EQUITABLE

Dental

Benefit Summary

Velocity Ventures Partners LLC

Effective Date: August 01, 2023

Policy Number: 016528

Class Definition: Class 1: All Active Full Time Owners, Executives, Management and General Staff working at least 30 hours per week

Plan: Dental PPO - High

Easily access the care you need with our comprehensive dental coverage

Regular dental care is one of the best ways to maintain a winning smile. It's also an important way to protect your overall health, though the cost of care can add up with preventive cleanings, exams, and more serious procedures. Dental insurance can help. Going in-network helps more! The Equitable Dental Network provides convenient access and comprehensive dental coverage to more than 105,000 unique dentists at over 300,000 dental practice locations nationwide. Find an in-network provider at www.equitable.com/finddentist.

Dental ID cards are not needed in order to receive treatment from a dentist, but can help to simplify our members' office experience so we encourage that they are printed. ID cards can be printed from www.equitable.com/employeebenefits.

Out-of-network dentists have the right to balance bill members for the difference between the provider charge and our maximum allowable charge.

Out-of-network dentists are not obligated by contractual agreement to submit claims on behalf of members. Claim forms may be requested by contacting the telephone number or email address indicated on your ID card or in the Manage Your Benefits section below.

We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured. A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed based on eligible services and subject to benefits availability at the time that the pre-treatment is received. A pre-treatment estimate is not required in order to receive benefits for covered services.

What your benefits cover:

Plan Benefits and Features	In-Network	Out-of-Network
Reimbursement	Contracted Allowances	MAC
Coinsurance	100/80/50	100/80/50
Annual Individual Deductible	$50 Calendar Year	$50 Calendar Year
Annual Family Deductible	$150	$150
Deductible Waived for Preventive	Yes	Yes
Annual Individual Maximum Benefit	$4,000 Calendar Year	$4,000 Calendar Year
Alternate Benefit	Included	
Missing Tooth Clause	Applies	Applies
Orthodontia		
Child Orthodontia Individual Deductible	$0	$0
Child Orthodontia Lifetime Maximum Benefit	$1,500	$1,500
Child Orthodontia covered to age	19	19
Prior Coverage Deductible Credit	No	No

Preventive Services	In-Network	Out-of-Network	Limitations
• Periodic and Comprehensive Oral Evaluations	100%	100%	2 per 12 consecutive months inclusive of Limited Evaluations and Office Visits After Regularly Scheduled Hours.
• Limited Evaluations	100%	100%	Limited Oral Evaluations: 2 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations and Office Visits After Regularly Scheduled Hours.
• Professional Consultations:	100%	100%	Professional Consultations: 1 per 12 consecutive months per specialty and no more than 2 for all specialties within this period, inclusive of Office Visit for Observation During Regularly Scheduled Hours- No Other Services Performed.
• Professional Office Visits:	100%	100%	Professional Office Visits: 1 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations, Limited Evaluations and Professional Consultations.
Treatments			
• Routine Dental Prophylaxis	100%	100%	2 per 12 consecutive months including periodontal cleanings and full mouth debridement
• Fluoride Treatment	100%	100%	2 per 12 consecutive months to age 16
• Sealants - child	100%	100%	Covered for a child up to age 13 Limited to one per tooth per 36 months for non-restored first and second permanent molars.
• Bitewing X-Rays	100%	100%	Bitewings: 2 sets per 12 consecutive months
• Complete Series or Panoramic X-Rays	100%	100%	Complete Series/Panoramic: Once per 36 consecutive months

Preventive Services	In-Network	Out-of-Network	Limitations
Labs and Tests			
• **Tests** - Brush Biopsy, Adjunctive Pre-Diagnostic, HBA1c and Pulp Vitality	100%	100%	1 per 12 consecutive months
• **Labs** - Accession of Tissue and Laboratory Accession of Sample	100%	100%	1 per 12 consecutive months

Basic Services Standard Benefit Waiting Period: None for All Employees	In-Network	Out-of-Network	Limitations
• Periapicals and Other X-Rays	80%	80%	Once per 36 consecutive months
• Emergency Palliative Treatment	80%	80%	Eligible only when no other procedure is performed on the same day except for Diagnostic procedures.
• Basic Restorative Services (amalgam fillings on all teeth, resin based composite fillings on anterior teeth)	80%	80%	1 per tooth surface per 12 consecutive months
• Basic Restorative Services (resin based composite fillings on posterior teeth)	80%	80%	1 per tooth surface per 12 consecutive months
• Space Maintainers and Recementation of Space Maintainers	80%	80%	Once per every 60 consecutive months for Children under age 16. Benefit includes all adjustments within 6 months of installation
• Simple Extractions	80%	80%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services
• Surgical Extractions and Removal of Impacted Teeth	80%	80%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services
• Oral Surgery	80%	80%	Limited to 1 unique site per 36 months
• Surgical Endodontics	80%	80%	1 per 36 consecutive months
• Non-Surgical Endodontics	80%	80%	Root Canal Treatment and Miscellaneous Services- 1 per tooth per lifetime Root Canal Retreatment 1 per tooth per 12 consecutive months
• Periodontal Maintenance	80%	80%	Only where periodontal treatment has been performed, limited to 4 per 12 consecutive months less the number of teeth cleanings and debridements received during such benefit period Full Mouth Debridement - 1 per 5 years when Dentally Necessary to enable comprehensive evaluation and

Basic Services Standard Benefit Waiting Period: None for All Employees	In-Network	Out-of-Network	Limitations
• Non-Surgical Periodontics	80%	80%	diagnosis. Counted towards Periodontal Maintenance and regular Cleanings. Scaling in Presence of Generalized Gingival Inflammation - 1 per full mouth per 24 consecutive months. Other Non-Surgical procedures - 1 per 36 consecutive months
• Surgical Periodontics	80%	80%	1 per quadrant per 36 consecutive months
• Anesthesia	80%	80%	General Anesthesia covered when medically or dentally necessary in conjunction with covered dental services. Local anesthesia is included in the fee for procedure being performed.

Major Services Standard Benefit Waiting Period: None for All Employees	In-Network	Out-of-Network	Limitations
• Inlays/Onlays/Crowns	50%	50%	1 replacement per tooth per 60 consecutive months. Covered when medically or dentally necessary.
• Dentures - Complete, partial, overdenture, (upper and lower)	50%	50%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Implants	50%	50%	1 per tooth per lifetime. Covered when medically or dentally necessary.
• Bridges	50%	50%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Other Dental Prosthetics	50%	50%	Overdentures 1 replacement per arch per 60 consecutive months against Dentures. Tissue Conditioning 1 per arch per 12 consecutive months.
• Adjustments, Repairs, Reline and Rebase of Dentures	50%	50%	Adjustments limited to after 6 months of installation if performed by the same dentist
Standard Services Not Covered	**In-Network**	**Out-of-Network**	**Limitations**
• Occlusal Guards	0%	0%	
Orthodontic Services Standard Benefit Waiting Period: None for All Employees	**In-Network**	**Out-of-Network**	**Limitations**
Child Orthodontic Services	50%	50%	Covered for dependent children only

A late entrant waiting period of 12 months apply to all services except Preventive services.

Manage Your Benefits

Go to www.equitable.com/employeebenefits and log on to **EB360®** to view your account details.

Find A Dentist

Visit www.equitable.com/finddentist

Choose from 300,000 dental access points and over 105,000 unique dental providers.

If you have any questions, please don't hesitate to contact us at 1-866-274-9887 or via email at EBCustomerService@equitable.com.

This includes questions on how we can provide language translation services at no cost to you and how we can assist the visually impaired with form completion and other information. Members requiring assistance with hearing impairment can contact our TDD line directly at 1-800-877-8973. You may also email Customer Service at EBCustomerService@equitable.com

We look forward to helping you manage your benefits with confidence and ease.

More about your Dental coverage

If you are working for your employer on the effective date - the waiting period is 0 continuous days.
If you start working for your employer after the effective date - the waiting period is 0 continuous days.

An Employee who is employed on the effective date of the policy will receive credit towards satisfying the waiting period for time employed with the employer provided he or she was employed on the day prior to the effective date of the policy.

Please contact your dentist for immediate attention in the event of an emergency. An emergency exists if services are necessary to treat a condition or illness that, without immediate attention, would seriously jeopardize the life or health of the member or the members ability to regain maximum function, or cause the member to be in danger to self or others. You may also call our customer service department during business hours for help in locating a network dentist.

If you visited an out-of-network dentist because an in-network dentist could not be located within standards, call our customer service department at 1-866-274-9887 to explain the issue. The case will be reviewed on an individual basis to determine the circumstances. If it is found that a network dentist was not available and accessible according to standards, your claim will be reprocessed so that you pay no more than you would have paid had a network dentist been used, providing you are covered for the services rendered, and subject to all policy provisions.

This applies to covered Emergency services only.

Standards:

- Primary Care Dentists (general practitioners)
  - Metro Area 1 within 10 miles or 15 minutes of their home zip code.
  - Micro Area 1 within 20 miles or 40 minutes of their home zip code.
  - Rural Area 1 within 30 miles or 1 hour of their home zip code.

- Specialty Care Dentists (endodontists, oral surgeons, orthodontists, pediatric dentists and periodontists)
    - Metro Area 1 within 20 miles or 30 minutes of their home zip code.
    - Micro Area 1 within 40 miles or 80 minutes of their home zip code.
    - Rural Area 1 within 80 miles or 2 hours of their home zip code.

What is not covered?

Limitations: Payment of benefits is limited under this certificate as shown below. Refer to the Group Dental Insurance Certificate for full limitations and exclusions.

1. Orthodontic services must begin while this insurance is in force. If the insurance ends during the course of the treatment plan, the monthly benefits will end. Services are considered to have begun when the initial banding or appliance is inserted.
2. Services must begin after the end of any applicable waiting period. Waiting periods for each category of service show under the What your benefits cover section.
3. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.
4. Alternate Benefit: If We determine that a service, less costly than the covered service the dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:
    - would produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the individual's dental condition; and
    - would qualify as a covered service. For example, if a high noble metal crown and a predominantly base metal crown are both professionally acceptable methods for restoring a tooth, we may base our determination on the less costly predominantly base metal material.

    If We pay benefits based upon a less costly service in accordance with this subsection, the dentist may charge for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an in-network dentist.
5. Basic restorative services are limited as follows:
    a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a covered service.
    b. Micro filled resin restorations which are non-cosmetic.
    c. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Any procedures not specifically listed as a covered service in the Schedule of Benefits and Benefits We Pay sections of the Group Dental Insurance Certificate.
2. Services which are not deemed to be necessary care or treatment and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
3. Services for which the insured person would not be required to pay in the absence of dental insurance.
4. Services or supplies received by an insured person before the dental insurance starts for that person.
5. Treatment or services received outside of the United States and Canada.
6. Services which are primarily cosmetic, except for services covered under the Teeth Whitening Benefit if Teeth Whitening is shown as a covered service under the What your benefits cover section.
7. 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:
    - scaling and polishing of teeth; or
    - fluoride treatments.
8. Services or appliances which restore or alter occlusion or vertical dimension.
9. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease or unless TMJ is listed as a covered service under the What your benefits cover section.
10. Restorations or appliances used for the purpose of periodontal splinting.
11. Surgical removal of 3rd molars are only covered if the removal is associated with symptoms of oral pathology.
12. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
13. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
14. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
15. Charges for missed appointments.
16. 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 required to pay; or
    - received at a facility maintained by your employer, labor union, mutual benefit association, or VA hospital.
17. Services covered under other coverage provided by your employer.
18. Temporary or provisional restorations.
19. Temporary or provisional appliances.
20. Prescription drugs.
21. Services for which the submitted documentation indicates a poor prognosis.

22. Fixed and removable appliances for correction of harmful habits unless Orthodontics is listed as a covered service under the What your benefits cover section..
23. Application of desensitizing agents.
24. Repair or replacement of an orthodontic device.
25. 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.
26. Caries susceptibility tests.
27. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, unless Occlusal Guards is listed as a covered service under the What your benefits cover section, then only the occlusal guard is covered.
28. Precision attachments associated with fixed and removable prostheses.
29. Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
30. Duplicate prosthetic devices or appliances.
31. Replacement of a lost or stolen appliance, cast restoration or denture.
32. Extra-oral photographic images, unless Orthodontics is listed as a covered service under the What your benefits cover section.
33. Cone beam imaging.
34. Diagnostic casts, unless part of overall treatment plan allowance for orthodontia if Orthodontia is shown as a covered service under the What your benefits cover section.
35. Labial veneers.
36. Modification of removable prosthodontic and other removable prosthetic services.
37. Occlusal adjustments
38. The following services are not covered services:
    - a connector bar,
    - a stress breaker,
    - coping,
    - pediatric partial dentures

The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form MOEBP19DEN, MOEBP19DEN_PPO; AXEBP19DEN and State Variations.

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