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355 – Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4381 – Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 – Periodontal maintenance procedures (following active therapy)
D5995 – Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary

D5996 – Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular
D7111 – Extraction, coronal remnants – primary tooth
D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 – Removal of impacted tooth – soft tissue
D7230 – Removal of impacted tooth – partial bony
D7240 – Removal of impacted tooth – completely bony
D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications
D7250 – Surgical removal of residual tooth roots (cutting procedure)
D7251 – Coronectomy – intentional partial tooth removal, impacted teeth only
D7252 – Partial extraction for immediate implant placement
D7259 – Nerve dissection
D7270 – Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7272 – Tooth transplantation (include reimplantation from one site to another and splinting and/or stabilization)
D7280 – Surgical access of an unerupted tooth
D7282 – Mobilization of erupted or malposition tooth to aid eruption
D7283 – Placement of device to facilitate eruption of impacted tooth
D7284 – Excisional biopsy of minor salivary glands
D7285 – Incisional biopsy of oral tissue – hard (bone, tooth)
D7286 – Biopsy of oral tissue – soft
D7287 – Exfoliative cytological sample collection
D7288 – Brush biopsy – transepithelial sample collection
D7290 – Surgical repositioning of teeth
D7291 – Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310 – Alveoloplasty in conjunction with extractions – per quadrant
D7311 – Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 – Alveoloplasty not in conjunction with extractions – per quadrant
D7321 – Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7340 – Vestibuloplasty – ridge extension (secondary epithelialization)
D7350 – Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410 – Excision of benign lesion up to 1.25 cm
D7411 – Excision of benign lesion greater than 1.25 cm
D7412 – Excision of benign lesion, complicated
D7413 – Excision of malignant lesion up to 1.25 cm
D7414 – Excision of malignant lesion greater than 1.25 cm
D7415 – Excision of malignant lesion, complicated
D7440 – Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441 – Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450 – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451 – Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460 – Removal of benign non–odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461 – Removal of benign non–odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7465 – Destruction of lesion by physical or chemical by report
D7509 – Marsupialization of odontogenic cyst
D7510 – Incision and drainage of abscess – intraoral soft tissue
D7511 – Incision and drainage of abscess – intraoral soft tissue – complicated
D7520 – Incision and drainage of abscess – extraoral soft tissue
D7521 – Incision and drainage of abscess – extraoral soft tissue – complicated

D7939 – Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7950 – Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
D7953 – Bone replacement graft for ridge preservation – per site
D7956 – Guided tissue regeneration, edentulous area – resorbable barrier, per site
D7957 – Guided tissue regeneration, edentulous area – non-resorbable barrier, per site
D7961 – Buccal/labial frenectomy (Frenulectomy)
D7962 – Lingual frenectomy (Frenulectomy)
D7963 – Frenuloplasty
D7970 – Excision of hyperplastic tissue – per arch
D7971 – Excision of pericoronal gingiva
D9222 – Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof
D9223 – Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof
D9224 – Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof
D9225 – Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof
D9239 – Administration of moderate sedation – intravenous – first 15 minutes increment, or any portion thereof
D9243 – Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof
D9246 – Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof
D9247 – Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof

Class III – Major Services
D2510 – Inlay – metallic – one surface – an alternate benefit will be provided
D2520 – Inlay – metallic – two surfaces – an alternate benefit will be provided
D2530 – Inlay – metallic – three surfaces – an alternate benefit will be provided
D2542 – Onlay – metallic – two surfaces
D2543 – Onlay – metallic – three surfaces
D2544 – Onlay – metallic – four or more surfaces
D2610 – Inlay – porcelain/ceramic – one surface
D2620 – Inlay – porcelain/ceramic – two surfaces
D2630 – Inlay – porcelain/ceramic – three surfaces
D2642 – Onlay – porcelain/ceramic – two surfaces
D2643 – Onlay – porcelain/ceramic – three surfaces
D2644 – Onlay – porcelain/ceramic – four or more surfaces
D2650 – Inlay – resin-based composite – one surface
D2651 – Inlay – resin-based composite – two surfaces
D2652 – Inlay – resin-based composite – three or more surfaces
D2662 – Onlay – resin-based composite – two surfaces
D2663 – Onlay – resin-based composite – three surfaces
D2664 – Onlay – resin-based composite – four or more surfaces
D2710 – Crown – resin-based composite (indirect)
D2712 – Crown – 3/4 resin-based composite (indirect)
D2720 – Crown – resin with high noble metal
D2721 – Crown – resin with predominately base metal
D2722 – Crown – resin with noble metal
D2740 – Crown – porcelain/ceramic
D2750 – Crown – porcelain fused to high noble metal
D2751 – Crown – porcelain fused to predominantly base metal

D2752 – Crown – porcelain fused to noble metal
D2753 – Crown – porcelain fused to titanium and titanium alloys
D2780 – Crown – 3/4 cast high noble metal
D2783 – Crown – 3/4 porcelain/ceramic (This code does not include facial veneers)
D2790 – Crown – full cast high noble metal
D2791 – Crown – full cast predominantly base metal
D2792 – Crown – full cast noble metal
D2794 – Crown – titanium and titanium alloys
D2910 – Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration
D2915 – Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 – Re-cement or re-bond crown
D2930 – Prefabricated stainless steel crown – primary tooth
D2931 – Prefabricated stainless steel crown – permanent tooth
D2932 – Prefabricated resin crown
D2933 – Prefabricated stainless steel crown with a resin window
D2934 – Prefabricated esthetic coated stainless steel crown – primary tooth
D2950 – Core buildup, including pins
D2951 – Pin retention – per tooth, in addition to restoration
D2952 – Post and core in addition to crown, indirectly fabricated
D2953 – Each additional cast post – same tooth
D2954 – Prefabricated post and core in addition to crown
D2955 – Post removal (not in conjunction with endodontic therapy)
D2956 – Removal of an indirect restoration on a natural tooth
D2957 – Each additional prefabricated post – same tooth
D2980 – Crown repair, by report
D2989 – Excavation of a tooth resulting in determination of non-restorability
D2991 – Application of hydroxyapatite regeneration medicament
D5110 – Complete denture – maxillary
D5120 – Complete denture – mandibular
D5130 – Immediate denture – maxillary
D5140 – Immediate denture – mandibular
D5211 – Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5212 – Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5213 – Maxillary partial denture – cast metal framework – resin denture bases (including retentive/clasping materials and teeth)
D5214 – Mandibular partial denture – cast metal framework – resin denture bases (including retentive/clasping materials, rests and teeth)
D5221 – Immediate maxillary partial denture – resin base (including retentive/clasping materials, rest, and teeth)
D5222 – Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5223 – Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5224 – Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5225 – Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)
D5226 – Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)
D5227 – Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5228 – Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)
D5282 – Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials and teeth), maxillary

D5283 – Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials and teeth), mandibular
D6205 – Pontic – indirect resin-based composite
D6210 – Pontic – cast high noble metal
D6211 – Pontic – cast predominantly base metal
D6212 – Pontic – cast noble metal
D6214 – Pontic – titanium and titanium alloys
D6240 – Pontic – porcelain fused to high noble metal
D6241 – Pontic – porcelain fused to predominantly base metal
D6242 – Pontic – porcelain fused to noble metal
D6545 – Retainer – cast metal for resin bonded fixed prosthesis
D6548 – Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6600 – Retainer inlay – porcelain/ceramic, two surfaces
D6601 – Retainer inlay – porcelain/ceramic, three or more surfaces
D6602 – Retainer inlay – cast high noble metal, two surfaces
D6603 – Retainer inlay – cast high noble metal, three or more surfaces
D6604 – Retainer inlay – cast predominantly base metal, two surfaces
D6605 – Retainer inlay – cast predominantly base metal, three or more surfaces
D6606 – Retainer inlay – cast noble metal, two surfaces
D6607 – Retainer inlay – cast noble metal, three or more surfaces
D6608 – Retainer onlay – porcelain/ceramic, two surfaces
D6609 – Retainer onlay – porcelain/ceramic, three or more surfaces
D6610 – Retainer onlay – cast high noble metal, two services
D6611 – Retainer onlay – cast high noble metal, three or more surfaces
D6612 – Retainer onlay – cast predominantly base metal, two surfaces
D6613 – Retainer onlay – cast predominantly base metal, three or more surfaces
D6614 – Retainer onlay – cast noble metal, two surfaces
D6615 – Retainer onlay – cast noble metal, three or more surfaces
D6624 – Retainer inlay – titanium
D6634 – Retainer onlay – titanium
D6710 – Retainer crown – indirect resin-based composite
D6720 – Retainer crown – resin with high noble metal
D6721 – Retainer crown – resin with predominantly base metal
D6722 – Retainer crown – resin with noble metal
D6740 – Retainer crown – porcelain/ceramic
D6750 – Retainer crown – porcelain fused to high noble metal
D6751 – Retainer crown – porcelain fused to predominantly base metal
D6752 – Retainer crown – porcelain fused to noble metal
D6780 – Retainer crown – 3/4 cast high noble metal
D6781 – Retainer crown – 3/4 cast predominantly base metal
D6782 – Retainer crown – 3/4 cast noble metal
D6783 – Retainer crown – 3/4 porcelain/ceramic
D6784 – Retainer crown – 3/4 titanium and titanium alloys
D6790 – Retainer crown – full cast high noble metal
D6791 – Retainer crown – full cast predominantly base metal
D6792 – Retainer crown – full cast noble metal
D6794 – Retainer crown – titanium
D5410 – Adjust complete denture – maxillary
D5411 – Adjust complete denture – mandibular
D5421 – Adjust partial denture – maxillary

D5422 – Adjust partial denture – mandibular – repair broken complete denture base
D5511 – Repair broken complete denture base – mandibular
D5512 – Repair broken complete denture base – maxillary
D5520 – Replace missing or broken teeth – complete denture, per tooth
D5611 – Repair resin partial denture base – mandibular
D5612 – Repair resin partial denture base – maxillary
D5621 – Repair cast partial framework – mandibular
D5622 – Repair cast partial framework – maxillary
D5630 – Repair or replace broken clasp
D5640 – Replace missing or broken teeth – partial denture, per tooth
D5650 – Add tooth to existing partial denture, per tooth
D5660 – Add clasp to existing partial denture
D5710 – Rebase complete maxillary denture (upper)
D5711 – Rebase complete mandibular denture
D5720 – Rebase maxillary partial denture (upper)
D5721 – Rebase mandibular partial denture (lower)
D5725 – Rebase hybrid prosthesis
D5730 – Reline complete maxillary denture (upper)
D5731 – Reline complete mandibular denture (lower)
D5740 – Reline maxillary partial denture (lower)
D5741 – Reline mandibular partial denture (lower)
D5750 – Reline complete maxillary denture (laboratory) (upper)
D5751 – Reline complete mandibular denture (laboratory) (lower)
D5760 – Reline maxillary partial denture (laboratory) (upper)
D5761 – Reline mandibular partial denture (laboratory) (lower)
D5765 – Soft liner for complete or partial removable denture – indirect
D5863 – Overdenture – complete maxillary – natural tooth borne
D5864 – Overdenture – partial maxillary – natural tooth borne
D5865 – Overdenture – complete mandibular – natural tooth borne
D5866 – Overdenture – partial mandibular – natural tooth borne
D6930 – Re-cement fixed partial denture
D6940 – Stress breaker
D6980 – Fixed partial denture repair necessitated by restorative material failure
D6010 – Endosteal implant
D6013 – Surgical placement of mini implant
D6040 – Eposteal implant
D6049 – Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure
D6050 – Transosteal implant, including hardware
D6055 – Connecting bar – implant or abutment supported
D6056 – Prefabricated abutment
D6057 – Custom abutment
D6058 – Abutment supported porcelain ceramic crown
D6059 – Abutment supported porcelain fused to high noble metal
D6060 – Abutment supported porcelain fused to predominately base metal crown
D6061 – Abutment supported porcelain fused to noble metal crown (ax/60 months)
D6062 – Abutment supported cast high noble metal crown
D6063 – Abutment supported cast predominately base metal crown
D6064 – Abutment supported cast noble metal crown
D6065 – Implant supported porcelain/ceramic crown

D6066 – Implant supported crown porcelain fused to high noble alloys
D6067 – Implant supported crown high noble alloys
D6068 – Abutment supported retainer for porcelain/ceramic fixed partial denture
D6069 – Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
D6070 – Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture
D6071 – Abutment supported retainer for porcelain fused to noble metal fixed partial denture
D6072 – Abutment supported retainer for cast high noble metal fixed partial denture
D6073 – Abutment supported retainer for predominately base metal fixed partial denture
D6074 – Abutment supported retainer for cast noble metal fixed partial denture
D6075 – Implant supported retainer for ceramic fixed partial denture
D6076 – Implant supported retainer for FPD – porcelain fused to high noble alloys
D6077 – Implant supported retainer for cast metal FPD – high noble alloys
D6080 – Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6280 – Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch
D6089 – Accessing and retorquing loose implant screw
D6100 – Surgical removal of implant body
D6105 – Removal of implant body not requiring bone removal or flap elevation
D6106 – Guided tissue regeneration – resorbable barrier, per implant
D6107 – Guided tissue regeneration – non-resorbable barrier, per implant
D6180 – Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6190 – Implant index (pre-surgical service)
D6193 – Replacement of an implant screw
D6194 – Abutment supported retainer crown for FPD – titanium and titanium alloys
D6197 – Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant

Class IV – Orthodontia Services
D8010 – Limited orthodontic treatment of the primary dentition
D8020 – Limited orthodontic treatment of the transitional dentition
D8030 – Limited orthodontic treatment of the adolescent dentition
D8040 – Limited orthodontic treatment of the adult dentition
D8070 – Comprehensive orthodontic treatment of the transitional dentition
D8080 – Comprehensive orthodontic treatment of the adolescent dentition
D8090 – Comprehensive orthodontic treatment of the adult dentition
D8091 – Comprehensive orthodontic treatment with orthognathic surgery
D8660 – Pre-orthodontic treatment visit
D8670 – Periodic orthodontic treatment visit (as part of contract)
D8671 – Periodic orthodontic treatment visit associated with orthognathic surgery
D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s)

NON-COVERED PROCEDURES

Benefits are not payable for procedures that are not listed in one of the above classes of procedures. Following are some of the procedures for which no benefits are payable:

Proc. No.	Description of Service
D0310	Sialography
D0320	Temporomandibular joint (TMJ) arthrogram, including injection
D0321	X-Rays, other temporomandibular joint (TMJ) films, by report
D0322	X-rays, tomographic survey
D0340	2D cephalometric film
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images
D0373	Intraoral tomosynthesis – bitewing radiographic image
D0374	Intraoral tomosynthesis – periapical radiographic image
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only
D0412	Blood glucose level test – in-office using a glucose meter
D0415	Collection of microorganisms for culture and sensitivity
D0425	Caries susceptibility test
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures
D0501	Histopathologic examination
D0502	Other oral pathology procedures, by report
D0801	3D intraoral surface scan – direct
D0802	3D dental surface scan – indirect
D0803	3D facial surface scan – direct
D0804	3D facial surface scan – indirect
D1204 – D1205	Topical application of fluoride for individuals age 19 and over
D1301	Immunization counseling
D1310	Nutritional counseling for the control or prevention of dental disease
D1320	Tobacco counseling for the control or prevention of oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with substance abuse
D1781	Vaccine administration – human papillomavirus – Dose 1
D1782	Vaccine administration – human papillomavirus – Dose 2
D1783	Vaccine administration – human papillomavirus – Dose 3
D2960 – D2962	Labial veneers
D2970	Temporary crown (for fractured tooth)
D3910	Surgical procedure for isolation of tooth with rubber dam
D3911	Intraorifice barrier
D3950	Canal preparation and fitting of preformed dowel or post
D3960	Bleaching of discolored tooth
D4920	Unscheduled dressing change by someone other than treating dentist
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5810 – D5821	Interim dentures
D5850 – D5851	Tissue conditioning

D5862	Precision attachment, by report
D5876	Add metal substructure to acrylic full denture (per arch)
D5911 – D5993	Various prostheses and related procedures
D5999	Unspecified maxillofacial prosthesis, by report
D6920	Connector bar
D6950	Precision attachment
D7298	Removal of temporary anchorage device (screw retained plate), requiring flap
D7299	Removal of temporary anchorage device, requiring flap
D7300	Removal of temporary anchorage device without flap
D7470	Removal of exostosis, maxilla or mandible
D7480	Partial ostectomy (guttering or saucerization)
D7490	Radical resection of maxilla or mandible
D7530	Removal of foreign body, skin, or subcutaneous tissue
D7540	Removal of reaction-producing foreign bodies from musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 – D7780	Various procedures for reduction of fractures
D7810 – D7877	Various procedures related to the temporomandibular joint
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment
D7899	Unspecified temporomandibular joint dysfunction therapy, by report
D7910 – D7912	Suture of wounds
D7920	Skin grafts
D7940 – D7949	Various osteoplastic, osteotomic, and grafting procedures for repair of defects
D7955	Repair of maxillofacial soft and hard tissue defect
D7980 – D7983	Various procedures related to the salivary gland
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft, mandible or facial bones, by report
D7996	Mandible implant for augmentation purposes (excluding alveolar ridge), by report
D9130	Temporomandibular joint dysfunction non-invasive physical therapies
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9211	Regional block anesthesia
D9212	Trigeminal block anesthesia
D9215	Local anesthesia
D9230	Analgesia
D9410	House call
D9420	Hospital call
D9430	Office visit for observation during regularly scheduled office hours with no other services performed
D9440	Office visit after regularly scheduled office hours
D9610	Therapeutic drug injection, by report
D9613	Infiltration of sustained release therapeutic drug, per quadrant
D9630	Other drugs and/or medicaments, by report
D9910	Application of desensitizing medicament
D9912	Pre-visit patient screening
D9913	Administration of neuromodulators
D9914	Administration of dermal fillers
D9920	Behavior management, by report
D9930	Treatment of postsurgical complications, unusual circumstances, by report
D9938	Fabrication of custom removable clear plastic temporary aesthetic appliance

D9939	Placement of custom removable clear plastic temporary aesthetic appliance
D9941	Fabrication of athletic mouthguard
D9936	Cleaning and inspection of occlusal guard – per appliance
D9944	Occlusal guard – hard appliance, full arch
D9945	Occulsal guard – soft appliance, full arch
D9946	Occlusal guard – hard appliance, partial arch
D9947	Custom sleep apnea appliance fabrication and placement
D9948	Adjustment of custom sleep apnea appliance
D9949	Repair of custom sleep apnea appliance
D9950	Occlusion analysis, mounted case
D9951 – D9952	Occlusal adjustment
D9953	Reline custom sleep apnea appliance (indirect)
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device
D9955	Oral appliance therapy (OAT) titration visit
D9956	Administration of home sleep apnea test
D9957	Screening for sleep related breathing disorders
D9959	Unspecified sleep apnea services procedure, by report
D9961	Duplicate/copy patient's records
D9970	Enamel microabrasion
D9990	Certified translation or sign-language services – per visit

For a complete list of the dental procedures for which benefits are payable, please visit our website at www.companionlife.com. No benefits are payable for a procedure that is not listed. You may also contact Companion Life customer service at 1-877-676-5789 or at CompanionService@companionlife.net for assistance.

SECTION 7 - LIMITATIONS AND EXCLUSIONS

FREQUENCY and AGE LIMITATIONS

1. Oral evaluation is limited to 2 in any 12 month period.
2. Prophylaxis is limited to 2 in any 12 month period.
3. Child prophylaxis applies to Dependent Children up to age 12.
4. Adult prophylaxis applies to ages 12 and above.
5. Fluoride application is limited to 1 in any 12 month period and once per year for Dependent Children aged 12 and above.
6. Bitewing x-rays is limited to 1 in any 12 month period.
7. Panoramic/Full-Mouth x-rays – Only one of two procedures D0210 and D0330 will be allowed once in any 3 year period.
8. Sealant is covered once per permanent and unrestored molar for Dependent Children aged 6 through 19.
9. Crowns are limited to one per tooth every 5 years.
10. Stainless steel and resin crowns are limited to Dependent Children under age 19.
11. Prosthodontics are limited to one per tooth every 5 years. Prosthodontics includes both partial and complete dentures and relining adjustments within 6 months after installation. Relines are not covered separately until more than 6 months after installation. Adjustments are not covered as separately until more than 6 months after installation. Precision attachments, overdentures, specialized techniques, and characterizations are considered optional and the additional expense for these shall be borne by the Insured Individual. All placements of partial dentures include conventional clasps, rests, and teeth. Benefits for overdentures will not exceed the benefit for a corresponding denture (complete or partial, upper, or lower).
12. Orthodontic services for Dependent Children are covered through age 19.
13. Space maintainers are limited to Dependent Children under age 19.
14. Surgical Periodontics are limited to once per quadrant and once per tooth every 24 months.
15. Non-Surgical Periodontics – scaling and root planning is limited to once per quadrant every 24 months.
16. Non-Surgical Periodontics – full mouth debridement is limited to once per lifetime.
17. Implants are available only to Insured Individuals age 17 or older.
18. Replacement of an existing implant supported prosthetic device is covered only once every 10 years from the placement date of such device only then if it is unserviceable and cannot be made serviceable.
19. Non-Surgical Periodontics – periodontics maintenance procedures are limited to 4 times per year, in combination with 2 prophies.

EXCLUSIONS

Covered Expenses will not include and no benefits will be payable for the following:

1. Expenses in any Class of services that are incurred during the Insured's waiting period for services in that Class (as shown in the Schedule of Benefits), except as may be provided under the Takeover Provisions provision. An Insured is not eligible for Takeover Provisions if Takeover Provisions are not provided, or if Takeover Provisions are provided but the person:
   a) is a Late Entrant;
   b) became insured under the Policy after the Employer's Effective Date; or
   c) was not insured under the Employer's prior plan that was replaced by coverage under the Policy.

2. Any treatment which is for cosmetic purposes, or to correct congenital malformations, other than Medically Necessary treatment of congenital cleft in the lip, palate, or other birth abnormalities of a newborn, foster child, or adopted child.

3. Initial placement of any full or partial denture, implants, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such placement is needed because of the extraction of one or more of the Insured's natural teeth during the same period of continuous coverage. Any portion of the expense that is identifiable as applying specifically to the replacement of a tooth extracted before that period of continuous coverage is not a Covered Expense. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment. Any such appliance must include the replacement of the extracted tooth or teeth.

4. Replacement of any full or partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration within 5 year(s) of the date of the last placement of the item. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.

5. Replacement of an existing implant and/or supported prosthetic device is covered only once every 10 year(s) from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.

6. Addition of a new tooth or teeth to an existing full or partial denture, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such addition is a replacement of a natural tooth or teeth extracted during the same period of continuous coverage. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment.

7. Any expense incurred before the Insured's insurance under the Policy starts; or any expense incurred during any period of continuous coverage for the Insured under the Policy if the procedure starts before the period of continuous coverage starts.

8. Any procedure that starts, or any expense that is incurred (regardless of when the procedure starts), after the Insured's insurance under the Policy ends. But this exclusion does not apply for any denture, partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration if both:
   a) the procedure starts while the Insured's insurance under the Policy is in effect; and
   b) the expense is incurred within 90 days after the Insured's insurance under the Policy ends.

9. Duplication of appliances, or replacement of lost or stolen appliances.

10. Appliances, restorations, or procedures to:
    a) alter vertical dimension;
    b) restore or maintain occlusion;
    c) splint or replace tooth structure lost as a result of abrasion or attrition; or
    d) treat jaw fractures or disturbances of the temporomandibular joint.

11. Any procedure that is not shown on the list of Covered Dental Expense Procedures.

12. Education or training in, or supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

13. Charges for broken appointments or the completion of claim forms.

14. Root planing (procedure number D4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.

15. Charges for services or supplies for the treatment of an occupational injury which are paid, or payable, under the North Carolina Workers' Compensation Act only to the extent the Employer, Employee, or Carrier is liable or responsible according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
16. Services that:
    a) are not recommended by a Dentist;
    b) are not required for necessary care and treatment; or
    c) do not have a reasonably favorable prognosis.

17. Charges because of an Insured's sickness, injury, or other condition due to war or any act of war, declared or not, or sustained while on full-time active duty in the armed forces of any country, excluding an act of terrorism.

18. Benefits payable to an Insured Individual if payment is not legal where the Insured Individual is living when expenses are incurred.

19. Services related to: equilibration; bite registration or bite analysis.

20. Crowns for the purpose of periodontal splinting.

21. Charges for overdentures, precision or semi-precision attachments and associated endodontic treatment, any other customized attachments, or any specialized prosthodontic techniques or characterizations.

22. Charges for: myofunctional therapy, orthognathic surgery, or athletic mouthguards.

23. Implant or implant services where loss of the tooth was prior to the Insured Individual’s Effective Date of coverage under the Policy.

24. Procedures for which benefits are payable under the Employer's medical expense benefit plan for Employees and their Dependents. See the Coordination of Benefits provision for an explanation.

25. Services rendered by the Insured's Spouse, parent, parent-in-law, brother or sister, brother-in-law or sister-in-law, child (of the Insured or the Insured's Spouse), or any person residing in the Insured's household.

SECTION 8 - GENERAL PROVISIONS

Entire Contract
The contract between the parties consists of:
1) the Policy;
2) the application of the Policyholder, which is made a part of the Policy when issued;
3) this Certificate;
4) any endorsements, amendments, or riders; and
5) the enrollment forms, if any, of each Insured.

All statements made by the Policyholder and Insured shall be deemed representations and not warranties and no statement made by an Insured shall void the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Insured.

Clerical Error
Clerical errors or delays in keeping records for the Policy:
1) will not deny insurance which would otherwise have been granted;
2) will not continue insurance which otherwise would have ceased; and
3) may call for an adjustment of premium benefits to correct the error.

Certificates
The Company will supply individual Certificates for each Insured. This Certificate will describe:
1) the insurance benefits;
2) to whom benefits will be paid;
3) any limitations of the Policy; and
4) all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect. If requested, the Certificates will be provided electronically at no additional cost.

Misstatement of Age
If the date of birth or age of any Insured Individual has been misstated, an adjustment of premium will be of an amount that the premium paid would have purchased at the correct date of birth or age.

Legal Action
No legal action can be brought against Us until at least 60 days after the Insured sends Us the required proof of loss. No such action may be brought against Us after three years after proof of loss is required.

Conformity with State Laws
If any provision of the Policy is contrary to the law of the jurisdiction in which the Insured resides on such dates, such provision is hereby amended to conform to that law. If any change to state or federal law affects the Company's liability under the Policy, the Company may change the Policy, the premiums or both. Such change:
1) will be effective as of the date of change to the state or federal law; and
2) will not be made until the Company gives the Policyholder 45 days' notice for premium changes and 31 days' notice for all other changes.

Incontestability
The validity of the Policy cannot be contested after two years from its date of issue. After coverage for an Insured Individual has been in force for two years, the Company cannot: (a) void the coverage; or (b) deny a claim for loss that starts after the two-year period, because of statements in the application unless.

Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

Not in Lieu of Workers' Compensation
The Policy is not in lieu of and does not affect any requirement for coverage by workers' compensation.

Physical Examination
We can, at Our own expense, examine any pre-operative dental x-rays when and so often as it may reasonably be required while a dental claim is pending to determine the proper procedures to be considered.

Change of Beneficiary
Unless the Insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the Insured. The consent of the beneficiary shall not be required to surrender or assign the Certificate, or to change beneficiary, or to make any other changes to the Certificate.

Coordination of Benefits
This coordination of benefits (COB) provision applies when an Insured Individual has dental care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. 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. 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.

Definitions
The following definitions apply only to this provision of the Policy,

A. A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   (1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; and Medicare or any other federal governmental plan, as permitted by law.

   (2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; dental benefits under group or individual automobile contracts; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. "**This Plan**" means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a "primary Plan" or "secondary Plan" when compared to another Plan covering the Insured Individual.

   When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. "**Allowable Expense**" is a dental care expense, including coinsurance or copayments, without reduction for an applicable deductible, that is covered in full or at least in part by any Plan covering the Insured Individual. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Insured Individual is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Individual is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

(1) If an Insured Individual is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
(2) If an Insured Individual is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
(3) If an Insured Individual is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.
(4) The amount of any benefit reduction by the primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.
(5) If the primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the primary Plan because the Insured Individual uses a non-panel provider, except for Emergency Services that are paid or provided by the primary.

E. "**Claim Determination Period**" is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. "**Closed Panel Plan**" is a Plan that provides health benefits to Insured Individual primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order-of-Benefit Determination Rules
When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent**. The Plan that covers the person other than as a Dependent, for example as an Employee, Member, subscriber, or Retiree is primary and the Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an Employee, Member, subscriber or Retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

a. For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
   i. The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or
   ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

b. For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      • The Plan covering the Custodial Parent;
      • The Plan covering the Spouse of the Custodial Parent;
      • The Plan covering the non-custodial parent; and then
      • The Plan covering the Spouse of the non-custodial parent.

c. For a Dependent Child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an Active Employee, that is, an Employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same person as a retired or laid-off Employee is the secondary Plan. The same would hold true if a person is a Dependent of an Active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, Member, subscriber or Retiree or covering the person as a Dependent of an Employee, Member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage**. The Plan that covered the person as an Employee, Member, policyholder, subscriber, or Retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary Plan.

Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If an Insured Individual is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information
Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Insured Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9 - CLAIMS PROCEDURES

Notice of Claim
Written notice of claim must be given to Us within 30 days after the incurred date of the services provided for which benefits are payable or as soon as reasonably possible. Notice must be given to the Company, its Administrator, or to one of Our agents. Notice should include the Policyholder's name, Insured Individual's name, and Policy Number. If it will not be 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 claim, We will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after We have received the 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 180 days after the date for which services were provided. If it was not reasonably possible to give written proof within the 180-day period , We will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. In any event, We must receive proof no later than one year from the time specified, except in the absence of legal capacity.

Time of Payment
We will pay all benefits within 30 days of receiving due proof.

Interest Payment: If We do not pay the claim payments in accordance with this Time of Payment provision, the claim will bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by Us, interest payments on the claim will begin to accrue on the 31st day after We received the additional information.

Payment of Claims
All benefits will be paid to the Insured unless an assignment of benefits has been requested by the Insured or We have the obligation to pay the facility or Provider directly. If the Insured dies before all payments due have been made, all remaining amounts payable will be paid to the Insured's estate. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of such payment.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200
Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A. Claims Filing PROCEDURES

Written notice of claim must be furnished to Companion Life Insurance Company, 1301 Gervais Street, Suite 900, Columbia, SC 29201, within twenty (20) days after the event on which the claim is based, or as soon thereafter as is reasonably possible. Notice of claim should include the Employer's name, Insured's name, and Employer's Group Number. Failure to give notice within the time does not invalidate nor reduce any claim if the claimant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, Companion Life will furnish or cause a claim form to be furnished to the claimant. If the claim form is not furnished within fifteen (15) days after Companion Life receives the notice, the claimant will be deemed to have complied with our proof of loss requirements. The claimant must submit written proof covering the nature and extent of the claim within the policy time limit for filing proof of loss.

PROOF OF CLAIM

1. Companion Life must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Insured Employee shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. In any event, except in the absence of legal capacity, claims must be filed by the end of the calendar year after the calendar year in which the loss occurred or the claim will be denied.

2. Receipt of a claim by Companion Life will be deemed written proof of loss and will serve as written authorization from the Insured Employee to Companion Life to obtain any medical or financial records and documents useful to Companion Life. Companion Life, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured's claim will be deemed to be acting as the agent of the Insured Employee.

3. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. Companion Life will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Insured Employee will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

    b. Urgent Care Claim.

        i. A determination will be sent to the Insured Employee in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

        ii. If the Insured Employee's Urgent Care Claim is determined to be incomplete, the Insured Employee will be sent a notice to this effect within twenty-four (24) hours of receipt of the

claim. The Insured Employee will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Insured Employee requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Insured Employee will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

d. Concurrent Care Claim.

The Insured Employee will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Insured Employee time to appeal the decision before the Benefits are reduced or terminated.

4 Notice of Determination.

a. If the Insured Employee's claim is filed properly, and the claim is in part or wholly denied, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Insured Employee's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Insured Employee will also receive a notice if the claim is approved.

B. Appeal procedures for an ADVERSE BENEFIT DETERMINATION

1. Insured Employee has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

a. An appeal must be in writing; and,

b. An appeal must be sent (via U.S. mail) to Companion Life Insurance Company at the address on the Insured's Identification Card; and,

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

d. An appeal must include the Insured's name, address, social security number and any other information, documentation or materials that support the Insured's appeal.

2. The Insured Employee will have the opportunity to submit written comments, documents, or other information in support of the appeal, and will have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, Companion Life will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. Companion Life will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

   b. Urgent Care Claim.

   The Insured Employee may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and Companion Life will communicate with the Insured Employee by telephone or facsimile. Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the Request for an expedited appeal.

   c. Post-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

   d. Concurrent Care Claim.

   Companion Life will decide the appeal of Concurrent Care Claims within the time frames set forth in (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

   a. If an Insured Employee's appeal is denied in whole or in part, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

      i. State specific reason(s) for the Adverse Benefit Determination;

      ii.. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;

iii. State that the Insured Employee is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

iv. Describe any voluntary appeal procedures offered by Companion Life and the Insured Employee's right to obtain such information;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

vii. Include a statement regarding the Insured Employee's right to bring an action under section 502(a) of ERISA.

b. The Insured Employee will also receive a notice if the claim on appeal is approved.

COMPANION LIFE INSURANCE COMPANY
1301 Gervais Street, Suite 900, Columbia, SC 29201
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
Raleigh, NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the next page* is a brief summary of this law's coverages,

exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximm of $5,000,000 to any one unallocated annuity contract holder.

NOTICE

THIS NOTICE IS TO BE ISSUED WITH ANY POLICY, CONTRACT, CERTIFICATE, OR EVIDENCE OF COVERAGE OF GROUP HEALTH OR LIFE INSURANCE ISSUED IN THE STATE OF NORTH CAROLINA.

STATE OF NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40

"UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE."

END OF NOTICE

NOTICE OF PRIVACY PRACTICES

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

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information Treatment,

Payment, Health Care Operations

We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:

- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends
We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plan
We may disclose summary information and enrollment information to your employer (or other plan sponsor). Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose our members' medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
  - To report adult abuse, neglect or domestic violence.
  - To health oversight agencies.
  - In response to court and administrative orders and other lawful processes.
  - To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
  - To coroners, medical examiners and funeral directors.
  - To organ procurement organizations.
  - To avert a serious threat to health or safety.
  - In connection with certain research activities.
  - To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
  - To correctional institutions regarding inmates.
  - As authorized by state workers' compensation laws.

Your Authorization
We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access
You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting

You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction

You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications

You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

Amendment

You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

Notice of Breach
We are required to notify affected individuals following a breach of unsecured medical information.

Electronic Notice
You may request a written copy of this notice at any time or download it from our website.

Privacy Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Attn: Privacy Officer
I 20 East@Alpine Road (AX-E0l) Columbia,
SC 29219

(803) 264-7258 (telephone) (803)
264- 7257 (fax)

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná níłwo'ígíí díí Bèeso Ách'ą́ąh naa'nílígi hää'ída yi na' ídíł kidgo, nihá'áhóót'i' nihi ká'a'doo wołgo kwii ha'át'ishíį bí na'idolkidígi doo bik'ë'azláagóó. Ata' halne'é ła' bich'į' ha desdzih ninízingo, kojį' béésh bee hółne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in elyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

Revised 08/27/2019

Companion Life

Companion Life Insurance Company

P.O. Box 100102

Columbia, SC 29202

NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Privacy Notice has been prepared to inform you of our practices related to information we collect about you. When necessary to provide our products and services to you, we may disclose the information we collect, as described below, (a) to companies that provide services on our behalf and (b) to affiliated and nonaffiliated third parties, such as to health care providers and those who process insurance applications, pay claims, coordinate benefits and administer premiums. Otherwise, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. If you are a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information that we collect about participants and beneficiaries of your employee benefit plan(s).

Information we collect and maintain: We collect information about you from the following sources:

- Information we receive from you on applications or on other forms
- Information we obtain from your transactions with us, our affiliates or others
- Information we receive from consumer-reporting agencies

How we protect information: We restrict access to nonpublic personal information about you to those who need to know the information to provide our products and services to you and as permitted by law. We maintain physical, electronic and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on web applications to help ensure that the information about you that we collect and maintain remains safe and secure.

Changes to this notice: We may amend our privacy policies and practices at any time, and we will inform you of any material changes, as required by law.

YOU DO NOT NEED TO DO ANYTHING IN RESPONSE TO THIS NOTICE.

THIS NOTICE IS MERELY TO INFORM YOU ABOUT OUR PRIVACY POLICIES AND PRACTICES.