ChoiceBuilder®

ENROLLMENT GUIDE FOR EMPLOYEES

The nation's premier dental, vision, chiropractic and life carriers all in ONE program.

Ameritas fulfilling life. Anthem Assurity DELTA DENTAL EyeMed LANDMARK HEALTHPLAN MetLife vsp vision care

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Welcome to ChoiceBuilder®

The lines of coverage you have to choose from were selected by your employer, **specifically for your company!** From these pre-selected lines of coverage you can choose the benefits that are right for you and your family. Simply follow the steps below to get started.

Steps To Enroll

1 **Review your benefit options**

Please refer to your personalized Employee Enrollment Worksheet or your ChoiceBuilder Enrollment Form which are included with your enrollment materials.

Both documents outline the carrier(s) and benefit options you have to choose from. Your personalized Employee Enrollment Worksheet also outlines the costs associated with each benefit, a great way to figure out what works with your budget (for more information on your personalized Employee Enrollment Worksheet, please see the following page).

If you do not have access to your personalized Employee Enrollment Worksheet or Enrollment Form, please contact your employer who can provide you with this information.

2 **Choose the benefits you want**

Once you have reviewed the carrier(s) and benefits available to you, use this brochure as a resource to find out more information about each benefit. Benefits are shown by lines of coverage (for example, all of our dental benefits are grouped together).

3 **Complete your Enrollment Form**

Your Enrollment Form is included with your enrollment materials. Please complete each section carefully and return it to your employer. If you need a new Enrollment Form please contact your employer.

If you have any questions about the enrollment process, please call our Customer Service Center at (866) 412-9279

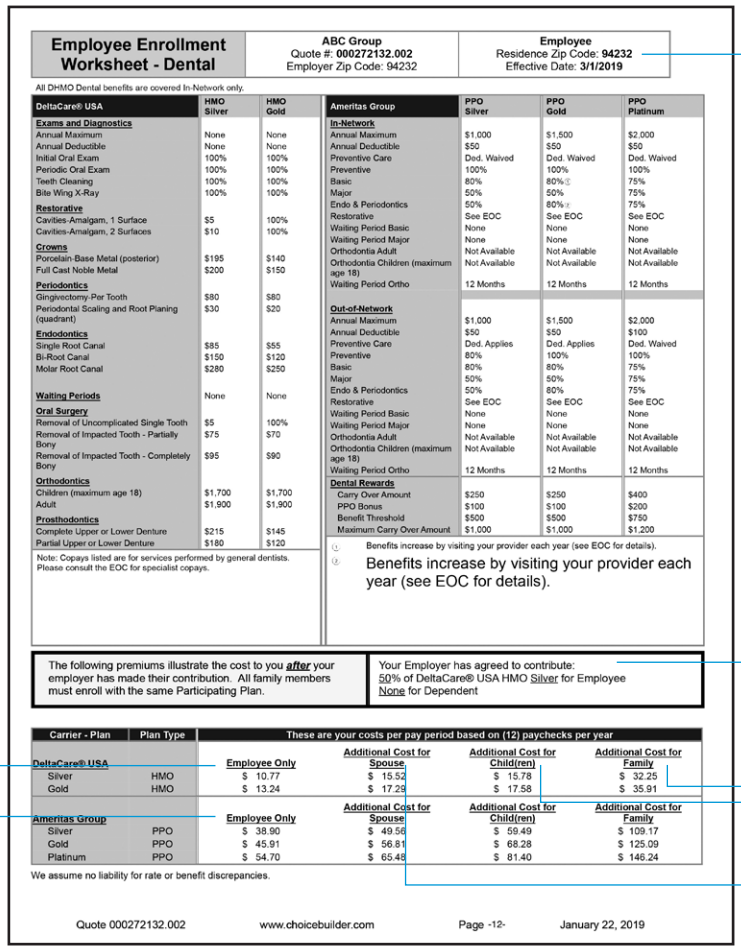
Using Your Personalized Employee Enrollment Worksheet

Your Personalized Employee Enrollment Worksheet is a great tool to use during your enrollment or renewal because it shows you exactly what your benefit options are. It also outlines the costs associated with each benefit so you can choose the benefit that makes sense to your budget.

Use your Personalized Worksheet to:

- Review the lines of coverage available to you (dental, vision, etc.)
- Review the pricing options for each benefit
- Verify your contact information (if there is information that needs to be updated, please notify your employer)

Once you have chosen the benefits you like best, complete your Enrollment Form and return it to your employer.



Employee Enrollment Worksheet - Dental

ABC Group
Quote #: **000272132.002**
Employer Zip Code: 94232

Employee
Residence Zip Code: **94232**
Effective Date: **3/1/2019**

All DHMO Dental benefits are covered In-Network only.

DeltaCare® USA	HMO Silver	HMO Gold
Exams and Diagnostics		
Annual Maximum	None	None
Annual Deductible	None	None
Initial Oral Exam	100%	100%
Periodic Oral Exam	100%	100%
Teeth Cleaning	100%	100%
Bite Wing X-Ray	100%	100%
Restorative		
Cavities-Amalgam, 1 Surface	$5	100%
Cavities-Amalgam, 2 Surfaces	$10	100%
Crowns		
Porcelain-Base Metal (posterior)	$195	$140
Full Cast Noble Metal	$200	$150
Periodontics		
Gingivectomy-Per Tooth	$80	$80
Periodontal Scaling and Root Planing (quadrant)	$30	$20
Endodontics		
Single Root Canal	$85	$55
Bi-Root Canal	$150	$120
Molar Root Canal	$280	$250
Waiting Periods	None	None
Oral Surgery		
Removal of Uncomplicated Single Tooth	$5	100%
Removal of Impacted Tooth - Partially Bony	$75	$70
Removal of Impacted Tooth - Completely Bony	$95	$90
Orthodontics		
Children (maximum age 18)	$1,700	$1,700
Adult	$1,900	$1,900
Prosthodontics		
Complete Upper or Lower Denture	$215	$145
Partial Upper or Lower Denture	$180	$120

Note: Copays listed are for services performed by general dentists. Please consult the EOC for specialist copays.

Ameritas Group	PPO Silver	PPO Gold	PPO Platinum
In-Network			
Annual Maximum	$1,000	$1,500	$2,000
Annual Deductible	$50	$50	$50
Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived
Preventive	100%	100%	100%
Basic	80%	80%	75%
Major	50%	50%	75%
Endo & Periodontics	50%	80%	75%
Restorative	See EOC	See EOC	See EOC
Waiting Period Basic	None	None	None
Waiting Period Major	None	None	None
Orthodontia Adult	Not Available	Not Available	Not Available
Orthodontia Children (maximum age 18)	Not Available	Not Available	Not Available
Waiting Period Ortho	12 Months	12 Months	12 Months
Out-of-Network			
Annual Maximum	$1,000	$1,500	$2,000
Annual Deductible	$50	$50	$100
Preventive Care	Ded. Applies	Ded. Applies	Ded. Waived
Preventive	80%	100%	100%
Basic	80%	80%	75%
Major	50%	50%	75%
Endo & Periodontics	50%	80%	75%
Restorative	See EOC	See EOC	See EOC
Waiting Period Basic	None	None	None
Waiting Period Major	None	None	None
Orthodontia Adult	Not Available	Not Available	Not Available
Orthodontia Children (maximum age 18)	Not Available	Not Available	Not Available
Waiting Period Ortho	12 Months	12 Months	12 Months
Dental Rewards			
Carry Over Amount	$250	$250	$400
PPO Bonus	$100	$100	$200
Benefit Threshold	$500	$500	$750
Maximum Carry Over Amount	$1,000	$1,000	$1,200

① Benefits increase by visiting your provider each year (see EOC for details).
② Benefits increase by visiting your provider each year (see EOC for details).

The following premiums illustrate the cost to you ***after*** your employer has made their contribution. All family members must enroll with the same Participating Plan.

Your Employer has agreed to contribute:
50% of DeltaCare® USA HMO Silver for Employee
None for Dependent

Carrier - Plan	Plan Type	These are your costs per pay period based on (12) paychecks per year			
		Employee Only	Additional Cost for Spouse	Additional Cost for Child(ren)	Additional Cost for Family
DeltaCare® USA					
Silver	HMO	$ 10.77	$ 15.52	$ 15.78	$ 32.25
Gold	HMO	$ 13.24	$ 17.29	$ 17.58	$ 35.91
		Employee Only	Additional Cost for Spouse	Additional Cost for Child(ren)	Additional Cost for Family
Ameritas Group					
Silver	PPO	$ 38.90	$ 49.56	$ 59.49	$ 109.17
Gold	PPO	$ 45.91	$ 56.81	$ 68.28	$ 125.09
Platinum	PPO	$ 54.70	$ 65.48	$ 81.40	$ 146.24

We assume no liability for rate or benefit discrepancies.

Quote 000272132.002 www.choicebuilder.com Page -12- January 22, 2019

Verify your age and home ZIP Code.

Your employer's contribution appears here. If your employer has chosen to offer Voluntary benefits, you will be responsible for 100% of the cost for the benefit(s) you choose.

Your cost for the benefit of your choice appears here – your employer's contribution has already been subtracted.

The dependent column shows you the additional cost if you want to add a dependent(s).

Your Coverage Options

ChoiceBuilder® offers a variety of different benefit options including Dental HMO and PPO plans. Before you choose your benefits, review each benefit type so you know exactly how they work.

If you have any questions about the information below, please call our Customer Service Center at (866) 412-9279.

DHMO Benefits

A DHMO provides services through contracted providers. All of your services are managed "in-network" through your Primary Care Dentist (PCD).

- You first select a PCD (your provider)
- Referrals to specialists are managed by your PCD

PPO Benefits

A PPO provides benefits within the carrier's network of providers with the option of going "out-of-network" for a slightly higher cost and/or reduced benefit.

- PPOs do not require you to select a PCD
- You pay less for seeing an "in-network" provider
- You pay more for seeing an "out-of-network" provider

Is your dentist available with your new plan?

Find out by visiting **www.choicebuilder.com**. Use the Provider Search tool to look for your dentist, or find a new dentist near your home.

You can also review your benefits, download forms and so much more!

Just visit **www.choicebuilder.com** and login today!

Dental – Employer Sponsored HMO

DeltaCare® USA

Plan Name	Bronze	Silver	Gold
Exam & Diagnostics			
Office Exam	$5	100%	100%
Initial Oral Exam	100%	100%	100%
Periodic Oral Exam	100%	100%	100%
Teeth Cleaning	100%	100%	100%
Bite-Wing X-Ray	100%	100%	100%
Oral Surgery			
Removal of Uncomplicated Single Tooth	$45	$5	100%
Removal of Impacted Tooth-Partially Bony	$65	$75	$70
Removal of Impacted Tooth-Completely Bony	$80	$95	$90
Restorative			
Cavities-Amalgam, 1 Surface	100%	$5	100%
Cavities-Amalgam, 2 Surfaces	100%	$10	100%
Endodontics			
Single Root Canal	$110	$85	$55
Bi-Root Canal	$195	$150	$120
Molar Root Canal	$245	$280	$250
Periodontics			
Gingivectomy-Per Tooth	$50	$80	$80
Periodontal Scaling and Root Planning (quadrant)	$40	$30	$20
Crowns			
Porcelain	$410	$195	$140
Full Cast Noble Metal	$465	$200	$150
Orthodontics			
Children (maximum age 18)	$2,100	$1,700	$1,700
Adult	$2,250	$1,900	$1,900
Prosthetics			
Complete Upper or Lower Denture (each)	$510	$215	$145
Partial Upper or Lower Denture (each)	$535	$180	$120
Waiting Periods	None	None	None

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Dental – Employer Sponsored PPO

Ameritas[4]

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,100 $50	$1,100 $50	$1,600 $50	$1,600 $50	$2,100 $50	$2,100 $100
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 50% See EOC	Ded. Applies 80% 80% 50% 50% See EOC	Ded. Waived 100% 80%-90%-100%[1] 50% 80%-90%-100%[1] See EOC	Ded. Applies 100% 80% 50% 80% See EOC	Ded. Waived 100% 75% 75% 75% See EOC	Ded. Waived 100% 75% 75% 75% See EOC
Orthodontic Care[3] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000
Waiting Periods Basic Major Ortho	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months
Orthodontic Takeover Credit	At initial group enrollment employer sponsored groups with 10+ eligible employees and prior continuous uninterrupted orthodontic coverage of 12 months, will waive orthodontic waiting period.					
UCR		Average Prevailing Fee[2]		80% of U & C		80% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Benefit increase by visiting your provider each year (See EOC for details).

[2] With the Average Prevailing Fee, the plan allowance for each covered procedure is established according to the median dentist charges in the ZIP Code area where services are provided. Reimbursement allowances automatically adjust if there's an increase or decrease in the overall charges in the area.

[3] Child only.

[4] Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).

Dental Rewards® by Ameritas

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit - if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $250 on Silver and Gold Plans or $400 on Platinum. Plus they can earn an additional $100 on Silver or Gold or $200 on Platinum if they visited a network provider. For more information on Dental Rewards please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	Silver	Gold	Platinum
Carry Over Amount	$250	$250	$400
PPO Bonus	$100	$100	$200
Benefit Threshold	$500	$500	$750
Maximum Carry Over Amount	$1,000	$1,000	$1,200

Dental – Employer Sponsored PPO

Anthem Blue Cross						
Plan Name	**Silver**		**Gold**		**Platinum**	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,500 $50[1]	$1,500 $50[1]	$2,000 $50[1]	$2,000 $50[1]	$2,500 $50[1]	$2,500 $50[1]
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 80%[2] See EOC	Ded. Waived 80% 60% 50% 60%[2] See EOC	Ded. Waived 100% 90% 60% 90%[2] See EOC	Ded. Waived 100% 80% 50% 80%[2] See EOC	Ded. Waived 100% 90% 60% 90%[2] See EOC	Ded. Waived 100% 90% 60% 90%[2] See EOC
Orthodontic Care (optional) Coinsurance Annual Maximum Lifetime Maximum	 Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered	 50%[3] None $2,000[3]	 50%[3] None $2,000[3]	 50%[3] None $2,500[3]	 50%[3] None $2,500[3]
Waiting Periods Basic Major Ortho	 None None Not Covered	 None None Not Covered	 None None None	 None None None	 None None None	 None None None
Orthodontic Takeover Credit	Does Not Apply		See Plan Specific EOC			
UCR		Maximum Allowable Charge		90% of U & C		90% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Limit 3x per family.

[2] Including Oral Surgery.

[3] Covered adults and dependent children.

Annual Carry Over

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $400 on Gold or $450 on Platinum. Plus they can earn an additional $200 on Gold or $225 on Platinum if they only visited network providers.

	Silver	Gold	Platinum
Carry Over Amount	$350	$400	$450
PPO Bonus	$175	$200	$225
Benefit Threshold	$700	$800	$900
Maximum Carry Over Amount	$1,500	$2,000	$2,500

Dental – Employer Sponsored PPO

Delta Dental®

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,000 $50	$1,000 $50	$1,500 $50	$1,500 $50	$2,000 $50	$2,000 $50
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 50% See EOC	Ded. Waived 80% 80% 50% 50% See EOC	Ded. Waived 100% 80% 50% 80% See EOC	Ded. Waived 100% 80% 50% 80% See EOC	Ded. Waived 100% 80% 50% 80% See EOC	Ded. Waived 100% 80% 50% 80% See EOC
Orthodontic Care[2] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000
Waiting Periods Basic Major Ortho	None None None	None None None	None None None	None None None	None None None	None None None
Orthodontic Takeover Credit	Does Not Apply					
UCR		Maximum Allowable Charge		Maximum Allowable Charge		See Footnote 1

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Premier dentists agree to accept their Premier Contracted Fee as payment in full. Non-contracted dentists are reimbursed according to the program allowance, which is the amount determined by a set percentile level of all charges for such services by providers with similar professional standing in the same geographical area.

[2] Child only.

Dental – Employer Sponsored PPO

MetLife [3]

Plan Name	Silver		Platinum		Platinum Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,250 $50	$750 $75	$2,250 $25	$1,750 $50	$2,500 None	$2,000 $50
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100%[4] 80% 50% 50% See EOC	Ded. Applies 90%[4] 60% 40% 40% See EOC	Ded. Waived 100%[4] 80% 50% 80%-50%[2] See EOC	Ded. Applies 100%[4] 70% 40% 70%-40%[2] See EOC	Ded. Waived 100%[4] 90% 50% 90%-50%[2] See EOC	Ded. Waived 100%[4] 80% 50% 80%-50%[2] See EOC
Orthodontic Care[1] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,500	 50% None $1,500
Waiting Periods Basic Major Ortho	 None None None	 None None None	 None None None	 None None None	 None None None	 None None None
Orthodontic Takeover Credit	Does Not Apply					
UCR		Maximum Allowable Charge		70% of U & C		90% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Child only.

[2] Endodontics and Periodontics can be classified as either Basic or Major services depending on the procedure.

[3] In-network reimbursement for MetLife plans is based on the negotiated fee, which is the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Out-of-network reimbursement is based on either the negotiated fee (for the Silver plan) or the Usual and Customary (U&C) Fee (for the Platinum and Platinum-Plus plans). The U&C Fee is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

[4] Benefits paid for Preventive services will not count toward the annual maximum benefit. Only benefits paid for Basic and Major services are applied to the annual benefit maximum. Refer to MetLife plan documents for specific details.

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Dental – Voluntary HMO

DeltaCare® USA

Plan Name	Bronze	Silver	Gold
Exam & Diagnostics			
Office Exam	$5	100%	100%
Initial Oral Exam	100%	100%	100%
Periodic Oral Exam	100%	100%	100%
Teeth Cleaning	100%	100%	100%
Bite-Wing X-Ray	100%	100%	100%
Oral Surgery			
Removal of Uncomplicated Single Tooth	$45	$5	100%
Removal of Impacted Tooth-Partially Bony	$65	$75	$70
Removal of Impacted Tooth-Completely Bony	$80	$95	$90
Restorative			
Cavities-Amalgam, 1 Surface	100%	$5	100%
Cavities-Amalgam, 2 Surfaces	100%	$10	100%
Endodontics			
Single Root Canal	$110	$85	$55
Bi-Root Canal	$195	$150	$120
Molar Root Canal	$245	$280	$250
Periodontics			
Gingivectomy-Per Tooth	$50	$80	$80
Periodontal Scaling and Root Planning (quadrant)	$40	$30	$20
Crowns			
Porcelain	$410	$195	$140
Full Cast Noble Metal	$465	$200	$150
Orthodontics			
Children (maximum age 18)	$2,100	$1,700	$1,700
Adult	$2,250	$1,900	$1,900
Prosthetics			
Complete Upper or Lower Denture (each)	$510	$215	$145
Partial Upper or Lower Denture (each)	$535	$180	$120
Waiting Periods	None	None	None

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Dental – Voluntary PPO

Ameritas[4]

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,100 $50	$1,100 $50	$1,600 $50	$1,600 $50	$2,100 $50	$2,100 $100
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 50% See EOC	Ded. Applies 80% 80% 50% 50% See EOC	Ded. Waived 100% 80%-90%-100%[1] 50% 80%-90%-100%[1] See EOC	Ded. Applies 100% 80% 50% 80% See EOC	Ded. Waived 100% 75% 75% 75% See EOC	Ded. Waived 100% 75% 75% 75% See EOC
Orthodontic Care[3] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000
Waiting Periods Basic Major Ortho	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months
Orthodontic Takeover Credit	Does Not Apply					
UCR		Average Prevailing Fee[2]		80% of U & C		80% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Benefit increase by visiting your provider each year (See EOC for details).

[2] With the Average Prevailing Fee, the plan allowance for each covered procedure is established according to the median dentist charges in the ZIP Code area where services are provided. Reimbursement allowances automatically adjust if there's an increase or decrease in the overall charges in the area.

[3] Child only.

[4] Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).

Dental Rewards® by Ameritas

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit - if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $250 on Silver and Gold Plans or $400 on Platinum Plan. Plus they can earn an additional $100 on Silver or Gold or $200 on Platinum if they visited a network provider. For more information on Dental Rewards please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	Silver	Gold	Platinum
Carry Over Amount	$250	$250	$400
PPO Bonus	$100	$100	$200
Benefit Threshold	$500	$500	$750
Maximum Carry Over Amount	$1,000	$1,000	$1,200

Dental – Voluntary PPO

Anthem Blue Cross		
Plan Name	**Silver**	
	In-Network	Out-of-Network
Annual Maximum Annual Deductible	$1,500 $50[1]	$1,500 $50[1]
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 80%[2] See EOC	Ded. Waived 80% 60% 50% 60%[2] See EOC
Orthodontic Care (optional) Coinsurance Annual Maximum Lifetime Maximum	 Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered
Waiting Periods Basic Major Ortho	 None 12 Months[3] Not Covered	 None 12 Months[3] Not Covered
Orthodontic Takeover Credit	Does Not Apply	
UCR		Maximum Allowable Charge

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Limit 3x per family.

[2] Including Oral Surgery.

[3] Waiting period waived for initial enrollees covered under the prior group plan.

Annual Carry Over

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $350 on Silver Plan. Plus they can earn an additional $175 on Silver if they only visited network providers.

	Silver
Carry Over Amount	$350
PPO Bonus	$175
Benefit Threshold	$700
Maximum Carry Over Amount	$1,500

Dental – Voluntary PPO

Delta Dental®		
Plan Name	**Silver**	
	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,000 $50	$1,000 $50
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 50% See EOC	Ded. Waived 100% 80% 50% 50% See EOC
Orthodontic Care[1] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000
Waiting Periods Basic Major Ortho	 None 12 Months 12 Months	 None 12 Months 12 Months
Orthodontic Takeover Credit	Does Not Apply	
UCR		Maximum Allowable Charge

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Child only.

Dental – Voluntary PPO

MetLife [2]		
Plan Name	**Silver**	
	In-Network	Out-of-Network
Annual Maximum **Annual Deductible**	$1,250 $50	$750 $75
Diagnostic and Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100%[3] 80% 50% 50% See EOC	Ded. Applies 90%[3] 60% 40% 40% See EOC
Orthodontic Care[1] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000
Waiting Periods Basic Major Ortho	 None None None	 None None None
Orthodontic Takeover Credit	Does Not Apply	
UCR		Maximum Allowable Charge

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] Child only.

[2] In-network reimbursement for MetLife plans is based on the negotiated fee, which is the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Out-of-network reimbursement is based on either the negotiated fee (for the Silver plan) or the Usual and Customary (U&C) Fee (for the Platinum and Platinum-Plus plans). The U&C Fee is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

[3] Benefits paid for Preventive services will not count toward the annual maximum benefit. Only benefits paid for Basic and Major services are applied to the annual benefit maximum. Refer to MetLife plan documents for specific details.

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Vision – Employer Sponsored

EyeMed (Provided by Ameritas)

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$10 Copay	Up to $25	$10 Copay	Up to $25	100%	Up to $25
Frames	$100 Allowance, 20% off balance over $100	Up to $40	$130 Allowance, 20% off balance over $130	Up to $40	$150 Allowance, 20% off balance over $150	Up to $40
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Standard Progressive	 $15 Copay $15 Copay $15 Copay Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered	 $10 Copay $10 Copay $10 Copay Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered	 100% 100% 100% Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered
Contact Lenses (in lieu of lenses & frames)	$100 Allowance, 15% off balance over $100	Up to $65	$130 Allowance, 15% off balance over $130	Up to $65	$150 Allowance, 15% off balance over $150	Up to $65
Benefit Frequency*	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12

VSP® Vision Care[2,3,4,6,7,8]

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$20[1] Copay	Up to $45	$10 Copay	Up to $45	$10 Copay	Up to $45
Frames	$180 Allowance	Up to $70	$200 Allowance	Up to $70	$250 Allowance	Up to $70
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Standard Progressive	 Covered In Full Covered In Full Covered In Full Covered In Full	 Up to $30 Up to $50 Up to $65 Up to $50	 $25 Copay $25 Copay $25 Copay Covered In Full	 Up to $30 Up to $50 Up to $65 Up to $50	 $25 Copay $25 Copay $25 Copay Covered In Full	 Up to $30 Up to $50 Up to $65 Up to $50
Contact Lenses (in lieu of lenses & frames)	$150 Allowance	Up to $105	$180 Allowance	Up to $105	$200 Allowance	Up to $105

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Benefit Frequency - Exams/lenses/frames.

[1] The $20 Copay applies to exam and/or materials once in an eligibility period.

[2] Average 20 - 25% savings on non-covered lens enhancements.

[3] 20% off additional glasses and sunglasses, including lens options, from any VSP Vision Care doctor within 12 months of your last WellVision Exam.

[4] Includes $250 per eye laser surgery benefit (in-network).

[5] Premium Progressive in-network are discounted.

[6] Sun Care included- provides Plano Sunglasses to members who do not have a prescription.

[7] Essential Medical Eye Care included – members have access to supplemental coverage for urgent and medical eye care.

[8] VSP LightCare™ included – members can use frame and lens benefits to get non-prescription eyewear from a VSP network doctor.

Vision – Voluntary

EyeMed (Provided by Ameritas)

Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$10 Copay	Up to $25	$10 Copay	Up to $25	100%	Up to $25
Frames	$100 Allowance, 20% off balance over $100	Up to $40	$130 Allowance, 20% off balance over $130	Up to $40	$150 Allowance, 20% off balance over $150	Up to $40
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Standard Progressive	 $15 Copay $15 Copay $15 Copay Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered	 $10 Copay $10 Copay $10 Copay Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered	 100% 100% 100% Covered In Full[5]	 Up to $20 Up to $35 Up to $60 Not Covered
Contact Lenses (in lieu of lenses & frames)	$100 Allowance, 15% off balance over $100	Up to $65	$130 Allowance, 15% off balance over $130	Up to $65	$150 Allowance, 15% off balance over $150	Up to $65
Benefit Frequency*	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12

VSP® Vision Care[1,2,3,5,6,7]

Plan Name	Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$10 Copay	Up to $45	$10 Copay	Up to $45
Frames	$200 Allowance	Up to $70	$250 Allowance	Up to $70
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Standard Progressive	 $25 Copay $25 Copay $25 Copay Covered In Full	 Up to $30 Up to $50 Up to $65 Up to $50	 $25 Copay $25 Copay $25 Copay Covered In Full	 Up to $30 Up to $50 Up to $65 Up to $50
Contact Lenses (in lieu of lenses & frames)	$180 Allowance	Up to $105	$200 Allowance	Up to $105
Benefit Frequency*	12/12/24	12/12/24	12/12/12	12/12/12

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Benefit Frequency - Exams/lenses/frames.

[1] Average 20 - 25% savings on non-covered lens enhancements.

[2] 20% off additional glasses and sunglasses, including lens option, from any VSP Vision Care doctor within 12 months of your last WellVision Exam.

[3] Includes $250 per eye laser surgery benefit (in-network).

[4] Premium Progressive in-network are discounted.

[5] Sun Care included- provides Plano Sunglasses to members who do not have a prescription.

[6] Essential Medical Eye Care included – members have access to supplemental coverage for urgent and medical eye care.

[7] VSP LightCare™ included – members can use frame and lens benefits to get non-prescription eyewear from a VSP network doctor.

Chiropractic/Acupuncture – Employer Sponsored & Voluntary

Chiropractic (Provided by Landmark Healthplan) [3]

New Patient Evaluation & Management Initial evaluation, problem-focused Initial evaluation, expanded Initial evaluation (history and examination), detailed Home visit, new patient, problem-focused	$65[1] per visit
Established Patient Re-Examination & Management Re-examination Re-examination, expanded Home visit, established patient, problem-focused	$50[2] per visit
Modalities Hot or cold packs, supervised Mechanical traction, supervised Unattended electrical stimulation, supervised Whirlpool, supervised Diathermy (microwave), supervised Infrared, supervised Attended electrical stimulation, constant attendance Iontophoresis, constant attendance Contrast baths, constant attendance Ultrasound, constant attendance (phonophoresis)	$50[2] per visit
Therapeutic Procedures Physical medicine; treatment to one area, therapeutic exercise Manual therapy techniques (myofascial release, trigger point therapy, or manual traction)	$50[2] per visit
Chiropractic Manipulative Treatment Spinal, one to two regions Spinal, three to four regions Spinal, five regions Extraspinal, one or more regions	$50[2] per visit
Special Services Service after hours Office service on emergency basis	$50[2] per visit

Acupuncture (Provided by Landmark Healthplan)

New Patient Evaluation Initial evaluation, problem-focused Initial evaluation, expanded Initial evaluation (history and examination), detailed	$75 per visit
Established Patient Re-Evaluation & Management Re-Examination, low to moderate severity	$75 per visit
Acupuncture Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient Each additional 15 minutes of personal one-on-one contact with patient, with reinsertion of needle(s)	$75 per visit
Modalities Myofascial release, trigger point therapy, or acupressure Cupping/Moxibustion	$75 per visit
Electroacupuncture Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient Each additional 15 minutes of personal one-on-one contact with patient, with reinsertion of needle(s)	$75 per visit

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

[1] This rate is inclusive of covered services for initial visit/new patient evaluation, modalities, therapeutic procedures, and/or manipulation, but is exclusive of radiology. Radiology reimbursement is in addition, and is also outlined in the fee schedule.

[2] This rate is inclusive of covered services for established patient re-examination, modalities, therapeutic procedures, and/or manipulation, but is exclusive of radiology. Radiology reimbursement is in addition, and is also outlined in the fee schedule.

[3] There are two Choice Builder chiropractic fee schedules. To identify which fee schedule applies to the chiropractor that you wish to visit, go to Landmark Healthplan's Provider Directory by visiting www.lhp-ca.com/Members/ProviderDirectory.aspx. Under "Select Your Plan," choose "ChoiceBuilder" and then select a chiropractor using the search tools. To determine which fee schedule applies to the selected chiropractor, click on the "View Details" page for that chiropractor. Fee schedule A is listed above ($65 for new patient initial visits/$50 for recurring visits) and fee schedule B is a lower amount ($60 for new patient initial visits/$40 for recurring visits).

Chiropractic/Acupuncture – Employer Sponsored & Voluntary

Chiropractic Radiology – Includes both technical and professional components of radiology services:

Radiological Exam, Chest	
Ribs, unilateral, two views	$48
Ribs, bilateral, three views	$59
Sternum, minimum of two views	$41
Sternoclavicular joint(s), minimum of three views	$44
Radiological Exam, Spine and Pelvis	
Spine, entire, survey study, AP and lateral	$90
Spine, single view, specify level	$30
Cervical, AP, lateral and AP open mouth	$41
Cervical, minimum of four views	$66
Cervical, complete, including flexion and/or extension studies	$82
Thoracolumbar, standing (scoliosis)	$48
Thoracic, AP and lateral	$45
Thoracic, AP and lateral, including swimmer's view	$53
Thoracic, complete, minimum of four views	$57
Thoracolumbar, AP and lateral	$48
Scoliosis study, including supine and erect studies	$49
Lumbosacral, AP and lateral	$45
Lumbosacral, complete with oblique	$61
Lumbosacral, complete with bending views	$74
Lumbosacral, bending views only, minimum of four views	$52
Pelvis, AP only	$41
Pelvis, complete, minimum of three views	$49
Sacroiliac joints, less than three views	$41
Sacroiliac joints, three or more views	$44
Sacrum and coccyx, minimum of two views	$41

Chiropractic Radiology – Includes both technical and professional components of radiology services:

Radiological Exam, Upper Extremities	
Clavicle, complete	$33
Scapula, complete	$37
Shoulder, one view	$30
Shoulder, complete, minimum of two views	$37
Acromioclavicular joints, bilateral, weighted or unweighted	$41
Humerus, minimum of two views	$38
Elbow, AP and lateral views	$36
Elbow, complete, minimum of three views	$37
Forearm, AP and lateral views	$34
Wrist, AP and lateral views	$34
Wrist, complete, minimum of three views	$37
Hand, two views	$30
Hand, minimum of three views	$38
Finger(s), minimum of two views	$29
Radiological Exam, Lower Extremities	
Hip, unilateral, one view	$34
Hip, complete, minimum of two views	$41
Hips, bilateral, minimum of two views each hip	$48
Femur, AP and lateral views	$38
Knee, AP and lateral views	$34
Knee, AP and lateral, including oblique(s), and tunnel, and/or patellar and/or standing views	$38
Knee, complete, including oblique(s), and tunnel, and/or patellar and/or standing views	$41
Both knees, standing, AP	$61
Tibia and fibula, AP and lateral views	$34
Ankle, AP and lateral views	$31
Ankle, complete, minimum of three views	$38
Foot, AP and lateral views	$31
Foot, complete, minimum of three views	$37
Calcaneus, minimum of two views	$31
Toe(s), minimum of two views	$27

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Life – Employer Sponsored

Assurity Life Insurance Company - Employer Sponsored only

Group Size	2 to 10	11 to 25	26 to 199	200 to 500
Life & AD&D Amounts[1]	$10,000 - $25,000	$10,000 - $50,000	$10,000 - $75,000	$10,000 - $150,000
Disability Waiver of Premium	Disability prior to age 60; benefits to age 65			
Reduction Schedule	Reduce 30% at age 70; Reduce 60% at age 75			

MetLife – Employer Sponsored only

Group Size	2 to 4	5 to 9	10 to 24	25 to 49	50 to 199	200 to 500
Life & AD&D Amounts[2]	$10,000 $25,000	$10,000 $25,000 $35,000 $50,000	$10,000 $25,000 $35,000 $50,000 $75,000	$10,000 $25,000 $35,000 $50,000 $75,000	$10,000 $25,000 $35,000 $50,000 $75,000 $100,000 $150,000	$10,000 $25,000 $35,000 $50,000 $75,000 $100,000 $150,000
Disability Waiver of Premium	Disability prior to age 60; benefits to age 65					
Reduction Schedule	Reduce 35% at age 65; Reduce 50% at age 70					

Assurity Life coverage Certificates are mailed directly to the Group/Member.

MetLife coverage Confirmation Statement is available on the Employee portal after log-in at choicebuilder.com. The MetLife Life Certificate is available on the public site and after log-in. Click on the "Forms" tab, then the "Evidence of Coverage" tab to access and print the "MetLife Life Certificate" that matches your group's effective date. The Confirmation Statement and MetLife Life Certificate should be retained together for future reference.

[1] Available in increments of $5,000.

[2] Only available at Initial Enrollment and at Renewal.

Family Coverage

Coverage for spouse and children

- If you are enrolled and have a spouse and/or children, they may also be eligible for coverage.

  SPOUSE: Must be legally married to you in order to be eligible for coverage through the ChoiceBuilder® Program.

  CHILDREN: Eligible children include: born to, a step-child or legal ward, or adopted by the eligible employee, employee spouse, or domestic partner.

  Unmarried financially dependent children under age 26*.

  * Children incapable of self-support because of a continuous and pre-existing mental or physical disability are eligible for coverage until the incapacity ends. Documentation to prove disability may be requested.

- You are not required to extend coverage to either your spouse or your dependent children. If you do not wish to do so, you must check the appropriate boxes and sign the WAIVER Form, stating that you decline dependent coverage.
- Any family members enrolling for coverage through the ChoiceBuilder Program must choose the same participating carrier and benefit for dental, although each is free to choose a different primary care provider if selecting DHMO.
- If you are in the middle of treatment AND your current provider is not contracted with the carrier you wish to select, please contact our Customer Service Center at (866) 412-9279 for further information and assistance.

Coverage for domestic partner

Requirements:

The employee and partner must fall into all of the following categories:

- Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to ChoiceBuilder within 60 days of its issue
- Agree to notify ChoiceBuilder immediately upon termination of domestic partnership

Domestic Partners are required to submit a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If Domestic Partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance.

Delta Dental® Limitations of Benefits

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon authorization by the Plan, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new Delta Dental Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the Delta Dental program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. The Plan is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Delta Dental® Exclusions of Benefits

Exclusions:

1. Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.
2. Any procedure that in the professional opinion of the Contract Dentist: a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9972, External bleaching, per arch, or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the Delta Dental program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Ameritas Limitations & Exclusions

No benefits will be paid for expenses incurred:

- For overdentures and associated procedures.
- For charges in excess of those considered reasonable and customary.
- For cosmetic procedures.
- For the replacement of dentures, bridge inlays, onlays or crowns that can be repaired or restored to normal function.
- For implants and:
  - Replacement of lost or stolen appliances
  - Replacement of retainers
  - Athletic mouthguards
  - Precision or semi-precision attachments
  - Dental duplication or sealants
- For oral hygiene instructions and:
  - Plaque control
  - Completion of a claim form
  - Acid etch
- Missed appointments
- Prescription of take home fluoride
- Diagnostic photographs
- For services not completed when insurance ends, except that certain services which began while insured may be covered if completed within 31 days of termination of coverage.
- For procedures that have begun but have not been completed.
- For services and treatment provided at no charge, with or without insurance coverage.
- For services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
- For a condition covered under any Workers' Compensation Act or similar law.
- That are applied toward satisfying a deductible.
- That are generally considered by the dental profession as experimental or investigational.
- For the treatment of cleft palate and anodontia.
- For services or supplies payable under any medical expense plan.
- For orthodontia, unless included within Coverage Schedule.
- Prior to the date the insured is covered under the policy.
- For the diagnosis or treatment of TMJ.
- For hospital services.
- For any child 26 years of age and over.
- During any waiting period we require, when you voluntarily end your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date your coverage first ended.
- Charges for infection control, sterilization and waste disposal.

Anthem Blue Cross Limitations and Exclusions

Limitations:

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, if more than one treatment plan would be considered for a dental condition, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such Dental Procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such services are dental reconstructive surgical services.

c) Benefits for inpatient or outpatient expenses arising from Dental Services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate. For programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan's Certificate shall be primary and the other policy or contract shall be secondary.

d) Some procedures are an integral part of another completed service covered by the plan's Certificate. If the Dentist bills these procedures separately from the covered service, the Plan will disallow coverage for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your Dentist directly.

e) Optional Treatment Plans: In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, if more than one treatment plan would be considered for a dental condition, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

Exclusions:

a) Dental Services which a Member would be entitled to receive for a nominal charge or without charge if this plans Certificate were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for Dental Services under any governmental program, then this exclusion shall not apply. Benefits under this plans Certificate will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.

b) Dental Services or health care services not specifically listed in the Covered Services section of this plans Certificate (including any hospital charges, prescription drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).

c) Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist.

(continued on page 25)

Anthem Blue Cross Limitations and Exclusions

(continued)

Exclusions (continued):

d) Dental Services completed prior to the date the Member became eligible for coverage.

e) Services of anesthesiologists.

f) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a Dentist or an employee of the Dentist who is certified in their profession to provide anesthesia services.

g) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

h) Dental Services performed other than by a licensed Dentist, licensed physician, his or her employees.

i) Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

j) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration (Employer Sponsored only). Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants (Voluntary only).

k) Tooth whitening agents, tooth bonding and veneers.

l) Orthodontic treatment services, unless specified in this plans Certificate as a covered Dental Service benefit.

m) Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed and consultations.

n) A permanent appliance or restoration (such as a partial, denture, bridge or crown) that has not been permanently cemented.

o) Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plans Certificate. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plans Certificate for more 24 months.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this plans Certificate.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plans Certificate.

s) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

t) Bacteriologic tests.

u) Cytology sample collection.

v) Separate services billed when they are an inherent component of a Dental Service.

w) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

x) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

y) Services for the replacement of an existing partial denture with a bridge.

z) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

aa) Provisional splinting, temporary procedures or interim stabilization.

bb) Placement or removal of sedative filling, base or liner used under a restoration.

(continued on page 26)

Anthem Blue Cross Limitations and Exclusions

(continued)

Exclusions (continued):

cc) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

dd) Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.

ee) Occlusal procedures.

ff) Any charges which exceed the Maximum Allowed Amount.

gg) Pulp vitality tests.

hh) Secondary diagnostic tests in addition to the primary therapy.

ii) Diagnostic casts.

jj) Incomplete root canals.

kk) Cone beam images.

ll) Anatomical crown exposure.

mm) Temporary anchorage devices.

nn) Sinus augmentation.

oo) Orthodontic Services (unless offered by employer).

pp) Amalgam or composite restorations placed for preventive or cosmetic purposes.

qq) Guided tissue regeneration (Voluntary only).

rr) Implant maintenance or repair to an implant or implant abutment (Voluntary only).

Delta Dental® PPO Limitations and Exclusions

Limitations:

(a) Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, provided to an Enrollee in a calendar year while he or she is an Enrollee under any Delta Dental plan are Benefits under this plan. See Note on additional Benefits during pregnancy.

(b) Delta Dental pays for full-mouth x-rays only after five years have elapsed since any prior set of full-mouth x-rays was provided under any Delta Dental plan.

Delta Dental pays for a panoramic x-ray provided as an individual service only after five years have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan.

(c) Bitewing x-rays are provided on request by the Dentist, but not more than twice in a calendar year for children to age 18, or once in a calendar year for adults ages 18 and over, while enrolled under any Delta Dental plan.

(d) Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under this plan.

(e) A prophylaxis (cleaning) or Single Procedure that includes a prophylaxis is a Benefit twice each calendar year under any Delta Dental plan. See Note on additional Benefits during pregnancy.

Routine prophylaxis are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Periodontal Benefit.

(f) Periodontal scaling and root planing is a Benefit once for each quadrant each 24-month period. See Note on additional Benefits during pregnancy.

(g) Fluoride treatment is a Benefit twice each calendar year under any Delta Dental plan.

(h) Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

(i) Direct composite (resin) restorations are Benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services and Delta Dental's payment is limited to the cost of the equivalent amalgam restorations.

(j) Crowns, Inlays, Onlays or Cast Restoration are Benefits on the same tooth only once every five years while enrolled under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

(k) Prosthodontic appliances and implants that were provided under any Delta Dental plan will be replaced only after five years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing fixed bridge, partial denture or complete denture cannot be made satisfactory. Replacement of a prosthodontic appliance or implant supported prosthesis not provided under a Delta Dental plan will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to one for each tooth during the Enrollee's lifetime whether provided under a Delta Dental or any other dental care plan.

(l) Delta Dental will pay the applicable percentage of the Dentist's Fee for a standard cast chrome or acrylic partial denture or a standard complete denture. A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.

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Delta Dental® PPO Limitations and Exclusions

Limitations (continued):

(m) If an Enrollee selects a more expensive plan of treatment than is customarily provided or specialized techniques, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee and the Enrollee is responsible for the remainder of the Dentist's fee. For example: a crown, where an amalgam filling would restore the tooth, or a precision denture, where a standard denture would suffice.

If the dental plan has Orthodontic coverage as shown in the matrix, then the following Orthodontic limitations will apply:

Orthodontic benefits may not be covered under this dental plan. The primary enrollee's evidence of coverage will indicate delta dental's applicable percentage and the maximum amount for orthodontic benefits to be paid by delta dental, if covered.

(n) Orthodontics, if covered, is limited to eligible dependent children.

(o) The lifetime maximum amount payable by Delta Dental for all Orthodontics whether paid for under the provisions of this Contract or under any prior dental plan is shown in the matrix included in the Primary Enrollee's Evidence of Coverage.

(p) The obligation of Delta Dental to make payments for an Orthodontic treatment plan begun prior to the Eligibility Date of the Enrollee shall commence with the first payment due following the Enrollee's Eligibility Date. The maximum amount payable will apply fully to this and subsequent payments.

(q) The obligation of Delta Dental to make payments for Orthodontics shall terminate on the payment due next following the date the Dependent loses eligibility or the employee loses eligibility, or upon the termination of treatment for any reason prior to completion of the case, or upon termination of the Contract, whichever shall occur first.

(r) Delta Dental will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this plan.

(s) X-rays and extraction procedures incident to Orthodontics are not covered by Orthodontic Benefits, but may be covered under the provisions of the Contract, subject to all of the terms and provisions thereof.

(t) Delta Dental will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the Enrollee selects specialized orthodontic appliances or procedures, an allowance will be made for the cost of the standard orthodontic treatment plan and the Enrollee is responsible for the remainder of the Dentist's fee.

Exclusions: The following services are not Benefits:

(a) Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws.

(b) Services which are provided to the Enrollee by any Federal or State Government Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in California Health and Safety Code Section 1373(a).

(c) Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

(d) Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion,

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Delta Dental® PPO Limitations and Exclusions

Exclusions (continued):

or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.

(e) Prosthodontic services or any Single Procedure started prior to the date the person became eligible for such services under this Contract.

(f) Prescribed or applied therapeutic drugs, premedication or analgesia.

(g) Experimental procedures.

(h) All hospital costs and any additional fees charged by the Dentist for hospital treatment.

(i) Charges for anesthesia, other than general anesthesia or I.V. sedation administered by a licensed Dentist in connection with covered Oral Surgery services and select Endodontic and Periodontic procedures.

(j) Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

(k) Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

(l) Replacements of existing restorations for any purpose other than active tooth decay.

(m) Occlusal guards and complete occlusal adjustment.

(n) Orthodontic Services unless Delta Dental's Applicable Percentage and an Orthodontic Maximum is shown in the matrix of the Primary Enrollee's Evidence of Coverage.

(o) Delta Dental will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this plan.

Metlife PPO Limitations and Exclusions

No benefits will be paid for expenses incurred:

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
- Services for which you would not be required to pay in the absence of dental insurance;
- Services or supplies received by you or your dependent before the dental insurance starts for that person;
- Services which are primarily cosmetic;
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
  - Services or appliances which restore or alter occlusion or vertical dimension; or
  - Fluoride treatments;
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital;
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first. (Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.) The term does not include:
- Any plan, program or coverage provided by a government as an employer; or
- Medicare.
- The following when charged by the dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide;
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Precision attachments except when the precision attachment is related to implant prosthetics;
- Duplicate prosthetic devices or appliances;
- Services covered under other coverage provided by the Policyholder;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- Replacement of a lost or stolen appliance, Cast Restoration or Denture;
- Replacement of an orthodontic device;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota;
- Intra and extraoral photographic images.

VSP® Vision Care Limitations and Exclusions

Limitations and Exclusions:

- Covered in full materials and services are less any applicable copay. Based on applicable laws, benefits and savings may vary by location. Promotions like rebates are continually evaluated and subject to change without notice.
- The following items are excluded under this plan: plano lenses (lenses with refractive correction of less than ± .50 diopter), two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing.
- Items not covered under the contact lens coverage insurance policies or service agreements: artistically painted or non-prescription lenses: additional office visits for contact lens pathology; contact lens modification, polishing or cleaning.

Carrier Customer Service Information

Each carrier also has customer services available to members. Please contact your carrier if you have questions regarding your provider services, claims assistance, or require authorization for services.

Dental

Ameritas ..... (800) 487-5553
English/Español, Monday–Thursday 7:00 a.m.–12:00 a.m. Central Time
Friday 7:00 a.m.–6:30 p.m. Central Time

Anthem Blue Cross ..... (877) 567-1804
English/Español, Monday–Friday 5:00 a.m.–6:00 p.m. Pacific Time

Delta Dental DHMO ..... (800) 422-4234
English/Español, Monday–Friday 5:00 a.m.–6:00 p.m. Pacific Time

Delta Dental DPPO ..... (888) 335-8227
English/Español, Monday–Friday 5:00 a.m.–6:00 p.m. Pacific Time

MetLife ..... (800) 942-0854
English/Español, Monday–Friday 8:00 a.m.–11:00 p.m. Eastern Time

Vision

EyeMed (provided by Ameritas) ..... (866) 289-0614
English/Español, Monday–Friday 8:00 a.m.–11:00 p.m. Eastern Time

VSP® Vision Care (800) 877-7195
English/Español, Monday–Friday 5:00 a.m.–8:00 p.m. Pacific Time
Saturday 7:00 a.m.–7:00 p.m. Pacific Time
Sunday 7:00 a.m.–7:00 p.m. Pacific Time

Chiropractic/Acupuncture

Landmark Healthplan ..... (800) 638-4557
English/Español, Monday–Friday 5:00 a.m.–5:00 p.m. Pacific Time

Life

Assurity Life Insurance Company ..... (800) 869-0355
English/Español, Monday–Friday 7:00 a.m.–5:00 p.m. Central Time

MetLife ..... (800) 638-6420
English, Monday–Thursday 8:00 a.m.–8:00 p.m. Eastern Time
Friday 8:00 a.m. – 5:00 p.m. Eastern Time

If you have administrative and/or billing questions, please contact ChoiceBuilder® at (866) 412-9279.

A California Different® Approach to Ancillary Benefits

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