A STOCK COMPANY
SUFFERN, NEW YORK

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **HAMILTON COLLEGE**

Policy Number	**26-201361**	**Insured Person**
Plan Effective Date	**May 1, 2003**	**Certificate Effective Date** **Refer to Exceptions on 9070.**
		Plan Change Effective Date **January 1, 2008**
		Class Number 1

First Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

Phyllis Carsten-Boyle

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 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

TABLE OF CONTENTS

Name of Provision	Page Number
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Increased Maximum Benefit	9042
Definitions	
Late Entrant, Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Elimination Period	
Contribution Requirement	
Effective Date	
Termination Date	
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods, Missing Tooth Clause, Cosmetic Clause, Late Entrant	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
ERISA Information and Notice of Your Rights	ERISA Notice

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.

Benefit Class	Class Description
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

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.

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 fo 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 circusmstances 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 Expense
LIMITED ORAL EVALUATION		
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
- 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
- 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
- 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
- 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
- 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
- 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

Code	Procedure	Maximum Covered Expense
D2161	Amalgam - four or more surfaces, primary or permanent.	$72.00

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)

Code	Procedure	Maximum Covered Expense
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)

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
D2940	Sedative filling.	$29.00

FULL MOUTH DEBRIDEMENT

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
D7111	Extraction, coronal remnants - deciduous tooth.	$44.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$44.00

SURGICAL EXTRACTIONS

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$33.00

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

INLAY RESTORATIONS		Maximum Covered 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

- 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

- 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

Code	Procedure	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

Code	Procedure	Maximum Covered Expense
D2950	Core buildup, including any pins.	$50.00
D6973	Core build up for retainer, including any pins.	$50.00

POST AND CORE

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	Maximum Covered Expense
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	Apexication/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)

Code	Procedure	Maximum Covered Expense
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

Code	Procedure	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.

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.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. Eligibility and Benefits Provided Under the Group Policy

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

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

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

C. Termination Of The Group Policy

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

After the first policy year, First Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

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

D. Claims For Benefits

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

E. Continuation of Coverage Provisions (COBRA)

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

i. Definitions For This Section

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

A Qualifying Event occurs when:

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

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

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

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

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

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

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

ii. Electing COBRA Continuation

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

1. The date on which Insurance would otherwise end; and

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

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

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

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

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

iii. Notice Requirements

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

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

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

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security

Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

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

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

a. The date of the Qualifying Event; or

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

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

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

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

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

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

4. COBRA Continuation For Certain Bankruptcy Proceedings

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

v. Premium Requirements

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

F. Your Rights under ERISA

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and

collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

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

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

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights
If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

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

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

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

We are required by law to maintain the privacy of our insured members' and their dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be provided to you directly or to your group's Plan Sponsor (usually your employer) by regular mail or e-mail with instructions to deliver a paper copy to each certificate holder.

THIS NOTICE DESCRIBES OUR PRACTICES REGARDING YOUR PROTECTED HEALTH INFORMATION MAINTAINED BY THE GROUP DENTAL LINE OF BUSINESS WITHIN THE UNIFI COMPANIES.

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

Contact Information

All of the entities affiliated under the common control of the UNIFI Mutual Holding Company that pay for the cost of healthcare, including Ameritas Life Insurance Corp. and First Ameritas Life Insurance Corp. of New York, are required by federal law to maintain the privacy of your protected health information and to provide notice of the legal duties and privacy practices with respect to your protected health information. This Notice fulfills the "Notice" requirements of the Final Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about any part of this Notice of Protected Health Information Privacy Practices or desire to have further information concerning the information practices at the UNIFI Companies, please direct your inquiries to: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

THIS NOTICE IS PUBLISHED AND BECOMES EFFECTIVE: APRIL 14, 2003

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that information about you and your family is personal and we are committed to protecting your privacy and the security of your protected health information. This Notice explains the ways in which we use and disclose protected health information about you and your covered dependents and details certain obligations we have in connection with such use and disclosure. It also describes your rights with regard to your protected health information. **We are required by both law and internal policy to: make sure that protected health information that identifies you and/or your covered dependents is kept private; give you notice of our legal duties and privacy practices and your rights with respect to your protected health information; and follow the practices outlined in this Notice.**

WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE

The Protected Health Information Privacy Practices described in this Notice have been adopted and implemented by all of the divisions and associates who work directly or indirectly with your protected health information within the following UNIFI Companies: Ameritas Life Insurance Corp.; and First Ameritas Life Insurance Corp. of New York. All of the associates who need access to your protected health information in order to service your products and administer your claims have received proper training about how to protect your privacy, secure your protected health information and adhere to our Privacy of Protected Health Information Policies, Practices and Procedures.

In order to keep costs of your coverage down and provide you with the best customer service, we may contract with outside carriers and/or vendors, known as "business associates," to assist us with the administration of your policy. For example, we may contract with third party administrators who process claims and collect premium payments; or paper-shredding companies who destroy records when they are no longer needed. Because these business associates need access to your protected health information in order to fulfill their obligations to us, we **require** them to agree in writing to keep **your protected health information confidential** in the same manner that we do as described in this Notice.

TYPES OF PROTECTED HEALTH INFORMATION WE MAY HAVE AND HOW WE OBTAIN IT

Protected Health Information is: Any information that identifies you that we obtain from you or others that relates to your past, present or future healthcare including the payment for such healthcare.

In the regular course of business we receive protected health information about you in order to provide you with our products and services. Some of this protected health information comes directly from you. For example, when you purchase one of our health insurance products for you and your family, you provide us with information about you and your covered dependents such as name, address, phone number, social security number, etc. Some of the protected health information we obtain about you comes from your provider. For example, as you and your covered dependents utilize your coverage, your healthcare provider sends us information about services and treatments performed so that we can process and pay your claims. All of this information we receive about you and your covered dependents is necessary in order for us to provide you and your covered dependents with quality health insurance products and to comply with legal requirements.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways we may use and disclose your protected health information without your authorization. For each category of uses and disclosures, we will explain what we mean and give an example. Not every use or disclosure in a category will be listed. All of the ways we are permitted to use and disclose information will fall within one of the identified categories.

For Payment: We may use and disclose protected health information about you and your covered dependents in order to verify your coverage to your provider, process payment for claims filed under your policy or coordinate benefits with another carrier. For example, we may need to disclose your protected health information to a provider whom you have seen or are planning to see in order to pre-approve that a particular treatment you are seeking is covered under your plan. It is also necessary for us to use the information received from your medical provider concerning the services rendered to you so the health plan can pay the provider or reimburse you for the cost of the treatment under the terms of your plan. Finally, when you have more than one insurance policy that covers some of the same procedures as your plan with us, it may be necessary for us to exchange payment information with the carrier of your other insurance plan in order to coordinate the payment of your claim with that other carrier.

For Health Care Operations: We may use and disclose protected health information about you and your covered dependents as necessary to operate your health insurance plan and promote quality service. For example, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management.

<u>Business Associates:</u> **We may disclose protected health information to other persons or organizations, known as business associates, who provide services on our behalf under contract.** However, in order to assure the protection of your private information, we require our business associates to adhere to our Privacy Policies concerning the use and disclosure of your protected health information and appropriately safeguard the information we disclose to them. We prohibit our business associates from using and disclosing any of your protected health information in any manner except for the purpose intended by the contract. Business associates are expressly prohibited from using your protected health information to create any marketing target lists.

Plan Sponsors: **We may disclose your protected health information to your plan sponsor (usually your employer).** It is our policy not to disclose your protected health information to your Plan's sponsor. There may by exceptional occasions that your Plan Sponsor requests protected health information. We will only disclose your protected health information to your Plan Sponsor if we have your authorization to do so, or if the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Public policy uses and disclosures of your protected health information

We may use and disclose your protected health information for public policy purposes. For example:

As Required By Law: **We will disclose protected health information about you or your covered dependent when required to do so by federal, state or local law.** For example, we may be required by law to disclose certain protected health information about you pursuant to a court order or subpoena served upon us.

About Victims of Abuse, Neglect or Domestic Violence: For example, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

Workers' Compensation: We may release your protected health information for workers' compensation or similar programs that provide benefits to you for work-related injuries or illness but only in a manner consistent with applicable laws.

Public Health: **We may have an occasion to disclose protected health information about you or your covered dependent for public health activities to a public health authority that is permitted by law to collect or receive the information.** A public health activity would be, for example, an activity conducted by a public health authority in the furtherance of preventing or controlling disease, injury or disability; reporting births, deaths or reactions to medications; or notifying people of recalls of products they may be using.

AUTHORIZED USES AND DISCLOSURES

From time to time you may request that we disclose your protected health information to other individuals or entities. For example, you may request that we disclose your claims history to an attorney that you have hired to assist you in a civil matter. **Likewise, we may ask your permission to use or disclose your protected health information.** Any disclosures, such as these that do not fit into one of the categories in the previous section require us to obtain your written authorization prior to making such disclosure. In the event that you do provide us with written authorization to use or disclose your information, you may revoke such authorization at any time by writing to the Privacy Officer at the address indicated in the "Contact" section of this Notice below.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that we maintain about you. All requests must be made in writing.

Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You have a right to receive this Notice because you are insured by a health plan offered by Ameritas Life Insurance Corp. or First Ameritas Life Insurance Corp. of New York. You may ask us to give you a copy of this Notice at any time and we will comply. Even if you have agreed to receive this Notice electronically, you are entitled to a paper copy of this Notice if you so request.

Your Right to an Accounting of Disclosures: You have the right to request a listing of any disclosures of your protected health information that we have made that are required by law. This listing would exclude disclosures we made to you, or pursuant to your authorization or request, or for payment of your claims as described above, or for health care operations as described above. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically, fax etc.). The first accounting of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists during that same 12-month period. In the event that you may incur a charge, we will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Your Right to Request an Amendment: You have the right to request an amendment to the protected health information that we maintain about you if you believe that our information is incorrect or incomplete. You maintain the right to request an amendment for as long as the information is kept by or for the UNIFI Companies. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: 1) was not created by us; 2) is not part of the medical information kept by or for a UNIFI Company; 3) is not part of the information which you would be permitted to inspect and copy under the law; or 4) is accurate and complete.

Your Right to Request a Restriction: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for, payment or health plan operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for care, like a family member or friend. We are not required to agree to your request. If we do agree to a requested restriction, we will comply with your request unless the information is needed to facilitate emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about payment for your medical matters in an alternative means (such as by fax) or at an alternative location (such as to your office). To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Your Rights to Inspect and Copy: You have the right to inspect and copy protected health information that we maintain about you that may be used to make decisions about payment for your care. To inspect this protected health information you may contact the Privacy Officer. To obtain copies of such protected health information, you must submit your request in writing as indicated below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your protected health information, in most situations you may request that the denial be reviewed by a licensed health care professional who did not take part in the decision to deny access. We will comply with the outcome of the review.

Your Right to Make Complaints: If you believe that your privacy rights have been violated you may make a complaint to the UNIFI Companies Privacy Office or to the Secretary of Health and Human Resources as follows:

UNIFI Privacy Office
Attn. HIPAA Privacy
P.O. Box 81889
Lincoln, NE 68510

Secretary, Health and Human Services, Office of Civil Rights
United States Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington D.C. 20201

Any complaint you file will not cause you to suffer retaliation from our company. We will promptly investigate your complaint as soon as we receive it. When we have completed our investigation, we will notify you of our findings. If the investigation reveals that your privacy rights have indeed been violated, we will immediately take the appropriate measures to correct the violation pursuant to our Privacy Practices and Procedures.

Individual Rights Contact

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form.

Effective Date

This Notice will become effective as of April 14, 2003.