



A STOCK COMPANY
SUFFERN, NEW YORK

GROUP DENTAL INSURANCE POLICY

The Policyholder	HAMILTON COLLEGE	Policy Number	26-201361
State of Delivery	New York	Plan Effective Date	May 1, 2003
		Plan Change Effective Date	January 1, 2008
Premium Due Date 1st of each month.		Renewal Date	January 1, 2009

First Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

FIRST AMERITAS LIFE INSURANCE CORP. OF NEW YORK

Secretary

Vice President - Group Operations

Notice of Internal and External Appeal Procedures
In accordance with Article 49 of the New York Insurance Code

Please read this notice carefully. This notice contains important information about the appeal process available to you. You have the right to ask your insurer to assist you in filing a complaint, review its decisions involving your requests for service, or your requests to have your claims paid. Please contact:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
800-366-5933

I. Definitions

“Adverse Determination” means a determination made by us that a health care service has been reviewed and, based upon the information provided, is not medically necessary.

“Clinical Peer Reviewer” means a health care professional who possesses a current and valid non-restricted license and is in the same profession and same or similar specialty as the health care provider who rendered the health care service under review.

II. Levels of Review

The following levels of review will be available to an insured.

Expedited Internal Appeal Review - for appeals of an adverse determination involving a course of continued treatment or an adverse determination in which the health care provider believes an immediate appeal is warranted, except any retrospective determination.

Standard Appeal Review - for appeals received by phone or in writing requesting a review of an adverse determination.

External Review - an insured has the right to request an external review following a final adverse decision.

These levels of review are discussed more fully below.

A. Expedited Internal Appeal

An expedited internal appeal process is available for review of an adverse determination involving:

- (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider; or
- (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except for any retrospective determination.

A request for an expedited internal review shall be made by fax or telephone to the number(s) shown above. The appeal will be reviewed by a clinical peer reviewer within one business day of receiving notice of the request for expedited review. The decision concerning the expedited review will be determined within two business days of receipt of the necessary information to conduct such an appeal.

Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process. Both processes are described below.

B. Standard Internal Appeal Review

Appeals concerning an adverse determination may be submitted in writing, via email or by telephone by an insured, their designee or their health care provider. We will acknowledge receipt of the appeal and if additional information is needed to conduct the review, we will notify the insured and the provider, in writing, within 15 days of receipt of the appeal. If information is still missing, we will request the missing information within five business days of receipt of the partial information.

A determination regarding the appeal must be made within 60 days of the receipt of all necessary information and a written decision will be provided within 2 business days after making the determination. The person or persons reviewing the grievance will be a clinical peer reviewer and will not be the same person or persons who made the initial adverse determination.

C. External Review

- 1. External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal.

In this notice, "requested service" or "requested services" refers to the service or services for which you are requesting coverage. You may have the right to an expedited external appeal if your attending provider attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The time-frames for expedited external appeals are shorter than the time-frames for standard external appeals.

You may request an external appeal only if the requested service is a covered service under your Contract, Group Plan, or Certificate.

- 2. Coverage Determinations Subject to External Appeal.** This paragraph describes the general conditions for external appeal.

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal the adverse determination must be based on a determination that the requested service is not medically necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determinations even if those other determinations affect your coverage.

- 3. Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of medical necessity if you meet the conditions of this paragraph and the general requirements of paragraph "2" above. The provisions of this paragraph apply only to external appeal of medical necessity determinations.

To request external appeal under this paragraph, the final adverse determination must indicate that the requested service is not medically necessary.

Paragraph "7" below provides information on requesting an external appeal.

- 4. Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment.** This Paragraph governs external appeals of determinations involving experimental or investigational treatment. This paragraph does not govern determinations involving services provided in clinical trials that are governed by Paragraph "5" below.

In order to request an external appeal under this paragraph, your attending provider must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending provider, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending provider must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under your plan.

Your attending provider must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending provider must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

If you meet the requirements of this paragraph and all of the requirements of paragraph "2" you may request an external appeal. Paragraph "7" provides information on requesting an external appeal.

- 5. External Appeals of Determinations Involving Clinical Trials.** This paragraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this paragraph, your attending provider must certify that you have a life-threatening or disabling condition or disease as described in paragraph "4" above. In addition, you attending provider must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending provider must also recommend that you participate in the clinical trial. To make this recommendation, your attending provider must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- the National Institutes of Health (NIH), and NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- an entity that has identified by the NIH as a qualified non-governmental research entity; or
- an Institutional Review Board of a facility that has a multiple project assurance approved by

the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this paragraph and all of the requirements of paragraph "2", you may request an external appeal. Paragraph "7" below provides information on requesting an external appeal.

- 6. Effect of the External Appeal Agent's Decision; Coverage.** The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:
- for services denied as not medically necessary, we will treat the service as medically necessary and provide coverage subject to all other conditions of your coverage.
 - for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of your coverage.
 - for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under your Contract, Group Plan, or Certificate.

- 7. Requesting an External Appeal.** If you meet the conditions described in this notice, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your provider may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination. You or your provider may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a standard internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to \$50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.

- 8. Provisions Relating to the Internal Review Process.** This paragraph describes changes to the internal review process as provided in your Contract, Group Plan, or Certificate. If we have not

made and notified you of an adverse determination, as defined by law, within the specified time-frames, you may request an internal review without waiting for us to make the determination. Also, if you have requested an internal review of an adverse determination, and we have not made and notified you of our review decision within the specified time-frames, we are required to cover the service, subject to all other conditions of your coverages.

- 9. Other Provisions.** All of the terms, conditions and limitations of the Contract, Group Plan or Certificate to which this notice is attached also apply to this notice except where specifically changed by this notice.

III. Written Decision

When a decision is issued from an internal level of review, the following information will be included in the written decision:

1. a description of the health care services that were denied, including, the dates of service and the name of the provider;
2. the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include a clear statement describing the basis and the clinical rationale for such determination;
3. a clear statement that the notice constitutes the final adverse determination;
4. a contact name and telephone number you can contact with questions; and
5. a notice of the insured's right to an external appeal and the timeframes for requesting an appeal together with a copy of this notice and any forms necessary to submit a request for an external appeal.

IV. Contacts

A request for an external review should be sent certified or registered mail to:

New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209
1-800-400-8882

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Regular Employees Working Their Assigned Work Schedule

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 Procedures	\$0
Type 2 Procedures - Once per Lifetime	\$50
Type 3 Procedures - Each Benefit Period	\$50

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	\$1,000
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INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

- a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and
- b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

- a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or
- b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	\$13.96 per Insured Person
	\$12.24 One Dependent Only
	\$27.80 Two or More Dependents

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. Following approval by the New York Insurance Department, we may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to First Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 400 Rella Blvd, Suite 304, Suffern, New York 10908.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

DOMESTIC PARTNER means two unrelated individuals who can provide proof of economic interdependency upon each other. In the State of New York, the following proof is required to establish such interdependence:

1. Registration as a domestic partnership or signed affidavit, if such registration is not available;
2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
3. Evidence of two or more of the following:
 - a. a joint bank account;
 - b. a joint credit or charge card;
 - c. joint obligation on a loan;
 - d. status as authorized signatory on the partner's bank account, credit or charge card;
 - e. joint ownership of holding of investments;
 - f. joint ownership of residence;
 - g. joint ownership of real estate other than residence;
 - h. listing of both partners as tenants on the lease of the shared residence;
 - i. shared rental payments of residence (need not be shared 50/50);
 - j. listing of both partners as tenants on a lease; or shared rental payments, for property other than residence;
 - k. a common household and shared household expense, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
 - l. shared household budget for purposes of receiving government benefits;
 - m. status of one as representative payee for the other's government benefits;
 - n. joint ownership of major items of personal property (e.g., appliances, furniture);
 - o. joint ownership of a motor vehicle;
 - p. joint responsibility for child care (e.g., school documents, guardianship);
 - q. shared child care expenses, e.g., baby sitting, day care, school bills (need not be shared 50/50);
 - r. execution of wills naming each other as executor and/or beneficiary;
 - s. designation as beneficiary under the other's life insurance policy;
 - t. designation as beneficiary under the other's retirement benefits account
 - u. mutual grant of durable power of attorney;
 - v. mutual grant of authority to make health care decisions (e.g., health care power of attorney);
 - w. affidavit by creditor or other individual able to testify to partners' financial interdependence;
 - x. other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried child less than 19 years of age, for whom the Insured, the Insured's spouse or the Insured's Domestic Partner, is legally responsible and/or chiefly dependent upon for support and maintenance, to include:
 - 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.
 - iv. other children who are chiefly dependent upon the Insured, the Insured's spouse, or the Insured's Domestic Partner for support and maintenance.
- c. each unmarried child age 19 but less than 23 who is:
 - i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and
 - ii. primarily dependent on the Insured, the Insured's spouse or the Insured's Domestic Partner for support and maintenance.
- d. each unmarried child age 19 or older who:
 - i. is Totally Disabled as defined below; and
 - ii. becomes Totally Disabled while insured as a dependent under b. or c. 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 Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

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.

LATE ENTRANT refers to any person:

- a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or
- b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance 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 Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE 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 insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any regular employees working their assigned work schedule working at least 17.50 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are excluded from the Eligible Class for Insurance.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on 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.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth.

An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any regular employees working their assigned work schedule working at least 17.50 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are excluded from the Eligible Class for Dependent Insurance.

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

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, his or her spouse who had been considered a dependent but would be eligible to be a Member as explained above, will automatically be considered a Member with no waiting periods or limitations normally imposed on a late entrant.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next Annual Election Period. The first Annual Election Period will be in April 2003 and those who elect to participate in this program at that time will have their insurance become effective on May 1, 2003. Each Annual election Period thereafter will be in December for a January 1 effective date. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

A Member may change their election option only during an Annual Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required. This eligibility period will never be longer than twelve months.

If employment is the basis for membership in the Eligible Class for Members, an Insured 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 insurance.

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 insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, 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 insurance.
3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance 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 insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance 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."

EXTENSION OF BENEFITS. A 30-day extension of benefits will be provided for covered services if the course of treatment for such covered services began before the date of termination.

Any extension of benefits provided under the above provision will be considered in accordance with the policy provisions in effect at the time the individual's coverage terminates.

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

Injury or Sickness For Certain Dependents

Coverage will continue for a Dependent student (see Definition of Dependent on 9060) for a covered Dependent student who takes a leave of absence from school due to an injury or illness for a period of twelve months from the last day of attendance in school, provided, however, that nothing in this provision shall require coverage of a dependent student beyond the age at which coverage would otherwise terminate.

Termination of Employment or Membership Insureds and Dependents

1. Eligibility

Whenever any individual becomes ineligible for continued participation in this plan as a result of termination of employment or membership in the class or classes eligible for coverage under the policy, such employee or member shall be entitled without evidence of insurability upon application to continue benefits under this policy for himself or herself and his or her eligible dependents, subject to the group policy's terms and conditions and the conditions listed below.

This provision is not applicable where a continuation benefit is available to the employee or member pursuant to Chapter 18 of the Employment Retirement Income Security Act, 29 U.S.C. s 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. s300bb-1 et seq.

Continuation shall not be available for: (A) any person who is covered, becomes covered or could be covered under Title XVIII of the United States Social Security Act (Medicare) as amended or superseded; or (B) an employee, member or dependent by any other insured or uninsured arrangement which provides similar coverages for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent.

Please contact the person who handles the policyholders insurance matters to see if these provisions are available to you.

2. Extension Period

The extension period is:

- a. 18 months after the date the employee's or member's benefits under the policy would otherwise have terminated because of termination of employment or membership; or
- b. The end of the period for which premium payments were made, if the employee or member fails to make timely payment of a required premium payment; or
- c. In the case of an eligible dependent of an employee or member, the date thirty-six months after the date such person's benefits under the policy would otherwise have terminated by reason of:
 - i. the death of the employee or member;
 - ii. the divorce or legal separation of the employee or member from his or her spouse;
 - iii. the employee or member becoming entitled to benefits under Title XVIII of the United States Social Security Act (Medicare); or
 - iv. a dependent child ceasing to be a dependent child as defined under the terms of the policy; or
- d. 29 months in the case of an individual who is determined, under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date such individual becomes ineligible for continued participation in this plan; or
- e. The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this clause applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:
 - i. The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior

group policy in accordance with this paragraph had a termination described in this paragraph had not occurred, and

- ii. The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy, and
- iii. The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.

3. Requesting Coverage

An employer or member who wishes continuation of coverage must request such continuation in writing, along with the required first premium payment, to the policyholder or employer within the sixty day period following the later of:

- a. The date of such termination; or
- b. The date the employee is sent notice by first class mail of the right to continuation by either his employer or the group policyholder; or
- c. In the case of eligibility for continuation as a result of disability as defined under Title II or XVI of the Social Security Act (see 2.d. above), an employee or member must give notice to the employer or policyholder within sixty days of the days of the determination under these Acts.

4. Premiums

An employee or member electing continuation must pay the group policyholder or his employer, but not more than frequently than on a monthly basis in advance, the amount of the required premium payment, which will not exceed 102% of the group rate for the benefits being continued under the group policy on the due date of each payment.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other 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 Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, 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 Insured 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 an Insured.

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 limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Allowable Charge ("MAC") as determined by us.
3. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

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 x-ray films, 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. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. in the first 12 months that a person is insured for an initial placement of any prosthetic crown, appliance, or fixed partial denture if such placement is needed because of the extraction of one or more teeth that were extracted prior to the effective date of coverage for that person. If the extraction(s) occurred while the insured person is covered under this contract, then this limitation does not apply. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance or fixed partial denture must include the replacement of the extracted tooth or teeth.
3. 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.

unless such appliance, restoration or procedure is considered medically necessary.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes except that treatment for cosmetic purposes shall not include any services incidental to or following surgery resulting from trauma, infection or other diseases of the involved part, and treatment necessary due to congenital disease or anomaly.
7. 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.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

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.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Ø 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 insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Ø 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).
- Ø 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.
- Ø B/R means By Report.
- Ø X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- Ø 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 - Maximum Allowable Charge

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, 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.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

D1120 Prophylaxis - child.

D1203 Topical application of fluoride (prophylaxis not included) - child.

D1204 Topical application of fluoride (prophylaxis not included) - adult.

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- 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.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.

TYPE 1 PROCEDURES

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Covered Expense

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

	Maximum Covered
LIMITED ORAL EVALUATION	Expense
D0140 Limited oral evaluation - problem focused.	\$23.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$23.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none">Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$46.00
D0330 Panoramic film.	\$37.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none">Coverage is limited to 1 of any of these procedures per 3 year(s).	
OTHER XRAYs	
D0220 Intraoral - periapical first film.	\$8.00
D0230 Intraoral - periapical each additional film.	\$7.00
D0240 Intraoral - occlusal film.	\$12.00
D0250 Extraoral - first film.	\$15.00
D0260 Extraoral - each additional film.	\$12.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none">The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
BITEWING FILMS	
D0270 Bitewing - single film.	\$7.00
D0272 Bitewings - two films.	\$13.00
D0273 Bitewings - three films.	\$16.00
D0274 Bitewings - four films.	\$20.00
D0277 Vertical bitewings - 7 to 8 films.	\$31.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none">Coverage is limited to 2 of any of these procedures per 1 benefit period.D0277, also contribute(s) to this limitation.The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none">Coverage is limited to 1 of any of these procedures per 3 year(s).The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$27.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$54.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$54.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none">Coverage is limited to 1 of any of these procedures per 12 month(s).Coverage is limited to 1 examination per biopsy/excision.	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$39.00
D2150 Amalgam - two surfaces, primary or permanent.	\$49.00
D2160 Amalgam - three surfaces, primary or permanent.	\$60.00

TYPE 2 PROCEDURES

Maximum Covered

Expense
\$72.00

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior. \$47.00

D2331 Resin-based composite - two surfaces, anterior. \$60.00

D2332 Resin-based composite - three surfaces, anterior. \$75.00

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior). \$83.00

D2391 Resin-based composite - one surface, posterior. \$52.00

D2392 Resin-based composite - two surfaces, posterior. \$66.00

D2393 Resin-based composite - three surfaces, posterior. \$83.00

D2394 Resin-based composite - four or more surfaces, posterior. \$91.00

D2410 Gold foil - one surface. \$39.00

D2420 Gold foil - two surfaces. \$49.00

D2430 Gold foil - three surfaces. \$60.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior. \$101.00

D2930 Prefabricated stainless steel crown - primary tooth. \$85.00

D2931 Prefabricated stainless steel crown - permanent tooth. \$90.00

D2932 Prefabricated resin crown. \$101.00

D2933 Prefabricated stainless steel crown with resin window. \$101.00

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth. \$101.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration. \$31.00

D2915 Recement cast or prefabricated post and core. \$16.00

D2920 Recement crown. \$31.00

D6092 Recement implant/abutment supported crown. \$31.00

D6093 Recement implant/abutment supported fixed partial denture. \$31.00

D6930 Recement fixed partial denture. \$42.00

SEDATIVE FILLING

D2940 Sedative filling. \$29.00

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis. \$48.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance. \$49.00

PERIODONTAL MAINTENANCE: D4910

TYPE 2 PROCEDURES

Maximum Covered

Expense

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$49.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$41.00
D5610	Repair resin denture base.	\$49.00
D5620	Repair cast framework.	\$58.00
D5630	Repair or replace broken clasp.	\$60.00
D5640	Replace broken teeth - per tooth.	\$44.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$91.00
D5731	Reline complete mandibular denture (chairside).	\$90.00
D5740	Reline maxillary partial denture (chairside).	\$81.00
D5741	Reline mandibular partial denture (chairside).	\$82.00
D5750	Reline complete maxillary denture (laboratory).	\$135.00
D5751	Reline complete mandibular denture (laboratory).	\$133.00
D5760	Reline maxillary partial denture (laboratory).	\$135.00
D5761	Reline mandibular partial denture (laboratory).	\$136.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$44.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$44.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$84.00
D7220	Removal of impacted tooth - soft tissue.	\$105.00
D7230	Removal of impacted tooth - partially bony.	\$139.00
D7240	Removal of impacted tooth - completely bony.	\$163.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	\$185.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	\$87.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$205.00
D7261	Primary closure of a sinus perforation.	\$205.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$124.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$124.00
D7280	Surgical access of an unerupted tooth.	\$192.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$138.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$58.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$72.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$36.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$92.00

TYPE 2 PROCEDURES

Maximum Covered

		Expense
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$46.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$133.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$330.00
D7410	Excision of benign lesion up to 1.25 cm.	\$131.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$168.00
D7412	Excision of benign lesion, complicated.	\$185.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$177.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$130.00
D7415	Excision of malignant lesion, complicated.	\$143.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$177.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$130.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$131.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$168.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$131.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$168.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$40.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$117.00
D7472	Removal of torus palatinus.	\$117.00
D7473	Removal of torus mandibularis.	\$117.00
D7485	Surgical reduction of osseous tuberosity.	\$190.00
D7490	Radical resection of maxilla or mandible.	\$177.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$59.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$68.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$54.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$148.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$148.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$195.00
D7910	Suture of recent small wounds up to 5 cm.	\$26.00
D7911	Complicated suture - up to 5 cm.	\$29.00
D7912	Complicated suture - greater than 5 cm.	\$42.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	\$141.00
D7963	Frenuloplasty.	\$176.00
D7970	Excision of hyperplastic tissue - per arch.	\$109.00
D7972	Surgical reduction of fibrous tuberosity.	\$173.00
D7980	Sialolithotomy.	\$163.00
D7983	Closure of salivary fistula.	\$52.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$176.00
D7286	Biopsy of oral tissue - soft.	\$95.00
D7287	Exfoliative cytological sample collection.	\$47.00
D7288	Brush biopsy - transepithelial sample collection.	\$47.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$33.00
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PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

TYPE 2 PROCEDURES

Maximum Covered

Expense

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	\$125.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	\$41.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	\$83.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$20.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$33.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$23.00
D9440	Office visit - after regularly scheduled hours.	\$40.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$25.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

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 ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$31.00
D9952	Occlusal adjustment - complete.	\$157.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	\$27.00
D2951	Pin retention - per tooth, in addition to restoration.	\$15.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$47.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Covered Expense

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

	Maximum Covered
INLAY RESTORATIONS	Expense
D2510 Inlay - metallic - one surface.	\$159.00
D2520 Inlay - metallic - two surfaces.	\$190.00
D2530 Inlay - metallic - three or more surfaces.	\$204.00
D2610 Inlay - porcelain/ceramic - one surface.	\$176.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$191.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$209.00
D2650 Inlay - resin-based composite - one surface.	\$182.00
D2651 Inlay - resin-based composite - two surfaces.	\$180.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$186.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none">Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.	
ONLAY RESTORATIONS	
D2542 Onlay - metallic - two surfaces.	\$207.00
D2543 Onlay - metallic - three surfaces.	\$231.00
D2544 Onlay - metallic - four or more surfaces.	\$240.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$207.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$231.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$238.00
D2662 Onlay - resin-based composite - two surfaces.	\$194.00
D2663 Onlay - resin-based composite - three surfaces.	\$200.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$212.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none">Replacement is limited to 1 of any of these procedures per 5 year(s).D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.Frequency is waived for accidental injury.Porcelain and resin benefits are considered for anterior and bicuspid teeth only.Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$90.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$224.00
D2720 Crown - resin with high noble metal.	\$231.00
D2721 Crown - resin with predominantly base metal.	\$176.00
D2722 Crown - resin with noble metal.	\$216.00
D2740 Crown - porcelain/ceramic substrate.	\$249.00
D2750 Crown - porcelain fused to high noble metal.	\$242.00
D2751 Crown - porcelain fused to predominantly base metal.	\$207.00
D2752 Crown - porcelain fused to noble metal.	\$222.00
D2780 Crown - 3/4 cast high noble metal.	\$230.00
D2781 Crown - 3/4 cast predominantly base metal.	\$200.00
D2782 Crown - 3/4 cast noble metal.	\$209.00

TYPE 3 PROCEDURES

Maximum Covered

	Expense
D2783 Crown - 3/4 porcelain/ceramic.	\$249.00
D2790 Crown - full cast high noble metal.	\$230.00
D2791 Crown - full cast predominantly base metal.	\$200.00
D2792 Crown - full cast noble metal.	\$209.00
D2794 Crown - titanium.	\$230.00

CROWN: D2710, D2712, D2720, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins.	\$50.00
D6973 Core build up for retainer, including any pins.	\$50.00

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.	\$80.00
D2954 Prefabricated post and core in addition to crown.	\$66.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.	\$40.00
D6980 Fixed partial denture repair, by report.	\$45.00
D9120 Fixed partial denture sectioning.	\$45.00

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$32.00
D3221 Pulpal debridement, primary and permanent teeth.	\$32.00
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$42.00
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$37.00
D3333 Internal root repair of perforation defects.	\$52.00
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$52.00
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$35.00
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$103.00
D3430 Retrograde filling - per root.	\$41.00
D3450 Root amputation - per root.	\$97.00
D3920 Hemisection (including any root removal), not including root canal therapy.	\$82.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Anterior (excluding final restoration).	\$145.00
D3320 Bicuspid (excluding final restoration).	\$170.00

TYPE 3 PROCEDURES

Maximum Covered

	Expense
D3330 Molar (excluding final restoration).	\$223.00
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$85.00
D3346 Retreatment of previous root canal therapy - anterior.	\$180.00
D3347 Retreatment of previous root canal therapy - bicuspid.	\$207.00
D3348 Retreatment of previous root canal therapy - molar.	\$257.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.	\$149.00
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).	\$172.00
D3425 Apicoectomy/periradicular surgery - molar (first root).	\$186.00
D3426 Apicoectomy/periradicular surgery (each additional root).	\$66.00

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$94.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$47.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$129.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$65.00
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$237.00
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$119.00
D4263 Bone replacement graft - first site in quadrant.	\$77.00
D4264 Bone replacement graft - each additional site in quadrant.	\$58.00
D4265 Biologic materials to aid in soft and osseous tissue regeneration.	\$39.00
D4270 Pedicle soft tissue graft procedure.	\$175.00
D4271 Free soft tissue graft procedure (including donor site surgery).	\$185.00
D4273 Subepithelial connective tissue graft procedures, per tooth.	\$216.00
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$104.00
D4275 Soft tissue allograft.	\$185.00
D4276 Combined connective tissue and double pedicle graft, per tooth.	\$216.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

Maximum Covered

	Expense
CROWN LENGTHENING	
D4249 Clinical crown lengthening - hard tissue.	\$143.00

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.	\$48.00
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.	\$24.00
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$36.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.	\$257.00
D5120 Complete denture - mandibular.	\$250.00
D5130 Immediate denture - maxillary.	\$279.00
D5140 Immediate denture - mandibular.	\$270.00
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$185.00
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$214.00
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$298.00
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$298.00
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$185.00
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$214.00
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$160.00
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).	\$185.00
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).	\$214.00
D5810 Interim complete denture (maxillary).	\$114.00
D5811 Interim complete denture (mandibular).	\$120.00
D5820 Interim partial denture (maxillary).	\$100.00
D5821 Interim partial denture (mandibular).	\$105.00
D5860 Overdenture - complete, by report.	\$257.00
D5861 Overdenture - partial, by report.	\$298.00
D6053 Implant/abutment supported removable denture for completely edentulous arch.	\$257.00
D6054 Implant/abutment supported removable denture for partially edentulous arch.	\$298.00
D6078 Implant/abutment supported fixed denture for completely edentulous arch.	\$257.00
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$298.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

TYPE 3 PROCEDURES

Maximum Covered

	Expense
D5410 Adjust complete denture - maxillary.	\$14.00
D5411 Adjust complete denture - mandibular.	\$14.00
D5421 Adjust partial denture - maxillary.	\$15.00
D5422 Adjust partial denture - mandibular.	\$14.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422	
• Coverage is limited to dates of service more than 6 months after placement date.	
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$33.00
D5660 Add clasp to existing partial denture.	\$39.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$94.00
D5711 Rebase complete mandibular denture.	\$99.00
D5720 Rebase maxillary partial denture.	\$89.00
D5721 Rebase mandibular partial denture.	\$95.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$26.00
D5851 Tissue conditioning, mandibular.	\$28.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$215.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$234.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$234.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$215.00
D6062 Abutment supported cast metal crown (high noble metal).	\$234.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$234.00
D6064 Abutment supported cast metal crown (noble metal).	\$254.00
D6065 Implant supported porcelain/ceramic crown.	\$215.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$234.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$234.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$215.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$234.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$234.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$215.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$234.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$234.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$254.00
D6075 Implant supported retainer for ceramic FPD.	\$215.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$234.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$234.00
D6094 Abutment supported crown - (titanium).	\$234.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$234.00
D6205 Pontic - indirect resin based composite.	\$193.00
D6210 Pontic - cast high noble metal.	\$234.00
D6211 Pontic - cast predominantly base metal.	\$234.00
D6212 Pontic - cast noble metal.	\$254.00
D6214 Pontic - titanium.	\$234.00

TYPE 3 PROCEDURES

Maximum Covered

	Expense	
D6240	Pontic - porcelain fused to high noble metal.	\$234.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$234.00
D6242	Pontic - porcelain fused to noble metal.	\$215.00
D6245	Pontic - porcelain/ceramic.	\$215.00
D6250	Pontic - resin with high noble metal.	\$234.00
D6251	Pontic - resin with predominantly base metal.	\$215.00
D6252	Pontic - resin with noble metal.	\$254.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$78.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$78.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$191.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$210.00
D6602	Inlay - cast high noble metal, two surfaces.	\$172.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$189.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$148.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$163.00
D6606	Inlay - cast noble metal, two surfaces.	\$156.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$172.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$207.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$227.00
D6610	Onlay - cast high noble metal, two surfaces.	\$189.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$208.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$163.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$180.00
D6614	Onlay - cast noble metal, two surfaces.	\$172.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$189.00
D6624	Inlay - titanium.	\$189.00
D6634	Onlay - titanium.	\$208.00
D6710	Crown - indirect resin based composite.	\$193.00
D6720	Crown - resin with high noble metal.	\$234.00
D6721	Crown - resin with predominantly base metal.	\$122.00
D6722	Crown - resin with noble metal.	\$195.00
D6740	Crown - porcelain/ceramic.	\$215.00
D6750	Crown - porcelain fused to high noble metal.	\$254.00
D6751	Crown - porcelain fused to predominantly base metal.	\$234.00
D6752	Crown - porcelain fused to noble metal.	\$215.00
D6780	Crown - 3/4 cast high noble metal.	\$254.00
D6781	Crown - 3/4 cast predominantly base metal.	\$234.00
D6782	Crown - 3/4 cast noble metal.	\$215.00
D6783	Crown - 3/4 porcelain/ceramic.	\$215.00
D6790	Crown - full cast high noble metal.	\$234.00
D6791	Crown - full cast predominantly base metal.	\$234.00
D6792	Crown - full cast noble metal.	\$215.00
D6794	Crown - titanium.	\$234.00
D6940	Stress breaker.	\$65.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

Maximum Covered

Expense

- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$70.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	\$70.00

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverages under more than one Plan. "Plan" is defined below. All benefits provided under this policy 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 Expenses.

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 that have been submitted in the current Claim Determination Period.

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

1. "Plan" means the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental treatment:
 - a. Any group insurance and group remittance subscriber contracts.
 - b. Uninsured arrangements of group coverage.
 - c. Group coverage through HMO's and other prepayment, group practice and individual practice plans.
 - d. Blanket coverages except as stated in paragraph (2b) below.
 - e. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.
 - f. 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, direct payment subscriber contracts, coverage through HMO's or other prepayment arrangements, group practice and individual practice plans.
 - b. Blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.
3. "Allowable Expense" means 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 Insured person for whom 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 claim been made for them.
4. "Claim Determination Period" is the Benefit Period, over which allowable expenses are compared with total benefits payable in the absence of Coordination of Benefits, to determine:

- a. whether over insurance exists; and
- b. how much each plan will pay or provide.

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 which covers a person as an employee, member or subscriber are determined before those of a Plan which covers the person as a dependent.
 - b. When a Plan and another Plan cover the same child as a dependent of different persons, called parents, the benefits of the Plan of the parent whose birthday (month and day in a calendar year) falls earlier in a year are determined before those of a plan of the parent whose birthday falls later in that year. 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:
 - the Plan of the parent with custody of the child;
 - the Plan of the spouse of the parent with custody of the child;
 - the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree establish a parent's responsibility for the child's dental treatment 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 which covers 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 which 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. 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 policy; 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 which 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 Policyholder's name, Insured's name, and policy 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 Insured unless you authorize us in writing to make payment to the Provider providing the services or supplies.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, 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 Insured 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 Insured 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 Insured 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 Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

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

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

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

- i. necessary to calculate premiums;
- ii. necessary to determine a person's effective date or termination date of insurance;
- iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

- a. a certain percentage of all Members qualified for insurance must be insured at all times; and
- b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	91

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.
2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

**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. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:
First Ameritas Life Insurance Corp.
P.O. Box 82595
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it. We will provide you written notice regarding the payment under the claim within at least 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 Policy 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.

REVIEW PROCEDURE

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the 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 request for review. 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 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. Within at least 60 days after we receive your request for review we will send you a written decision on review.

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 Policy 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 judgement 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 contact your state insurance 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 claim review should be sent to:

Quality Control, P.O. Box 82629, Lincoln, NE 68501-2629.

Application is Hereby Made to

FIRST AMERITAS LIFE INSURANCE CORP.

by: HAMILTON COLLEGE

whose main office address is: 198 COLLEGE HILL RD
CLINTON, NY 13323-1218

for Group Policy No. 26-201361

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

HAMILTON COLLEGE

(Full or Corporate Name of Applicant)

Dated at _____ By _____
(Signature and Title)

On _____, 20__ Witness _____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

