Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE CERTIFICATE

The Policyholder **NORTH RANCH BENEFITS TRUST**

Policy Number **10-350785-1**

Employer Unit **NORTH RANCH BENEFITS TRUST**

Insured Person

Certificate Effective Date
Refer to Exceptions on 9070.

Class 2

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 laws of the state in which the group policy was delivered govern the group policy and this certificate.

Corporate Secretary

President

CALIFORNIA - IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, please contact your agent or feel free to contact us at the following:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1-877-897-4328 (Toll-Free)

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

CALIFORNIA
CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA)

NOTICE: These provisions are only applicable to certain plans as defined under the Act. Not all employers or groups are subject to this law. For further details to determine if this continuation coverage is available, please contact the person who handles the Policyholder's insurance matters.

The California Continuation Benefits Replacement Act (Cal-COBRA) signed into law effective January 1, 1998 requires that any **employer** meeting the definition under the Act allow a **qualified beneficiary** to continue group health coverage, including dental and vision care coverages after it would otherwise end, as a result of a **qualifying event**. Continuation coverage will be provided under the plan with the same terms and conditions that apply to similarly situated individuals.

A. DEFINITIONS

EMPLOYER means any employer that:

1. meets the definition of "small employer" as set forth in California;

2. employed 2-19 eligible employees on at least 50 percent of its working days during the preceding calendar year or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter; and

3. is not subject to Section 4980B of the United States Internal Revenue Code (Federal COBRA) or Chapter 18 of the Employee Retirement Income Security Act.

QUALIFIED BENEFICIARY means any individual who, on the day before the qualifying event, is an insured under a group benefit plan. An individual will not be considered to be a qualified beneficiary if:

1. The individual is entitled or becomes entitled to Medicare benefits. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

2. The individual is covered or becomes covered under another group benefit plan which does not impose any exclusion or limitation with respect to any preexisting condition.

3. The individual is covered, becomes covered or is eligible to coverage under Federal COBRA, Chapter 18 of the Employee Retirement Income Security Act, or Chapter 6A of the Public Health Service Act.

4. The qualified beneficiary fails to meet the notification requirements as stated within the Enrollment provision below.

5. The qualified beneficiary fails to submit the correct premium amount for continuation of coverage, or fails to satisfy other terms and conditions of the plan contract.

QUALIFYING EVENT means any of the following events that, but for the election of continuation of coverage under this provision, would result in a loss of coverage for the qualified beneficiary under the group benefit plan.

1. The death of the covered employee.

2. The termination of employment or reduction of hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying

event.

3. The divorce or legal separation of the covered employee from the covered employee's spouse.

4. The loss of dependent status by a dependent enrolled in the group benefit plan.

5. With respect to a covered dependent only, the covered employee's entitlement of benefits under Medicare (Title XVIII of the United States Social Security Act).

B. ENROLLMENT

NOTICE REQUIREMENTS. The qualified beneficiary must request the continuation of coverage in writing and deliver such notice, by first-class mail, or other reliable means of delivery, to the health services plan (or to the employer if the employer has contracted with the insurer to perform the administrative services under Cal-COBRA) within the 60-day period following the later of:

1. the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event;

2. the date the enrollee was sent notice of the ability to continue coverage.

PREMIUM PAYMENTS. The first premium payment must be delivered by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail, or private courier company to the health services plan (or the employer if the employer has contracted with the plan to perform the administrative services under Cal-COBRA) in accordance with the following terms and conditions:

1. the first premium must be delivered within 45 days of the date of the qualified beneficiary provided written notice to the health services plan; and

2. the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due.

Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage.

MONTHLY COST. The premium will be due monthly and will not be more than 110% of the applicable rate charged for a similarly situated individual under the group benefit plan.

C. CONTINUATION PERIOD

Continuation coverage shall terminate for those qualified beneficiaries at the first to occur of the following:

1. For those who are eligible for continuation coverage as a result of a termination of employment or reduction in work hours, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

2. For those who are eligible for continuation coverage as a result of: (a) the death of an employee, (b) a loss of dependent status, (c) divorce or legal separation, or (d) the employee's eligibility for Medicare (for dependent coverage), the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have

terminated by reason of a qualifying event.

3. For those qualified beneficiaries who are eligible for continuation coverage and are determined to be disabled by the Social Security Administration at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event. The qualified beneficiary must notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage based on this criteria.

4. For those who fail to make premium payments, at the end of the period for which premium payments were made.

5. In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage as a result of termination of employment or reduction of hours, as defined within paragraph (2) of "Qualifying Event", but who has another qualifying event as described in paragraphs (1), (3), (4) or (5) of "Qualifying Event", within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide the administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

6. The employer, or any successor employer ceases to provide any group benefit plan to his or her employees. See Additional Provisions below.

7. The qualified beneficiary moves out of the insurer's service area or the qualified beneficiary commits fraud or deception in the use of the insurer's services.

An individual who becomes a qualified beneficiary shall continue to receive coverage until continuation coverage is terminated at the qualified beneficiary's election or the period of time provided for continuation coverage as defined in Section C. Continuation Period, whichever comes first, even if the employer that sponsored the group benefit plan subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

D. ADDITIONAL PROVISIONS

CHANGE IN GROUP BENEFIT PLANS. If the continuation coverage would terminate prior to the end of the period the qualified beneficiary would have remained covered as a result of a termination of an agreement between the group benefit plan and the employer, and a new group benefit plan is available for active employees, then the qualified beneficiary may continue coverage based on the following terms and conditions:

1. the coverage will continue for the balance of the period that the qualified beneficiary would have remained covered under the prior plan;

2. notice must be provided to the new group benefit plan within 30 days after receiving notice of the termination of the prior plan;

3. any requirements for enrollment in, and payment to, the new group benefit plan must be met.

Coverage will terminate if the qualified beneficiary fails to comply with (2) or (3) above.

NEWBORN OR ADOPTED CHILDREN. Any child who is born to or is placed for adoption with a former employee who is a qualified beneficiary during the period of continuation coverage, shall be considered a qualified beneficiary and entitled to receive coverage benefits as well for the remainder of the period that the former employee is covered under the plan. Notice must be provided within 30 days of the child's birth or placement of adoption.

For purposes of this section:

"COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and as amended.

"Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

Thank you for choosing Ameritas Group for your dental care coverage. As a member, you always have complete freedom of choice in choosing your dental provider; however, by choosing a PPO network provider, you may reduce your out-of-pocket expenses due to the discounted fees on covered dental procedures.

Please read the following information so you will know from whom or what group of providers dental care may be obtained.

For the most current and complete provider listing and information, please visit the ***Plan Member*** section of our website, **www.ameritasgroup.com** and click on the ***Find a Provider*** tab. Additional information available online includes driving directions to the provider's office and how to nominate a dentist or specialist for our network.

If you do not have access to the Internet and are in need of dental participating provider information, contact our provider relations department at 1-800-755-8844.

For questions regarding your dental benefit coverage, contact our customer relations department at 1-800-487-5553 Monday-Thursday, 7:00am - midnight and Friday, 7:00am - 6:30 pm Central Time.

When scheduling your appointment, please verify the provider is an active network participant.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم **877-233-3797**. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ **877-233-3797** համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 **877-233-3797** 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis **877-233-3797**. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または **877-233-3797** までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ **877-233-3797** ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: **877-233-3797** 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویند مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره **877-233-3797** تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ **877-233-3797** 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или **877-233-3797**. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al **877-233-3797**. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa **877-233-3797**. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc **877-233-3797**. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 2	All Eligible Associates Electing High Plan

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-487-5553 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

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
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$ 150

Dental expenses incurred by an individual on or after January 1, 2014, but before September 1, 2014, will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to September 1, 2014; and

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period	$1,250

Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
PPO Bonus – Each Benefit Period	$100
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.

After the first Benefit Period following the coverage effective date, the Carry Over Amount will be increased by the PPO Bonus if:

a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and

c) 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 and the PPO Bonus.

The Carry Over Amount and the PPO Bonus 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 or PPO Bonus 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 or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount and the PPO Bonus 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 and/or the PPO Bonus, 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 or PPO Bonus calculations. The request for review must be within 24 months from the date the Carry Over Amount or the PPO Bonus was established.

DEFINITIONS

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

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.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

UN-REGISTERED DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another. This partnership has not been registered with the California Secretary of State as prescribed under Section 297 of the California Family Code or any other state or local jurisdiction.

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

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered Domestic Partner.

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

   i. natural born children;

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

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

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

Dependents that are ineligible under the Policyholder's separate medical plans will be ineligible under this Policy as well.

c. each child age 26 or older who:

i. is Totally Disabled as defined below; and

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

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Injury or Sickness for Certain Dependents
Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

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.

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

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.

EMPLOYER UNIT means any business organization which has elected to participate in the NORTH RANCH BENEFITS TRUST.

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 all eligible associates electing high plan with an Employer Unit working at least 30 hours per week.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

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

A Member must be 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 all eligible associates electing high plan with an Employer Unit working at least 30 hours per week and has eligible dependents.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not 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, has dependents insured, the Employer Unit has the option of offering the dependents of the deceased employee continued coverage. If elected by the Employer Unit 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.

PARTICIPATION REQUIREMENTS. The following requirement(s) must be met in order for coverage to be placed in force, and to remain in force for each Employer Unit:

Percentage of Members in an Employer Unit 100%

If the Employer Unit has 5 or more employees enrolled in the plan on the original plan effective date, those employees that are covered for group dental coverage elsewhere may be counted toward satisfying the participation requirement.

Minimum Number of insured employees required of each
Employer Unit for the insurance to remain in force for that Employer Unit 3

Dependent Insurance

Percentage of Members in an Employer Unit which, upon entry into the Trust, insured nine or less eligible employees 100%

Percentage of Members in an Employer Unit which, upon entry into the Trust, insured ten or more eligible employees:

When contributions are not required 100%
When contributions are required 80%

Those dependents that are covered for group dental coverage elsewhere may be counted toward satisfying the participation requirement.

CONTRIBUTION REQUIREMENTS. Dependent on the Employer Unit's choice, an Insured may, or may not, be required to contribute to the payment of his or her premium.

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

ELIGIBILITY PERIOD. For Members eligible on the date the Employer Unit was accepted into the Trust, coverage is effective immediately.

For persons who become Members after the date the Employer Unit was accepted into the Trust, the Eligibility Period will be one, two, or three months of continuous active employment. The Eligibility Period is selected by the Employer Unit, subject to the condition that the same Eligibility Period be applied to all Members within the same Employer Unit. New Members should check with their Employer Unit to determine which Eligibility Period was selected.

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 Unit on a full time basis at one of the Employer Unit's business establishments or at some location to which the Employer Unit'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.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

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 coverage for the Insured's Employer Unit is terminated.
4. the date the policy is terminated; or
5. the date the number of Insureds falls below any participation requirements shown above.

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;
5. the date all Dependent Insurance is cancelled for a specific Employer Unit; or
6. the date this policy is terminated.

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

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

In addition to the provision below, please review the provisions of the California Continuation Benefits Replacement Act (Cal-COBRA) included within this document.

<u>Labor Dispute</u>
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will

be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

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.

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 based on the lesser of:

1. the actual charge of the Provider.
2. the Maximum Allowable Charge ("MAC").
3. the Maximum Covered Expense, if services are provided by a Non-Participating Provider.

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 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. We reserve the right to pay a lesser alternate benefit for certain procedures. 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 alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

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

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

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

1. for Type 3 Procedures in the first 6 months the person is covered under this contract; unless the Insured is covered on September 1, 2014.

2. 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.

3. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the insured person is covered on September 1, 2014. For those Insureds covered on September 1, 2014, see b.

    b. Limitation a. will be waived for those Insureds whose coverage was effective on September 1, 2014 and

        i. the person has the tooth extracted while insured under the prior contract: and

        ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

        but such extraction and installation must take place within a twelve-month period; and

        iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

4. 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.

5. 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.

6. to replace lost or stolen appliances.

7. for any treatment which is for cosmetic purposes.

8. 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.)

9. 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).

10. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law,

or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

11. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

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

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

TABLE OF DENTAL PROCEDURES

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

The attached is a list of dental procedures for which benefits are payable under this section. **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 dental prosthesis or prosthetic crown 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 Radiographic images, 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 - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$51.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$51.00

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 1 of any of these procedures per 6 month(s).
- 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 1 of any of these procedures per 6 month(s).
- 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.

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - complete series of radiographic images.	$106.00
D0330	Panoramic radiographic image.	$85.00

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first radiographic image.	$19.00
D0230	Intraoral - periapical each additional radiographic image.	$15.00
D0240	Intraoral - occlusal radiographic image.	$27.00
D0250	Extraoral - first radiographic image.	$34.00
D0260	Extraoral - each additional radiographic image.	$27.00

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS		
D0270	Bitewing - single radiographic image.	$16.00
D0272	Bitewings - two radiographic images.	$30.00
D0273	Bitewings - three radiographic images.	$36.00
D0274	Bitewings - four radiographic images.	$46.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$70.00

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1206	Topical application of fluoride varnish.	$27.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1208	Topical application of fluoride.	$27.00

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- 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.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$27.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$27.00

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.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$32.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$64.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$64.00

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.

SEALANT		
D1351	Sealant - per tooth.	$20.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$21.00

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$46.00
D2150	Amalgam - two surfaces, primary or permanent.	$58.00
D2160	Amalgam - three surfaces, primary or permanent.	$71.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$84.00

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, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$56.00
D2331	Resin-based composite - two surfaces, anterior.	$71.00
D2332	Resin-based composite - three surfaces, anterior.	$88.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$97.00
D2391	Resin-based composite - one surface, posterior.	$61.00
D2392	Resin-based composite - two surfaces, posterior.	$77.00
D2393	Resin-based composite - three surfaces, posterior.	$97.00
D2394	Resin-based composite - four or more surfaces, posterior.	$107.00
D2410	Gold foil - one surface.	$46.00
D2420	Gold foil - two surfaces.	$58.00
D2430	Gold foil - three surfaces.	$71.00
D2990	Resin infiltration of incipient smooth surface lesions.	$56.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- 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.

TYPE 2 PROCEDURES

		Maximum Covered Expense
	• Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.	
	GOLD FOIL RESTORATIONS: D2410, D2420, D2430	
	• Gold foils are considered at an alternate benefit of an amalgam/composite restoration.	
	STAINLESS STEEL CROWN (PREFABRICATED CROWN)	
D2390	Resin-based composite crown, anterior.	$119.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$110.00
D2930	Prefabricated stainless steel crown - primary tooth.	$100.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$106.00
D2932	Prefabricated resin crown.	$119.00
D2933	Prefabricated stainless steel crown with resin window.	$119.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$119.00
	STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934	
	• Replacement is limited to 1 of any of these procedures per 12 month(s). • Porcelain and resin benefits are considered for anterior and bicuspid teeth only.	
	RECEMENT	
D2910	Recement inlay, onlay, or partial coverage restoration.	$37.00
D2915	Recement cast or prefabricated post and core.	$18.00
D2920	Recement crown.	$36.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$88.00
D6092	Recement implant/abutment supported crown.	$36.00
D6093	Recement implant/abutment supported fixed partial denture.	$36.00
D6930	Recement fixed partial denture.	$50.00
	SEDATIVE FILLING	
D2940	Protective restoration.	$34.00
D2941	Interim therapeutic restoration - primary dentition.	$25.00
	ENDODONTICS MISCELLANEOUS	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$62.00
D3221	Pulpal debridement, primary and permanent teeth.	$62.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$94.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$83.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$72.00
D3333	Internal root repair of perforation defects.	$102.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$102.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$69.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$202.00
D3357	Pulpal regeneration - completion of treatment.	$202.00
D3430	Retrograde filling - per root.	$80.00
D3450	Root amputation - per root.	$189.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$160.00
	ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920	
	• Procedure D3333 is limited to permanent teeth only.	
	ENDODONTIC THERAPY (ROOT CANALS)	
D3310	Endodontic therapy, anterior tooth.	$284.00
D3320	Endodontic therapy, bicuspid tooth.	$334.00
D3330	Endodontic therapy, molar.	$438.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$167.00
D3346	Retreatment of previous root canal therapy - anterior.	$353.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$407.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D3348	Retreatment of previous root canal therapy - molar.	$505.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$95.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$48.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$70.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$57.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$58.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$58.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$48.00
D5610	Repair resin denture base.	$58.00
D5620	Repair cast framework.	$68.00
D5630	Repair or replace broken clasp.	$71.00
D5640	Replace broken teeth - per tooth.	$51.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$107.00
D5731	Reline complete mandibular denture (chairside).	$107.00
D5740	Reline maxillary partial denture (chairside).	$96.00
D5741	Reline mandibular partial denture (chairside).	$97.00
D5750	Reline complete maxillary denture (laboratory).	$159.00
D5751	Reline complete mandibular denture (laboratory).	$156.00
D5760	Reline maxillary partial denture (laboratory).	$159.00
D5761	Reline mandibular partial denture (laboratory).	$160.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$51.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$51.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$242.00
D7261	Primary closure of a sinus perforation.	$242.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$146.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$146.00
D7280	Surgical access of an unerupted tooth.	$227.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$163.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$68.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$85.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$43.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$108.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$54.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$156.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$389.00
D7410	Excision of benign lesion up to 1.25 cm.	$155.00
D7411	Excision of benign lesion greater than 1.25 cm.	$199.00
D7412	Excision of benign lesion, complicated.	$219.00
D7413	Excision of malignant lesion up to 1.25 cm.	$209.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$153.00
D7415	Excision of malignant lesion, complicated.	$169.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$209.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$153.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$155.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$199.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$155.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$199.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$47.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$138.00
D7472	Removal of torus palatinus.	$138.00
D7473	Removal of torus mandibularis.	$138.00
D7485	Surgical reduction of osseous tuberosity.	$225.00
D7490	Radical resection of maxilla or mandible.	$209.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$69.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$80.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$64.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$175.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$175.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$230.00
D7910	Suture of recent small wounds up to 5 cm.	$31.00
D7911	Complicated suture - up to 5 cm.	$35.00
D7912	Complicated suture - greater than 5 cm.	$50.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	$166.00
D7963	Frenuloplasty.	$208.00
D7970	Excision of hyperplastic tissue - per arch.	$128.00
D7972	Surgical reduction of fibrous tuberosity.	$204.00
D7980	Sialolithotomy.	$192.00
D7983	Closure of salivary fistula.	$61.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE		
D7285	Biopsy of oral tissue - hard (bone, tooth).	$208.00
D7286	Biopsy of oral tissue - soft.	$112.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7287	Exfoliative cytological sample collection.	$56.00
D7288	Brush biopsy - transepithelial sample collection.	$56.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$38.00

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$39.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$27.00
D9440	Office visit - after regularly scheduled hours.	$48.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$29.00

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.	$37.00
D9952	Occlusal adjustment - complete.	$185.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	$32.00
D2951	Pin retention - per tooth, in addition to restoration.	$18.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$56.00

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, D2990, 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 - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$115.00
D1515	Space maintainer - fixed - bilateral.	$188.00
D1520	Space maintainer - removable - unilateral.	$180.00
D1525	Space maintainer - removable - bilateral.	$219.00
D1550	Re-cementation of space maintainer.	$24.00
D1555	Removal of fixed space maintainer.	$33.00

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.

INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$282.00
D2520	Inlay - metallic - two surfaces.	$336.00
D2530	Inlay - metallic - three or more surfaces.	$362.00
D2610	Inlay - porcelain/ceramic - one surface.	$311.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$338.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$371.00
D2650	Inlay - resin-based composite - one surface.	$323.00
D2651	Inlay - resin-based composite - two surfaces.	$319.00
D2652	Inlay - resin-based composite - three or more surfaces.	$330.00

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.	$366.00
D2543	Onlay - metallic - three surfaces.	$408.00
D2544	Onlay - metallic - four or more surfaces.	$425.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$366.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$409.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$422.00
D2662	Onlay - resin-based composite - two surfaces.	$343.00
D2663	Onlay - resin-based composite - three surfaces.	$353.00
D2664	Onlay - resin-based composite - four or more surfaces.	$376.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 10 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, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$160.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2712	Crown - 3/4 resin-based composite (indirect).	$396.00
D2720	Crown - resin with high noble metal.	$408.00
D2721	Crown - resin with predominantly base metal.	$311.00
D2722	Crown - resin with noble metal.	$382.00
D2740	Crown - porcelain/ceramic substrate.	$441.00
D2750	Crown - porcelain fused to high noble metal.	$428.00
D2751	Crown - porcelain fused to predominantly base metal.	$367.00
D2752	Crown - porcelain fused to noble metal.	$394.00
D2780	Crown - 3/4 cast high noble metal.	$407.00
D2781	Crown - 3/4 cast predominantly base metal.	$354.00
D2782	Crown - 3/4 cast noble metal.	$370.00
D2783	Crown - 3/4 porcelain/ceramic.	$441.00
D2790	Crown - full cast high noble metal.	$407.00
D2791	Crown - full cast predominantly base metal.	$354.00
D2792	Crown - full cast noble metal.	$370.00
D2794	Crown - titanium.	$407.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 10 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, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	$89.00

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$141.00
D2954	Prefabricated post and core in addition to crown.	$118.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	$71.00
D2981	Inlay repair necessitated by restorative material failure.	$57.00
D2982	Onlay repair necessitated by restorative material failure.	$57.00
D2983	Veneer repair necessitated by restorative material failure.	$57.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$80.00
D9120	Fixed partial denture sectioning.	$80.00

SURGICAL ENDODONTICS

D3355	Pulpal regeneration - initial visit.	$92.00
D3356	Pulpal regeneration - interim medication replacement.	$62.00
D3410	Apicoectomy - anterior.	$263.00
D3421	Apicoectomy - bicuspid (first root).	$304.00
D3425	Apicoectomy - molar (first root).	$329.00
D3426	Apicoectomy (each additional root).	$118.00
D3427	Periradicular surgery without apicoectomy.	$237.00

SURGICAL PERIODONTICS

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$167.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$84.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$229.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$115.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$420.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$210.00
D4263	Bone replacement graft - first site in quadrant.	$137.00
D4264	Bone replacement graft - each additional site in quadrant.	$103.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$68.00
D4270	Pedicle soft tissue graft procedure.	$309.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$382.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$184.00
D4275	Soft tissue allograft.	$327.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$382.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft.	$329.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site.	$131.00

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, D4273, D4275, D4276, D4277, D4278

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

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$252.00

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$456.00
D5120	Complete denture - mandibular.	$442.00
D5130	Immediate denture - maxillary.	$494.00
D5140	Immediate denture - mandibular.	$478.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$328.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$380.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$528.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$528.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$328.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$380.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$283.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$328.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$380.00
D5810	Interim complete denture (maxillary).	$201.00
D5811	Interim complete denture (mandibular).	$212.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5820	Interim partial denture (maxillary).	$177.00
D5821	Interim partial denture (mandibular).	$186.00
D5863	Overdenture - complete maxillary.	$456.00
D5864	Overdenture - partial maxillary.	$528.00
D5865	Overdenture - complete mandibular.	$456.00
D5866	Overdenture - partial mandibular.	$528.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$456.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$528.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$456.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$528.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6053 and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6054 and D6079 are considered at an alternate benefit of D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$26.00
D5411	Adjust complete denture - mandibular.	$24.00
D5421	Adjust partial denture - maxillary.	$27.00
D5422	Adjust partial denture - mandibular.	$26.00

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.	$59.00
D5660	Add clasp to existing partial denture.	$68.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$166.00
D5711	Rebase complete mandibular denture.	$176.00
D5720	Rebase maxillary partial denture.	$158.00
D5721	Rebase mandibular partial denture.	$167.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$46.00
D5851	Tissue conditioning, mandibular.	$50.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$380.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$415.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$415.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$380.00
D6062	Abutment supported cast metal crown (high noble metal).	$415.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$415.00
D6064	Abutment supported cast metal crown (noble metal).	$450.00
D6065	Implant supported porcelain/ceramic crown.	$380.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$415.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$415.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$380.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$415.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$415.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$380.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$415.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$415.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$450.00
D6075	Implant supported retainer for ceramic FPD.	$380.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$415.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$415.00
D6094	Abutment supported crown - (titanium).	$415.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$415.00
D6205	Pontic - indirect resin based composite.	$342.00
D6210	Pontic - cast high noble metal.	$415.00
D6211	Pontic - cast predominantly base metal.	$415.00
D6212	Pontic - cast noble metal.	$450.00
D6214	Pontic - titanium.	$415.00
D6240	Pontic - porcelain fused to high noble metal.	$415.00
D6241	Pontic - porcelain fused to predominantly base metal.	$415.00
D6242	Pontic - porcelain fused to noble metal.	$380.00
D6245	Pontic - porcelain/ceramic.	$380.00
D6250	Pontic - resin with high noble metal.	$415.00
D6251	Pontic - resin with predominantly base metal.	$380.00
D6252	Pontic - resin with noble metal.	$450.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$138.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$138.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$338.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$372.00
D6602	Inlay - cast high noble metal, two surfaces.	$304.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$335.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$263.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$289.00
D6606	Inlay - cast noble metal, two surfaces.	$277.00
D6607	Inlay - cast noble metal, three or more surfaces.	$304.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$366.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$403.00
D6610	Onlay - cast high noble metal, two surfaces.	$335.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$368.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$289.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$318.00
D6614	Onlay - cast noble metal, two surfaces.	$304.00
D6615	Onlay - cast noble metal, three or more surfaces.	$335.00
D6624	Inlay - titanium.	$335.00
D6634	Onlay - titanium.	$368.00
D6710	Crown - indirect resin based composite.	$342.00
D6720	Crown - resin with high noble metal.	$415.00
D6721	Crown - resin with predominantly base metal.	$215.00
D6722	Crown - resin with noble metal.	$346.00
D6740	Crown - porcelain/ceramic.	$380.00
D6750	Crown - porcelain fused to high noble metal.	$450.00
D6751	Crown - porcelain fused to predominantly base metal.	$415.00
D6752	Crown - porcelain fused to noble metal.	$380.00
D6780	Crown - 3/4 cast high noble metal.	$450.00
D6781	Crown - 3/4 cast predominantly base metal.	$415.00
D6782	Crown - 3/4 cast noble metal.	$380.00
D6783	Crown - 3/4 porcelain/ceramic.	$380.00
D6790	Crown - full cast high noble metal.	$415.00
D6791	Crown - full cast predominantly base metal.	$415.00
D6792	Crown - full cast noble metal.	$380.00
D6794	Crown - titanium.	$415.00
D6940	Stress breaker.	$115.00

TYPE 3 PROCEDURES

Maximum Covered Expense

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 10 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.
- Benefits will not be considered if procedure D2390, D2929, 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 10 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 10 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, D2929, 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 10 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 10 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 10 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.

TYPE 3 PROCEDURES

		Maximum Covered Expense
	• Porcelain and resin benefits are considered for anterior and bicuspid teeth only.	
SURGICAL EXTRACTIONS		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$89.00
D7220	Removal of impacted tooth - soft tissue.	$111.00
D7230	Removal of impacted tooth - partially bony.	$148.00
D7240	Removal of impacted tooth - completely bony.	$173.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$197.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$93.00
D7251	Coronectomy-intentional partial tooth removal.	$173.00
APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$173.00
D8220	Fixed appliance therapy.	$173.00
	APPLIANCE THERAPY: D8210, D8220	
	• Coverage is limited to the correction of thumb-sucking.	
ANESTHESIA-GENERAL/IV		
D9220	Deep sedation/general anesthesia - first 30 minutes.	$133.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$44.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$88.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$21.00
	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.	

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. 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 90 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 90 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. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

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. We cannot contest the validity of the policy after one year from the date of issue except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for one year while the Insured is alive. Any of the Insured's statements that we contest must be in a written application signed by the Insured.

TERMINATION OF EMPLOYER UNIT PARTICIPATION UNDER THE POLICY. In addition to the Policy termination rights contained elsewhere, we may terminate a particular Employer Unit's participation under the policy for any one or more of the following reasons:

a. failure to make required premium payments;

b. the number of Insureds falls below any participation requirements shown in the Conditions for Insurance Coverage.

c. the failure of the Employer Unit to satisfy the conditions for participation in the NORTH RANCH BENEFITS TRUST or the policy.

INSURANCE DATA. The Policyholder and the Employer Unit, including each Insured, will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to the following:

i. data necessary for us to calculate premiums;

ii. data necessary for us to determine a person's effective date or termination date of insurance;

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

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

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.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. 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.

Ameritas Privacy Office Contact Information: 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. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

YOUR RIGHTS
YOU HAVE THE RIGHT TO:

Get a copy of your claims records

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa /complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends**.
  At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation**.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

  Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.