GROUP DENTAL PLAN

GRANITE SCHOOL DISTRICT

Plan Number: 30-301045

Administered by:

Ameritas

Ameritas Life Insurance Corp.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third- party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your coverage or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 3	Eligible Employee Electing The Low Gold Plan

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 and Type 2 Procedures	$0

Copay:	Participating Provider	Non-Participating Provider
Type 1 Procedures	Fixed Copays (refer to Copay amount on Table of Dental Procedures)	Plan Payment on Table of Dental Procedures
Type 2 Procedures	Fixed Copays (refer to Copay amount on Table of Dental Procedures)	Plan Payment on Table of Dental Procedures

Maximum Amount - Each Benefit Period	Not Applicable

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Benefit Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier, and
b. is both:

   i. insured under the plan

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force, and

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the plan for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

DEFINITIONS

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

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for coverage by completing the eligibility period, if any; and

c. for whom the coverage has become effective.

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child refers to the child of the Member, a child of the Member's spouse or a child of the Member's Domestic Partner, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. a Member's spouse or Domestic Partner.

b. each child less than 26 years of age, for whom the Member, the Member's spouse, or the Member's Domestic Partner, is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while covered as a dependent under b. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the

child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Member's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental or physical handicap; and

2. Chiefly dependent upon the Member for support and maintenance.

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Members at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our Network Providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other Provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the Provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is January 1, 2012. The effective date of coverage for a Member is shown in the Planholder's records.

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

CONDITIONS FOR COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such coverage on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Member."

If employment is the basis for membership, a member of the Eligible Class for Coverage is any eligible employee electing the low gold plan working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

ELIGIBLE CLASS FOR DEPENDENT COVERAGE. Each Member of the eligible class for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any eligible employee electing the low gold plan working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

When a member of the Eligible Class for Dependent Coverage dies and, if at the date of death, has dependents covered, the Planholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Planholder and the affected dependents, the name of such deceased employee will continue to be listed as a member of the Eligible Class for Dependent Coverage.

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is required to contribute to the payment of coverage fees for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur on the first of the month falling on or first following the date of employment.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Planholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, a Member whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for coverage.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being covered and covering his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the coverage fees. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for coverage, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for coverage.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the coverage, or any increase in coverage, is to take effect. If not, the coverage will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the coverage, or any increase in coverage, is to take effect. The coverage will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the **earliest of:**

1. the date on which the Member's coverage terminates;
2. the date on which the Member ceases to be a Member;
3. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
4. the date all Dependent Coverage under the plan is terminated.

The coverage for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group plan for dental expenses incurred by a Member. A Covered person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Benefit Percentage(s) shown in the Schedule of Benefits.

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. Copay as covered under your plan if services are provided by a Participating Provider.
3. Plan Payment as covered under your plan if services are provided by a Non-Participating Provider.

Copay - The amount the Member is liable for per the Copay amount listed on the Table of Dental Procedures.

Plan Payment for services provided by Non-Participating General Dentists and Specialists are based on the fee schedule. Non-Participating General Dentists and Specialists do not accept the fee schedule as payment in full. The Member is responsible for paying the difference between the Plan Payment and the Non-Participating General Dentist or Specialist's billed charges. All charges above the Plan Payment are the Member's responsibility.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your Provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown,

appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

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

1. for appliances, restorations, or procedures to:

   a. alter vertical dimension;
   b. restore or maintain occlusion; or
   c. splint or replace tooth structure lost as a result of abrasion or attrition.

2. for any procedure begun after the covered person's coverage under this plan terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details).

6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this plan, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

7. for which the Covered person is entitled to benefits under any worker’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

8. for charges which the Covered person is not liable or which would not have been made had no coverage been in force.

9. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

10. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

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

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

The Copay responsibility for the Member varies depending on provider location. Please consult with your provider to confirm which schedule of Copay is applicable at their location or contact the Customer Care Department at 800-999-9789.

The Copay Fee Schedule is updated annually, to get a current Copay Fee Schedule, visit Ameritas.com or contact the Customer Care Department at 800-999-9789.

The Copay Fee Schedule is used in conjunction with a copay plan. The following is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. The Plan Payment amount listed below is the actual dollar allowance.

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

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Plan Payment
PAYMENT BASIS - PARTICIPATING PROVIDERS - Copay
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

Metro Copay Fee Schedule
Applies to the following counties in Utah: Davis, Salt Lake, Toole, Weber, and Utah

		General Dentist In Network Copay	Specialist In Network Copay	General Dentist or Specialist Out of Network Plan Payment
ROUTINE ORAL EVALUATION				
D0120	Periodic oral evaluation - established patient.	$0	$0	$36
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$0	$0	$36
D0150	Comprehensive oral evaluation - new or established patient.	$0	$0	$52
COMPREHENSIVE EVALUATION: D0150, D0180				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0140, D0145, D0160, D0170, also contribute(s) to this limitation.			
ROUTINE EVALUATION: D0120, D0145, D0160				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
COMPLETE SERIES OR PANORAMIC				
D0210	Intraoral - comprehensive series of radiographic images.	$0	$0	$87
D0330	Panoramic radiographic image.	$0	$0	$74
COMPLETE SERIES/PANORAMIC: D0210, D0330				
	Coverage is limited to 1 of any of these procedures per 3 year(s).			
OTHER XRAYS				
D0220	Intraoral - periapical first radiographic image.	$0	$0	$20
D0230	Intraoral - periapical each additional radiographic image.	$0	$0	$18
D0240	Intraoral - occlusal radiographic image.	$0	$0	$24
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$0	$0	$32
D0251	Extra-oral posterior dental radiographic image.	$0	$0	$31
EXTRAORAL: D0250, D0251				
	Coverage is limited to 1 of any of these procedures per 2 year(s).			
	The maximum amount considered for x-ray films taken on one day will be the equivalent to an allowance for a complete series.			
OCCLUSAL: D0240				
	Coverage is limited to 2 of any of these procedures per 2 year(s).			
PERIAPICAL: D0220, D0230				
	The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.			
BITEWINGS				
D0270	Bitewing - single radiographic image.	$0	$0	$18
D0272	Bitewings - two radiographic images.	$0	$0	$34
D0273	Bitewings - three radiographic images.	$0	$0	$39
D0274	Bitewings - four radiographic images.	$0	$0	$41
D0277	Vertical bitewings - 7 to 8 radiographic images.	$0	$0	$63
BITEWINGS: D0270, D0272, D0273, D0274				

TYPE 1 PROCEDURES

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

VERTICAL BITEWINGS: D0277

Coverage is limited to 2 of any of these procedures per benefit period.
D0270, D0272, D0273, D0274, also contribute(s) to this limitation.
Benefits will not be considered if performed on the same date as a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110	Prophylaxis - adult.	$0	$0	$61
D1120	Prophylaxis - child.	$0	$0	$42
D1206	Topical application of fluoride varnish.	$0	$0	$24
D1208	Topical application of fluoride-excluding varnish.	$0	$0	$24

FLUORIDE: D1206, D1208

Coverage is limited to 2 of any of these procedures per benefit period.
Benefits are considered for persons age 14 and under.

PROPHYLAXIS: D1110, D1120

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

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Plan Payment
PAYMENT BASIS - PARTICIPATING PROVIDERS - Copay
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

Metro Copay Fee Schedule
Applies to the following counties in Utah: Davis, Salt Lake, Toole, Weber, and Utah

		General Dentist In Network Copay	Specialist In Network Copay	General Dentist or Specialist Out of Network Plan Payment
ROUTINE ORAL EVALUATION				
D0180	Comprehensive periodontal evaluation - new or established patient.	$0	$0	$56
	COMPREHENSIVE EVALUATION: D0150, D0180			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0140, D0145, D0160, D0170, also contribute(s) to this limitation.			
	ROUTINE EVALUATION: D0120, D0145, D0160			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
LIMITED ORAL EVALUATION				
D0140	Limited oral evaluation - problem focused.	$0	$0	$48
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$0	$0	$36
	LIMITED ORAL EVALUATION: D0140, D0170			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0145, D0150, D0160, D0180, also contribute(s) to this limitation.			
SEALANTS AND CARIES MEDICAMENTS				
D1351	Sealant - per tooth.	$15	$25	$8
D1353	Sealant repair - per tooth.	$18	$27	$10
	SEALANT: D1351, D1353			
	Coverage is limited to 1 of any of these procedures per 3 year(s).			
	Benefits are considered for persons age 14 and under.			
	Benefits are considered on permanent molars and bicuspids only.			
	Coverage is allowed on the occlusal surface only.			
SPACE MAINTAINERS				
D1510	Space maintainer-fixed, unilateral-per quadrant.	$98	$172	$33
D1516	Space maintainer - fixed - bilateral, maxillary.	$138	$246	$46
D1517	Space maintainer - fixed - bilateral, mandibular.	$138	$246	$46
D1520	Space maintainer-removable, unilateral-per quadrant.	$107	$185	$36
D1526	Space maintainer - removable - bilateral, maxillary.	$165	$288	$55
D1527	Space maintainer - removable - bilateral, mandibular.	$165	$288	$55
D1551	Re-cement or re-bond bilateral space maintainer-maxillary.	$21	$36	$7
D1552	Re-cement or re-bond bilateral space maintainer-mandibular.	$21	$36	$7
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant.	$16	$27	$5
	RECEMENT SPACE MAINTAINER: D1551, D1552, D1553			
	Coverage is limited to 1 of any of these procedures per 12 month(s).			
	Coverage is not provided for charges made for recementation/repair within 6 months of placement date.			
	SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527			
	Coverage is limited to 1 of any of these procedures per lifetime.			
	Benefits are considered for persons age 14 and under.			

TYPE 2 PROCEDURES

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

AMALGAM RESTORATIONS (FILLINGS)				
D2140	Amalgam - one surface, primary or permanent.	$20	$43	$33
D2150	Amalgam - two surfaces, primary or permanent.	$27	$58	$37
D2160	Amalgam - three surfaces, primary or permanent.	$33	$69	$42
D2161	Amalgam - four or more surfaces, primary or permanent.	$43	$92	$42

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 2 year(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)				
D2330	Resin-based composite - one surface, anterior.	$40	$59	$35
D2331	Resin-based composite - two surfaces, anterior.	$44	$71	$43
D2332	Resin-based composite - three surfaces, anterior.	$52	$90	$47
D2335	Resin-based composite - four or more surfaces (anterior).	$57	$108	$53
D2391	Resin-based composite - one surface, posterior.	$38	$66	$36
D2392	Resin-based composite - two surfaces, posterior.	$58	$92	$42
D2393	Resin-based composite - three surfaces, posterior.	$71	$118	$48
D2394	Resin-based composite - four or more surfaces, posterior.	$76	$149	$49

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

Coverage is limited to 1 of any of these procedures per 2 year(s).

D2140, D2150, D2160, D2161, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

SEDATIVE FILLING				
D2940	Protective restoration.	$30	$52	$9
D2991	Application of hydroxyapatite regeneration medicament - per tooth.	$17	$27	$6

SEDATIVE FILLING: D2940, D2991

Coverage is limited to 1 of any of these procedures per lifetime.

NON-SURGICAL EXTRACTIONS				
D7111	Extraction, coronal remnants - primary tooth.	$27	$52	$17
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$39	$75	$19
SURGICAL EXTRACTIONS				
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$72	$148	$27
D7220	Removal of impacted tooth - soft tissue.	$96	$190	$30
D7230	Removal of impacted tooth - partially bony.	$128	$246	$38
D7240	Removal of impacted tooth - completely bony.	$158	$296	$39
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$185	$334	$49
D7250	Removal of residual tooth roots (cutting procedure).	$82	$157	$27
OTHER ORAL SURGERY				
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$137	$263	$45
D7471	Removal of lateral exostosis (maxilla or mandible).	$275	$520	$91
D7510	Incision and drainage of abscess - intraoral soft tissue.	$83	$150	$27
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).	$125	$226	$42
D7961	Buccal/labial frenectomy (frenulectomy).	$120	$213	$40
D7962	Lingual frenectomy (frenulectomy).	$120	$213	$40
BONE AUGMENTATION				
D7953	Bone replacement graft for ridge preservation - per site.	$123	$217	$41

TYPE 2 PROCEDURES

PALLIATIVE				
D9110	Palliative treatment of dental pain - per visit.	$29	$52	$10
PALLIATIVE TREATMENT: D9110				
	Coverage is limited to 1 of each of these procedures per benefit period.			
PROFESSIONAL CONSULT/VISIT/SERVICES				
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$19	$31	$6
D9440	Office visit - after regularly scheduled hours.	$37	$69	$12
OFFICE VISIT: D9430, D9440				
	Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.			
OCCLUSAL GUARD				
D9944	Occlusal guard - hard appliance, full arch.	$125	$213	$42
D9945	Occlusal guard - soft appliance, full arch.	$122	$207	$40
D9946	Occlusal guard - hard appliance, partial arch.	$92	$157	$31
OCCLUSAL GUARD: D9944, D9945, D9946				
	Coverage is limited to 1 of any of these procedures per 2 year(s).			
	Benefits will not be available if performed for athletic purposes.			
OCCLUSAL ADJUSTMENT				
D9951	Occlusal adjustment - limited.	$32	$58	$10
OCCLUSAL ADJUSTMENT: D9951				
	Coverage is limited to 1 of any of these procedures per 12 month(s).			
	Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.			
NON-SURGICAL MISCELLANEOUS				
D0160	Detailed and extensive oral evaluation - problem focused, by report.	$0	$0	$92
ROUTINE EVALUATION: D0120, D0145, D0160				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
MISCELLANEOUS				
D2951	Pin retention - per tooth, in addition to restoration.	$18	$30	$5
MISCELLANEOUS				
D9995	Teledentistry-synchronous; real-time encounter.	$0	$0	$36

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Plan Payment
PAYMENT BASIS - PARTICIPATING PROVIDERS - Copay
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

Rural Copay Fee Schedule
Applies to all counties in Utah except for: Davis, Salt Lake, Toole, Weber, and Utah

		General Dentist In Network Copay	Specialist In Network Copay	General Dentist or Specialist Out of Network Plan Payment
ROUTINE ORAL EVALUATION				
D0120	Periodic oral evaluation - established patient.	$0	$0	$36
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$0	$36	$36
D0150	Comprehensive oral evaluation - new or established patient.	$0	$1	$52
COMPREHENSIVE EVALUATION: D0150, D0180				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0140, D0145, D0160, D0170, also contribute(s) to this limitation.			
ROUTINE EVALUATION: D0120, D0145, D0160				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
COMPLETE SERIES OR PANORAMIC				
D0210	Intraoral - comprehensive series of radiographic images.	$0	$2	$87
D0330	Panoramic radiographic image.	$0	$1	$74
COMPLETE SERIES/PANORAMIC: D0210, D0330				
	Coverage is limited to 1 of any of these procedures per 3 year(s).			
OTHER XRAYS				
D0220	Intraoral - periapical first radiographic image.	$0	$1	$20
D0230	Intraoral - periapical each additional radiographic image.	$0	$1	$18
D0240	Intraoral - occlusal radiographic image.	$0	$0	$24
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$0	$1	$32
D0251	Extra-oral posterior dental radiographic image.	$0	$1	$31
EXTRAORAL: D0250, D0251				
	Coverage is limited to 1 of any of these procedures per 2 year(s).			
	The maximum amount considered for x-ray films taken on one day will be the equivalent to an allowance for a complete series.			
OCCLUSAL: D0240				
	Coverage is limited to 2 of any of these procedures per 2 year(s).			
PERIAPICAL: D0220, D0230				
	The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.			
BITEWINGS				
D0270	Bitewing - single radiographic image.	$0	$1	$18
D0272	Bitewings - two radiographic images.	$0	$1	$34
D0273	Bitewings - three radiographic images.	$0	$1	$39
D0274	Bitewings - four radiographic images.	$0	$1	$41
D0277	Vertical bitewings - 7 to 8 radiographic images.	$0	$1	$63
BITEWINGS: D0270, D0272, D0273, D0274				

TYPE 1 PROCEDURES

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

VERTICAL BITEWINGS: D0277

Coverage is limited to 2 of any of these procedures per benefit period.
D0270, D0272, D0273, D0274, also contribute(s) to this limitation.
Benefits will not be considered if performed on the same date as a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110	Prophylaxis - adult.	$0	$1	$61
D1120	Prophylaxis - child.	$0	$1	$42
D1206	Topical application of fluoride varnish.	$0	$1	$24
D1208	Topical application of fluoride-excluding varnish.	$0	$1	$24

FLUORIDE: D1206, D1208

Coverage is limited to 2 of any of these procedures per benefit period.
Benefits are considered for persons age 14 and under.

PROPHYLAXIS: D1110, D1120

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

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Plan Payment
PAYMENT BASIS - PARTICIPATING PROVIDERS - Copay
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

Rural Copay Fee Schedule
Applies to all counties in Utah except for: Davis, Salt Lake, Toole, Weber, and Utah

		General Dentist In Network Copay	Specialist In Network Copay	General Dentist or Specialist Out of Network Plan Payment
ROUTINE ORAL EVALUATION				
D0180	Comprehensive periodontal evaluation - new or established patient.	$0	$1	$56
	COMPREHENSIVE EVALUATION: D0150, D0180			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0140, D0145, D0160, D0170, also contribute(s) to this limitation.			
	ROUTINE EVALUATION: D0120, D0145, D0160			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
LIMITED ORAL EVALUATION				
D0140	Limited oral evaluation - problem focused.	$0	$1	$48
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$0	$1	$36
	LIMITED ORAL EVALUATION: D0140, D0170			
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0120, D0145, D0150, D0160, D0180, also contribute(s) to this limitation.			
SEALANTS AND CARIES MEDICAMENTS				
D1351	Sealant - per tooth.	$16	$24	$9
D1353	Sealant repair - per tooth.	$18	$26	$11
	SEALANT: D1351, D1353			
	Coverage is limited to 1 of any of these procedures per 3 year(s).			
	Benefits are considered for persons age 14 and under.			
	Benefits are considered on permanent molars and bicuspids only.			
	Coverage is allowed on the occlusal surface only.			
SPACE MAINTAINERS				
D1510	Space maintainer-fixed, unilateral-per quadrant.	$109	$170	$36
D1516	Space maintainer - fixed - bilateral, maxillary.	$153	$243	$51
D1517	Space maintainer - fixed - bilateral, mandibular.	$153	$243	$51
D1520	Space maintainer-removable, unilateral-per quadrant.	$111	$185	$37
D1526	Space maintainer - removable - bilateral, maxillary.	$173	$287	$58
D1527	Space maintainer - removable - bilateral, mandibular.	$173	$287	$58
D1551	Re-cement or re-bond bilateral space maintainer-maxillary.	$24	$35	$8
D1552	Re-cement or re-bond bilateral space maintainer-mandibular.	$24	$35	$8
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant.	$17	$27	$6
	RECEMENT SPACE MAINTAINER: D1551, D1552, D1553			
	Coverage is limited to 1 of any of these procedures per 12 month(s).			
	Coverage is not provided for charges made for recementation/repair within 6 months of placement date.			
	SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527			
	Coverage is limited to 1 of any of these procedures per lifetime.			
	Benefits are considered for persons age 14 and under.			

TYPE 2 PROCEDURES

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

AMALGAM RESTORATIONS (FILLINGS)				
D2140	Amalgam - one surface, primary or permanent.	$21	$43	$35
D2150	Amalgam - two surfaces, primary or permanent.	$29	$56	$40
D2160	Amalgam - three surfaces, primary or permanent.	$36	$69	$45
D2161	Amalgam - four or more surfaces, primary or permanent.	$47	$90	$47

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 2 year(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)				
D2330	Resin-based composite - one surface, anterior.	$41	$61	$35
D2331	Resin-based composite - two surfaces, anterior.	$45	$73	$43
D2332	Resin-based composite - three surfaces, anterior.	$53	$91	$49
D2335	Resin-based composite - four or more surfaces (anterior).	$60	$108	$57
D2391	Resin-based composite - one surface, posterior.	$40	$69	$35
D2392	Resin-based composite - two surfaces, posterior.	$60	$93	$43
D2393	Resin-based composite - three surfaces, posterior.	$72	$120	$49
D2394	Resin-based composite - four or more surfaces, posterior.	$82	$148	$54

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

Coverage is limited to 1 of any of these procedures per 2 year(s).

D2140, D2150, D2160, D2161, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

SEDATIVE FILLING				
D2940	Protective restoration.	$31	$51	$10
D2991	Application of hydroxyapatite regeneration medicament - per tooth.	$19	$33	$6

SEDATIVE FILLING: D2940, D2991

Coverage is limited to 1 of any of these procedures per lifetime.

NON-SURGICAL EXTRACTIONS				
D7111	Extraction, coronal remnants - primary tooth.	$30	$51	$19
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$42	$73	$21
SURGICAL EXTRACTIONS				
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$79	$146	$29
D7220	Removal of impacted tooth - soft tissue.	$99	$189	$31
D7230	Removal of impacted tooth - partially bony.	$136	$244	$40
D7240	Removal of impacted tooth - completely bony.	$162	$294	$41
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$202	$329	$54
D7250	Removal of residual tooth roots (cutting procedure).	$85	$156	$28
OTHER ORAL SURGERY				
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$144	$260	$48
D7471	Removal of lateral exostosis (maxilla or mandible).	$296	$513	$98
D7510	Incision and drainage of abscess - intraoral soft tissue.	$86	$149	$28
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).	$130	$225	$43
D7961	Buccal/labial frenectomy (frenulectomy).	$133	$209	$44
D7962	Lingual frenectomy (frenulectomy).	$133	$209	$44
BONE AUGMENTATION				
D7953	Bone replacement graft for ridge preservation - per site.	$135	$213	$45

TYPE 2 PROCEDURES

PALLIATIVE				
D9110	Palliative treatment of dental pain - per visit.	$30	$52	$10
PALLIATIVE TREATMENT: D9110				
	Coverage is limited to 1 of each of these procedures per benefit period.			
PROFESSIONAL CONSULT/VISIT/SERVICES				
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$21	$30	$7
D9440	Office visit - after regularly scheduled hours.	$39	$69	$12
OFFICE VISIT: D9430, D9440				
	Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.			
OCCLUSAL GUARD				
D9944	Occlusal guard - hard appliance, full arch.	$140	$209	$46
D9945	Occlusal guard - soft appliance, full arch.	$135	$202	$45
D9946	Occlusal guard - hard appliance, partial arch.	$103	$154	$34
OCCLUSAL GUARD: D9944, D9945, D9946				
	Coverage is limited to 1 of any of these procedures per 2 year(s).			
	Benefits will not be available if performed for athletic purposes.			
OCCLUSAL ADJUSTMENT				
D9951	Occlusal adjustment - limited.	$33	$58	$10
OCCLUSAL ADJUSTMENT: D9951				
	Coverage is limited to 1 of any of these procedures per 12 month(s).			
	Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.			
NON-SURGICAL MISCELLANEOUS				
D0160	Detailed and extensive oral evaluation - problem focused, by report.	$0	$2	$92
ROUTINE EVALUATION: D0120, D0145, D0160				
	Coverage is limited to 2 of any of these procedures per benefit period.			
	D0140, D0150, D0170, D0180, also contribute(s) to this limitation.			
	Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.			
MISCELLANEOUS				
D2951	Pin retention - per tooth, in addition to restoration.	$18	$29	$6
MISCELLANEOUS				
D9995	Teledentistry-synchronous; real-time encounter.	$0	$0	$36

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the plan for orthodontic expenses incurred by a Member.

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

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

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

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a Provider for necessary orthodontic treatment rendered while the person is covered under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

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

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

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

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

a. monthly of a Program for a Member who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for a Member who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Member's Program. They are pro-rated by monthly periods over the length of the Program. The last monthly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun before the Member became covered under this section, unless the Member was covered for Orthodontic Expense Benefits under the prior carrier and are both:

   a. member under this plan; and
   b. currently undergoing a Treatment Program.

2. in any month of a Program if the Member was not covered under this section for the entire month.

3. if the Member's coverage under this section terminates.

4. for which the Member is entitled to benefits under any worker's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

5. for charges the Member is not legally required to pay or would not have been made had no coverage been in force.

6. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

7. because of war or any act of war, declared or not.

8. to replace lost, missing, or stolen orthodontic appliances.

COORDINATION OF BENEFITS

This section applies if a covered person has dental coverage under more than one Plan definition below. All benefits provided under this plan are subject to this section.

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

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

DEFINITIONS. The following apply only to this provision of the plan.

1. "Plan" refers to the group plan and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

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

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide dental coverage.

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

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

1. Release any information with respect to your coverage and benefits under the plan; and

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

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

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

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

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Member unless otherwise agreed upon through your authorization or Provider contracts.

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

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

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

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

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

1. The Plan would not have been issued if we had known the truth; and

2. We have given the Planholder a copy of a written instrument signed by the Planholder that contains the misrepresentation.

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

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Dental Plan
Name, Address of Plan Sponsor:	GRANITE SCHOOL DISTRICT 2500 S STATE ST S SALT LAKE, UT 84115
Plan Sponsor Tax ID Number:	87-6000494
Plan Number:	501
Type of Plan:	Group Plan
Name, Address, Phone Number of Plan Administrator	BERKLEY KING GRANITE SCHOOL DISTRICT 2500 S STATE ST S SALT LAKE, UT 84115 385-646-4179
Name, Address of Registered Agent For Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Plan Additional Notification of Legal Process Must Be Sent To:	Ameritas Life Insurance Corp. P.O. Box 82595 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Self Funded
Plan Fiscal Year End:	December 31
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Plan

Please refer to the Conditions for Coverage within the Group Plan and Document of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Plan, you may call Customer Service Toll Free at 1-800-999-9789.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Plan

The Group Plan which provides benefits for this plan may be terminated by the Planholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Planholder fails to pay the required fees. Ameritas Life Insurance Corp. may terminate the Group Plan on any Fee Due Date if the number of persons covered is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Planholder has failed to perform its obligations relating to the Group Plan.

After the first Plan year, Ameritas Life Insurance Corp. may also terminate the Group Plan on any Fee Due Date for any reason by providing a 30-day advance written notice to the Planholder.

The Group Plan may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after the Plan ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means a Covered Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is covered on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which this plan would otherwise end;

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member’s Coverage ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Coverage ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes covered, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or
b. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

   a. The date of the disability determination;

   b. The date of the Qualifying Event; or

   c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Coverage for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Covered Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified

Beneficiary who is entitled to continue Coverage for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Fee Requirements

The Plan continued under this provision will be retroactive to the date the Plan would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required fee not later than 45 days after electing COBRA continuation, and monthly fee on or before the Fee Due Date thereafter. The monthly fee is a percentage of the total fee (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Fee Due Date. The fee may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Plan terminates;

2. 31 days after the date the last period ends for which a required fee payment was made;

3. The last day of the COBRA continuation period

4 The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental Plan and (b) not subject to any preexisting condition limitation in that Plan.

H. Your Rights under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 operate and administer this plan 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.

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 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.

Assistance with Your Rights
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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Plan on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Plan on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate of coverage for such information, call us, or contact your state regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.