

SERFF Tracking Number: AMFA-126588682 State: Arkansas  
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 45751  
Company Tracking Number:  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: WALKING HORSE TRAINERS ASSOCIATION, INC.  
Project Name/Number: WALKING HORSE TRAINERS ASSOCIATION, INC./WALKING HORSE TRAINERS ASSOCIATION, INC.

## Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: WALKING HORSE TRAINERS ASSOCIATION, INC. SERFF Tr Num: AMFA-126588682 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- Closed State Tr Num: 45751

Sub-TOI: H10G.000 Health - Dental Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Janis Landon Disposition Date: 05/24/2010  
Date Submitted: 05/24/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: WALKING HORSE TRAINERS ASSOCIATION, INC. Status of Filing in Domicile: Not Filed  
Project Number: WALKING HORSE TRAINERS ASSOCIATION, INC. Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Overall Rate Impact: Group Market Type: Association  
Filing Status Changed: 05/24/2010 Explanation for Other Group Market Type:  
State Status Changed: 05/24/2010  
Deemer Date: Created By: Janis Landon  
Submitted By: Janis Landon Corresponding Filing Tracking Number:  
Filing Description:  
RE: Request for Review - Eligibility of a Group under §23-86-106(2)(A)  
Walking Horse Trainers Association

Dear Sir/Madam:

Enclosed for your review and approval is the above captioned out-of-state group. Ameritas Life Insurance Corp. ("Ameritas") is an Arkansas licensed insurer and has recently issued a group policy providing dental benefits to the members of the Walking Horse Trainers Association (WHTA).

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Ameritas has requested and reviewed the By-Laws of the Association. A copy has been attached for your review. In addition, Ameritas also reviewed the statutory provisions of Arkansas Code to ensure that this potential group constituted an eligible group under §23-86-106.

Specifically, under Arkansas §23-86-106(2)(A), an eligible group is defined as an association, including a labor union, which shall have a constitution or by-laws and the Insurance Commissioner finds, regardless of where the association is domiciled or does business, which has been organized and is maintained in good faith for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

Therefore, Ameritas is requesting the Department's review and approval of this group as an eligible group under §23-86-106(2)(A) of Arkansas Code. The by-laws confirm that the association meets all of the above requirements and Ameritas is confident that the Commissioner will find that the issuance of the policy is not contrary to the best interest of the public and the issuance of the policy would meet result in economies of acquisition or administration. Ameritas represents that the benefits of the policy are reasonable in relation to the premium charged.

The Walking Horse Trainers Association, Inc. was established in 1968 under the first President Mr. Vic Thompson. The purpose of forming this non-profit organization was to promote and develop activities on behalf of and in interest of the protection of the members of their Association.

WHTA began with approximately 200 members in their general membership. Today they have reached an astonishing 850 members.

This Association concentrates on the positive aspects of the Walking Horse Industry and offers its support to many worthwhile projects. Some of these include:

- The National Walking Horse Trainers show is an annual event held each year in March. It is the greatest funding asset to WHTA. This event has made contributions to several different charities such as: NAHRA, Feed the Children and Healthy Families. In 2002 a class was added for Walking Horse exhibitors overcoming obstacles. This class was introduced to the Association by an organization known as Silver Bullets, which works with terminally ill individuals.
- WHAT has been involved in several Community projects as well. Some listed below: 4-H Youth Judging Project, Co-Sponsors of the Annual Youth Celebration Dance, donations to the Bedford County Medical Center Pediatric Wing, Bemis Pencil Country Classic golf tournament which benefits children with developmental delays and the latest Silver Bullets.
- In January 1992 the endorsement of the Show Horse Support Fund, Inc. became effective. The purpose of this fund is to establish an emergency legal defense fund and to promote the Tennessee Walking Horse and Racking Horse breeds and to lobby appropriate governmental agencies relating to the rules and regulations promulgated by such agencies as to such horses.
- The Young generation is very important to WHTA. To support the educational efforts of those in need, in 1989 a yearly

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scholarship fund was established. This very proactive venture has proved most worthwhile in helping our future generation progress. So far there have been 23 recipients to be awarded. In 2002 - 2003 the Walking Horse Trainers will once again offer a scholarship(s). Applications may be obtained through the WHTA office and deadline is always July 1.

- In 1995 a Youth Council Group was established under the direction of Mr. Benny Johnson. The first meeting was held March 25, 1995 during the National Walking Horse Trainers Show. Their goal for the future was and still is to learn responsibility for showing and exhibiting which includes versatility. They have several worthwhile projects, which include the Vanderbilt Children's Hospital Toy Drive, helping others in time of need and an annual Tack Box Giveaway. Their membership stands at approximately 100+ members. Applications and membership cards are available at no cost from the Walking Horse Trainers Association.
- In 1971 the Trainer's Wives Auxiliary was formed with 43 members. Their first President to reign was Mrs. Mary Ruth Motes. Goals were to raise money for the Trainer's Association with all fundraisers and projects to be approved by the WHTA. They held the First Annual Money Tree Classic in 1985 and today this show still exist with record breaking entries each year. They soon began to realize that an award for Auxiliary Member of the Year should be given. So in 1990 the first recipient to receive this award was Mrs. Dee Cantrell. Applications may be obtained from the WHTA Auxiliary Secretary.
- In 1988 Trainers would be allowed to show. It became mandatory that any trainer wishing to show in National Horse Show Commission shows would be required to have a license. The types of license one a member should apply for was based on the amount of income a member received from training horses.

Ameritas has already filed the group policy with Tennessee and a copy is attached for your reference. Following approval by your Department, Ameritas will issue a certificate form to any Arkansas members of this group under certificate form 9021 Rev. 03-08. The content of this certificate form was previously approved by the Department on April 1, 2008 for true employer groups. There will be seven different plan options.

The current address for this out-of-state group is:

Walking Horse Trainers Association  
1101 North Main Street  
Shelbyville, NT 37162

Anyone who is not eligible to be an amateur or juvenile must hold a trainer's license. Membership fees range from the initial fee of \$250.00. The renewal fee by Jan. 1 would be \$100.00, after Jan. 1, the fee increases to \$110.00 until March 15. After March 15, the fee increases to \$250.00 and a new application would be required. The following memberships are available:

- Halter License
- A License
- AA License
- AAA License

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• Associate Membership

More detailed information on membership has been provided.

This form is in final print. When scored with the policy, this form achieves a 50 on the Flesch Readability Scale.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email [jlandon@ameritas.com](mailto:jlandon@ameritas.com).

Sincerely,

Janis Landon  
Senior Contract Analyst

## Company and Contact

### Filing Contact Information

Janis Landon, Senior Contract Analyst  
475 Fallbrook Blvd.  
Lincoln, NE 68521  
[jlandon@ameritas.com](mailto:jlandon@ameritas.com)  
800-745-1112 [Phone] 82444 [Ext]  
402-309-2573 [FAX]

### Filing Company Information

Ameritas Life Insurance Corp.  
5900 O Street  
P O Box 81889  
Lincoln, NE 68501-1889  
(800) 756-1112 ext. [Phone]  
CoCode: 61301  
Group Code: 943  
Group Name:  
FEIN Number: 47-0098400  
State of Domicile: Nebraska  
Company Type:  
State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	\$50.00	05/24/2010	36774215

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/24/2010	05/24/2010

*SERFF Tracking Number:* AMFA-126588682 *State:* Arkansas  
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## **Disposition**

Disposition Date: 05/24/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Bylaws	Approved-Closed	Yes
<b>Supporting Document</b>	Signed Application	Approved-Closed	Yes
<b>Supporting Document</b>	Group Policy	Approved-Closed	Yes
<b>Supporting Document</b>	Member Info	Approved-Closed	Yes

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	05/24/2010
<b>Comments:</b>			
<b>Attachment:</b>			
AR Readability .pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	05/24/2010
<b>Bypass Reason:</b>	n/a		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Bylaws	Approved-Closed	05/24/2010
<b>Comments:</b>			
<b>Attachments:</b>			
ByLaws.pdf			
Code of Ethics.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Signed Application	Approved-Closed	05/24/2010
<b>Comments:</b>			
<b>Attachment:</b>			
Signed App.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Group Policy	Approved-Closed	05/24/2010
<b>Comments:</b>			

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**Attachment:**

010035007\_B00005023\_EPOL.PDF

**Item Status:**

**Status**

**Satisfied - Item:** Member Info

Approved-Closed

**Date:**

05/24/2010

**Comments:**

**Attachment:**

WHTA Member Lives as of 022310.pdf

**STATE OF ARKANSAS**  
**CERTIFICATE OF READABILITY**

INSURER:

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:

FLESCH SCORE:

FORM NAME:

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: \_\_\_\_\_

TYPED NAME:

TITLE:

DATE: \_\_\_\_\_



**STATE OF TENNESSEE**  
**Tre Hargett, Secretary of State**  
Division of Business Services  
312 Rosa L. Parks Avenue  
6th Floor, William R. Snodgrass Tower  
Nashville, TN 37243

## Filing Information

Name: **WALKING HORSE TRAINERS ASSOCIATION, INC. ("")**

### General Information

**Control # :** 86924  
**Filing Type:** Corporation Non-Profit - Domestic  
**Filing Date:** 01/18/1968 4:30 PM  
**Status:** Active  
**Duration Term:** Perpetual  
**Managed By:** Member Managed  
**Public/Mutual Benefit:** Mutual

**Formation Locale:** Bedford County  
**Date Formed:** 01/18/1968  
**Fiscal Year Close:** 12

### Registered Agent Address

MARCIA ALLISON  
1101 N MAIN ST  
SHELBYVILLE, TN 371600000 USA

### Principal Address

1101 NORTH MAIN ST  
SHELBYVILLE, TN 371600000 USA

The following document(s) was/were filed in this office on the date(s) indicated below:

<u>Date Filed</u>	<u>Filing Description</u>	<u>Image #</u>
02/06/2009	2008 Annual Report	6441-2353
01/29/2008	2007 Annual Report	6199-1030
03/09/2007	2006 Annual Report	5980-2532
01/27/2006	2005 Annual Report	5667-2307
01/10/2005	2004 Annual Report	5318-1307
02/19/2004	2003 Annual Report	5041-1170
02/13/2003	2003 Annual Report	4728-1621
06/13/2002	2002 Annual Report	4527-0504
01/26/2001	2001 Annual Report	4105-3535
02/15/2000	2000 Annual Report	3828-2080
02/26/1993	Annual Report Filed	2652-2443
08/16/1991	Annual Report Filed	2245-0445
07/19/1991	Notice of Determination	ROLL 2223
06/27/1988	Articles of Amendment	860-1205
07/14/1986	Administrative Amendment	623 02436
02/25/1981	Registered Agent Change (by Entity)	198 00677
02/25/1981	Articles of Amendment	198 00676
01/18/1968	Initial Filing	B027P0056

### Active Assumed Names (if any)

Date

Expires

WALKING HORSE TRAINERS ASSOCIATION, INC.

BY-LAWS

ARTICLE I

NAME

This organization shall be known as "THE WALKING HORSE TRAINERS ASSOCIATION, INC.", under which name it is incorporated under the laws of the State of Tennessee as provided for such organizations.

ARTICLE II

PURPOSE

This Association is a non-profit organization and its purpose is to promote and develop activities on behalf of and in interest of the walking horse and training profession for the benefit and protection of the members of this Association.

ARTICLE III

OFFICERS

SECTION 1. The officers of this association shall be a President, a 1st Vice President, a 2nd Vice President, and a Secretary-Treasurer.

SECTION 2. The President and Vice Presidents shall be elected at the Fall annual meeting and shall hold office for a term of one year or until their successors shall be elected. The officers shall assume office on January 1. The Secretary-Treasurer shall be appointed by the President and may be replaced by the President.

SECTION 3. The President shall preside at all meetings of the Association and the Board of Directors. He shall be signatory of all contracts and written agreements of the Association, other than checks, and shall perform such duties as generally pertain to this office. He shall be a member ex-officio to all committees of the Association. He shall likewise have one vote at the meetings of the Board of Directors.

SECTION 4. The 1st Vice President shall conduct the duties of the President in his absence. He may be signatory to checks of the Association when required and shall succeed to the office of President upon the resignation, removal or disability of the

President to perform his duties. He shall likewise have one vote at all meetings of the Board of Directors.

SECTION 5. The 2nd Vice President shall conduct the duties of the President in the absence of the President and the 1st Vice-President. He may be signatory to checks of the Association when required. He shall succeed to the office of President upon the resignation, removal or disability of both the President and 1st Vice-President to perform their duties. He shall likewise have one vote at all meetings of the Board of Directors.

SECTION 6. The Secretary-Treasurer shall keep a record of all meetings of the Association and of the Board of Directors. He shall give notice of all general meetings of the Association and all meetings of the Board of Directors. He shall conduct the correspondence of the Association. He shall collect all revenues of the Association and shall make disbursements and pay bills of the Association upon the approval of the Board of Directors, and shall keep and maintain all records and accounts of the Association. He shall furnish a bond in the amount fixed by the Board of Directors, the cost of which shall be paid by the Association. His accounts shall be audited in such manner as directed by the Board of Directors. He shall deposit the funds of the Association in one or more accounts as directed by the Board of Directors under the name "Walking Horse Trainers Association, Inc.", providing for withdrawal by check or draft signed by any two of the following: The President, the 1st Vice-President, or the 2nd Vice-President, and the Secretary-Treasurer. A full report of the recorded activities and of the treasury of the Association shall be made by the Secretary-Treasurer at each quarterly meeting of the Board of Directors. The fiscal year of the Association shall begin on January 1.

SECTION 7. For a member to be eligible to be an officer or a member of the Board of Directors, such member must be a full time walking horse trainer and a member of the association for Five (5) consecutive years.

#### ARTICLE IV

##### BOARD OF DIRECTORS

SECTION 1. There shall be a Board of Directors of this Association consisting of the following: Eleven (11) members from the "full membership" list of members. Three (3) shall be elected for a term of one year; four (4) for a term of two (2) years; and four (4) for a term of three years. Directors shall be elected for three year terms as these terms expire. The President shall, after the expiration of his term, become the President ex-officio to the Board of Directors for one year and he shall be a voting member during that year.

SECTION 2. The Board of Directors, President, First Vice-President, and Second Vice-President and Past Presidents shall be the governing body of the Association and shall have charge of the affairs, funds and property of the Association and shall report its activities to the Association by Secretary-Treasurer at each general meeting.

SECTION 3. The Board of Directors and Officers shall meet four (4) times each year at a time and place designated by the President of the Association. The first such meeting each year shall be held as soon as practicable following the election of Directors and in no event shall the first meeting be held later than March 15th. Insofar as it is practicable, subsequent meetings each year shall be held at approximately three (3) month intervals.

SECTION 3(a) Special meetings may be called at the discretion of the President or upon request of any three (3) members of the Board of Directors.

SECTION 3(b) Each member of the Board of Directors shall be notified of the time and place of each meeting, at least ten (10) days prior to each meeting, regular or special, but such notice may be waived by written agreement, signed by all members of the Board of Directors.

SECTION 4. Voting at the Board of Directors meetings shall be in person.

SECTION 5. A quorum of the Board of Directors shall consist of two-thirds (2/3) of all the members of the Board of Directors in person.

SECTION 6. The Board of Directors shall be empowered to suspend or remove any member of the board for conduct detrimental to the interests of the Association, by a three-quarters (3/4) majority vote of Officers and the entire Board at a meeting duly called for that stated purpose.

SECTION 7. In the event that any Director shall vacate his office, his successor shall be elected by other members of the Board. Such election to be held within thirty (30) days of the date such office is officially vacated.

SECTION 8. In the event that the office of a Vice-President shall be vacated, a successor shall be elected by a majority vote of the Board of Directors and Officers at a meeting duly called for that stated purpose.

SECTION 9. The Board of Directors and Officers may appoint sub-committees at its discretion; but no such sub-committee shall serve longer than until the Officers elected at the annual meeting take office.

## ARTICLE V

### MEETINGS AND ELECTIONS

SECTION 1. The annual meeting of the Association shall be held during the month of December each year or within reasonable time thereafter. The Board of Directors and Officers shall fix the place, date and time.

SECTION 2. A special meeting of the Association may be called by the President, the Board of Directors and Officers, or 10 members of the Association. A special meeting may be called by 10 members only if they have applied in writing to the President to call the meeting, and he has refused or has failed to act within 10 days after receiving the request. The call shall be signed and filed with the Secretary.

A special meeting is called by sending a copy of the call to every member of the Association at his last known address by first class U.S. Mail at least 10 days before the meeting. The call shall specify the place, date and time the meeting is to be held and the purpose for which it is convened.

SECTION 3. At the annual meeting of the Association it may transact any business that may come up, but at a special meeting, it may transact only such business as may be specified in the call.

SECTION 4. The annual meeting is held after sending a notice to every member of the Association at his last known address by first class U.S. Mail at least 10 days before the meeting. The notice shall specify the place, date and time the meeting is to be held and be accompanied by an agenda listing the business expected to be transacted.

SECTION 5. Voting at a meeting of the Association shall be in person and by proxy. A proxy may only be held by a voting member who is present at a meeting. For a proxy to be valid, the person seeking to vote by proxy must contact the Association office and obtain a numbered proxy. The proxy shall be signed before a notary and returned to the Association accountant at least one week prior to the meeting. (A form Proxy is attached hereto as Appendix A)

SECTION 6. There shall be a Credentials Committee composed of five members appointed by the President. The duties of the Committee shall be to determine the eligibility of members to vote, including in person and by proxy; keep a true record of those eligible to vote and issue ballots. The ballots shall serve as credentials and only a member who has been issued ballots can vote at a meeting.

The Credentials Committee shall meet at the place where the meeting of the Association is to be held, at least one hour before

the meeting begins. It shall issue printed ballots to each member and each ballot shall bear a ballot number. Each ballot shall have written on it the number of votes the member is entitled to cast, including in person and by proxy.

The decision of the Credentials Committee regarding eligibility to vote shall be final unless changed by the majority vote of those present at the meeting.

SECTION 7. Officers, including Directors whose terms are expiring, shall be elected at the annual meeting by a plurality of those voting in person.

SECTION 8. There shall be a Nominating Committee composed of three members appointed by the President. The Committee shall nominate a candidate for each office. The nominations shall be sent out to the members with the notice of the annual meeting.

At the annual meeting, any member may nominate from the floor a candidate for any office to be filled.

The consent of a member must be obtained before he can be nominated for office.

SECTION 9. A quorum shall consist of a majority of those present in person and by proxy as recorded by the Credentials Committee.

## ARTICLE VI

### OWNERSHIP AND RESPONSIBILITY

SECTION 1. Membership in this Association is a privilege, not a right and no member shall obtain any property right in Association property.

SECTION 1(a). When a member in good standing reaches age sixty five (65) in this organization, he or she shall be granted a life-time membership with full privileges and benefits of the Association.

SECTION 2. The Association shall not be responsible for any debt, obligation, or liability of any individual member thereof. Persons entitled to associate membership in this organization shall consist of persons interested in the promotion of the breed.

SECTION 3. No member shall attempt to represent the opinion of the Association without the express approval of the Board of Directors and Officers, except as pertaining to established policy. Persons entitled to become a member of the Century Club of the Association shall consist of those individuals that contribute \$100.00 to the Association each year for the welfare of the Association.

## ARTICLE VII

### MEMBERS AND DUES

SECTION 1. There shall be members of the Association and associate members. Members (referred to as active members, full members and the like) have all the rights of membership and associate members have all such rights except the right to vote and hold office.

SECTION 2. To be a member of the Association, one must be a full time professional trainer of Tennessee Walking Horses. Full time shall be defined as having 100% of their income from work as a professional trainer of Tennessee Walking horses. In addition, he must be otherwise qualified, be admitted to membership by the Officers and Board of Directors, and pay the fees and dues in such amount as established by the Board of Directors.

SECTION 3. To be an associate member of the Association, one must be admitted to associate membership by the Officers and Board of Directors and pay the dues and fees required by these by-laws. An Associate member is not required to be professional trainer.

SECTION 4. It shall be the duty of every member and associate member to keep the Secretary informed of his correct mailing address. When any notice to a member is required by these by-laws, such notice shall be sufficient if sent to his last known address by first class U.S. Mail.

SECTION 5. To become a member or associate member, one must apply for membership to the Secretary and pay such initiation fee as required. In addition, he must pay the annual dues for the calendar year in which is membership is to begin.

SECTION 6. Each member and associate member shall pay annual dues as established by the Board of Directors, in advance, for each calendar year. The Secretary may, but is not required to, send out bills for dues.

SECTION 7. Any member or associate member who neglects to pay his annual dues before March 15th of the calendar year shall be automatically suspended for non payment of dues. Provided, however, that for the calendar year 1991, the payment of dues shall be required on or before July 1, 1991, but in each succeeding year thereafter, the annual dues must be paid on or before the 15th day of March. In the event dues are not paid by March 15th, then there may be a penalty for late payment of dues. Such late payment penalty shall be determined on an annual basis by the Board of Directors. The Secretary may but is not required to notify any member that they have been suspended for non payment of dues.

SECTION 8. Only members in good standing on March 15th can vote at the annual meeting for that calendar year. The Secretary shall make up a list of all such members and furnish a copy to the Credentials Committee.

SECTION 9. A member or associate member who has been suspended for non payment of dues may be restored to membership by the Officers and Board of Directors upon the payment of dues for a calendar year. But if he is restored after March 15th, the restoration shall be for the succeeding year.

SECTION 10. Any person who is a member of the Association may remain a member even if he is not a full time walking horse trainer and earning 100% of his income from work as a professional trainer of Tennessee Walking Horses, as defined in Section 2. But if he is suspended or resigns, he may not be readmitted as a member unless he meets the qualifications provided in Section 2.

## ARTICLE VIII

### DISCIPLINE

SECTION 1. Any active member may be censured, suspended or expelled and fined for cause, by a majority vote of the Board of Directors and Officers, provided that before such disciplinary action is taken, such member shall have been notified in writing by registered mail directed to his address appearing in the records of the Secretary-Treasurer, not less than ten (10) days before the date of the Board Meeting at which such action is contemplated. Said notice shall state the charge preferred against him and the time and place of the hearing at which he shall be afforded an opportunity to be heard by the Board of Directors and Officers on his own behalf.

SECTION 2. Any disciplinary action taken by the Association regarding any active member within its jurisdiction shall be binding.

## ARTICLE IX

### COMMITTEES

#### SECTION 1.

(a) The following shall be permanent committees of this Association and shall have the number of members and associate members as shown who shall be appointed annually by the President of the Association:

Nominations  
Membership

Organization  
Horse Show Rules  
Horse Shows and Promotion  
Finance  
Public Relations  
Credentials  
Election

(b) In addition, the President shall have the authority to establish such additional committees as deemed necessary.

## ARTICLE X

### AMENDMENTS

SECTION 1. These By-laws may be amended by a two-thirds (2/3) majority vote of the members present in person at a meeting of the Association regularly called or held, provided that all members are notified of the proposed change at least ten (10) days prior to the meeting.

SECTION 2. Any proposed amendment to these By-laws must be submitted in writing to the Board of Directors and Officers at least thirty (30) days prior to the date of the meeting for ratification.

## **I. PREAMBLE**

The Walking Horse Trainers Association is committed to promoting and protecting the welfare of the Tennessee Walking Horse, and preserving the Walking Horse industry for future generations. To do so, the Association has developed and is committed to the following Code of Ethics.

## **II. CODE OF ETHICS**

Individuals licensed by the Walking Horse Trainers Association shall accept and abide by the following ethical rules of conduct. Any individual who is found to be in violation of one, some, or all of the ethical rules shall be disciplined accordingly by the Board of Directors of the Walking Horse Trainers Association, and is subject to loss of license.

Licensed individuals of the Walking Horse Trainers Association shall:

1. Treat all horses in their care humanely, and with dignity and respect. Trainers shall use proper care in training, handling, and showing them, And shall not utilize techniques known to inflict pain for the purposes of performance enhancement. Trainers found to have used pressure shoeing shall lose their training license and be banned from the Walking Horse Trainers Association for life.
2. Accurately represent any data or information about a horse which affects the sale of said horse, and conduct all business transactions in a straight-forward and honest manner. If a buyer requests information regarding a horse's fitness and health, trainers will refer such questions to a qualified veterinarian.
3. Support and promote the overall objectives of the Walking Horse Trainers Association which are:
  - a. To improve the public image and reputation of the Tennessee Walking Horse Breed.
  - b. Promote the ownership and showing of the Tennessee Walking Horse.
  - c. Develop improved training techniques of the Tennessee Walking Horse Breed focused on humane handling that complements the natural abilities of the breed.
  - d. Educate the public about the uniqueness and value of the Tennessee Walking Horse.
  - e. Work cooperative, collaboratively and professionally with USDA and DQPs to ensure compliance with the Horse Protection Act.



# application

See reverse side for additional information.



Lincoln, NE

## for association group dental and/or vision insurance

1. Applicant's Legal Name Walking Horse Trainers Association, Inc.

2. P.O. Box 61  
P.O. Box / ZIP Code  
1101 North Main St.  
Street Address  
Shelbyville, TN 37162  
City / State / ZIP  
931 684-5866 931 684-5895  
Phone No. Fax No.  
mdumas@hugles.net 62-0816488  
E-mail Address Tax I.D. No.

3. What is the type and occupational nature of the association?  
(Please provide copy of association bylaws.)  
 Trade  
 Professional HORSE TRAINERS  
 Other

4. Eligibility  
Total number of eligible employees ..... 725  
Employees in waiting period ..... 0

5. Are any Association chapters, classes of members or locations excluded? .....  No  
Are domestic partners included? .....  No  
Are retirees included? .....  No  
(If yes, please use reverse side for explanation.)

6. Are employees of Association members or Non-Association members eligible to participate? .....  Yes  No  
(If yes, please use reverse side to list name and location.)

7. Who is responsible for eligibility verification?  
 Association Office  Broker/TPA  
 Other

8. The following coverages are applied for:  
**Employee & Dependents Benefits**  
 Dental  Orthodontia  Eye Care  
 Other  
**Employee Only Benefits**  
 Dental  Orthodontia  Eye Care  
 Other

9. Member Participation/Contribution  
 Members pay 100% of premiums  
 Premiums paid by Association dues  
 Other:

10. Dependent Participation/Contribution  
 Members pay 100% of premiums  
 Premiums paid by Association dues  
 Other:

11. Waiting Period  
 0 days for those employed on or before the policy effective date.  
 0 days for those employed after the new policy effective date.

12. Effective Date and Termination Date  
 Immediate  
 First of Month Effective date End of Month Termination date  
 Other

13. Premium Payment Mode (In advance)  
 Monthly  Quarterly  Semi-Annual  Annual

14. If a policy effective date is other than first of the month, is a first-of-the-month premium due date desired? .....  Yes  No

15. Billing Options  
 Home Office  
 Third-Party Administration (TPA must be approved by us.)  
LARRY EMMETT / Benefits Workshop  
Contact Name  
Senior Consultant  
Title  
P.O. Box 56828  
Street Address  
Jacksonville, FL 32241  
City / State / ZIP  
888 537-3539 904 880-2830  
Phone No. Fax No.  
info@benefitsworkshop.com  
E-mail Address

16. Policy and Certificate Delivery (select one)  
A. eCert\*/ePolicy (\*generic cert, non-personalized)  
 via PDF format sent via e-mail to:  
  
 via eService and member portal  
B. Paper policy/personalized certificates  
 Initial employees only  
 Subsequently added employees  
Note: eCert will be available on member portal for all members.

**17. Insurance requested on this application will replace the coverage(s) checked.**

Coverages:  Dental  Orthodontia  Eye Care

Other N/A

Name of Current Carrier \_\_\_\_\_

Policy No. \_\_\_\_\_

Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

Termination Date \_\_\_\_\_ Original Effective date \_\_\_\_\_

**Item 5: Exclusions**

a. Classes, include reason for exclusion.

\_\_\_\_\_ NONE

b. Locations, if location is different from applicant's, list city and state.

\_\_\_\_\_  
\_\_\_\_\_

**Plan Design and Proposed Rates:**

\_\_\_\_\_  
\_\_\_\_\_

**Additional Remarks:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Agreements**

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

**Statements**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.) • **Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. • **Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts for information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. • **Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. • **Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. • **Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. • **Note for New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. • **Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO providers, check this box.

Signed at: City Shelbyville State TN Date 1-25-10

Signed by: (Policyholder Representative)

Printed name and title Winky Groover, President, WHTA

Signature [Handwritten Signature]

**Soliciting Agent:** I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name Jim White For FL agents only, provide FL license # \_\_\_\_\_

Signature [Handwritten Signature]

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? I Yes  No If yes, then amount \$ \_\_\_\_\_

Check received by (agent) \_\_\_\_\_ Authorized by (policyholder) \_\_\_\_\_

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.  
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.



A STOCK COMPANY  
LINCOLN, NEBRASKA

**GROUP DENTAL AND EYE CARE INSURANCE POLICY**

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<b>The Policyholder</b>	<b>WALKING HORSE TRAINERS ASSOCIATION, INC.</b>	<b>Policy Number</b>	<b>10-35007</b>
<b>State of Delivery</b>	<b>Tennessee</b>	<b>Plan Effective Date</b>	<b>April 1, 2010</b>
<b>Premium Due Date 1st of each month.</b>		<b>Renewal Date - Dental</b>	<b>April 1, 2011</b>
		<b>Renewal Date - Eye Care</b>	<b>April 1, 2012</b>

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

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

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

**AMERITAS LIFE INSURANCE CORP.**

Secretary

President

**Notice of Internal Appeal Procedures  
In accordance with Tennessee Insurance Code**

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

**Quality Control Unit  
P.O. Box 82657  
Lincoln, NE 68501-2657  
877-897-4328 (Toll-Free)402-309-2579 (FAX)**

**I. Definitions**

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

“Grievance” means a written complaint submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding benefits or claims payment, handling, or reimbursement for health care services covered under this plan, including adverse determinations.

**II. Levels of Review**

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

Expedited Internal Appeal Review - for appeals of an adverse determination involving an emergency or life-threatening situation. The expedited appeals process is not applicable to retrospective reviews.

Standard Appeal Review - for appeals of an adverse determination involving a prospective or retrospective review not meeting the criteria of an emergency or life-threatening situation.

These levels of review are discussed more fully below.

**A. Expedited Internal Appeal**

An expedited internal appeal process is available for review of an adverse determination involving an emergency or life-threatening situation. The expedited appeals process is not applicable to retrospective reviews, i.e., after the services have already been performed. This process is only applicable to those emergency situations where treatment has not yet been rendered.

A request for an expedited internal review shall be made by fax or telephone to the number(s) shown above. The appeal will be reviewed by a licensed provider and a decision concerning the review will be completed within forty-eight hours of receiving notice of the request for expedited review and the receipt of all necessary information.

Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard internal appeal process.

**B. Standard Internal Appeal Review**

Appeals concerning a grievance may be submitted in writing, via email or by telephone by an insured, their designee or their health care provider. The complainant will be kept apprised as to the status of the complaint in a timely fashion. In no event however, will the final determination be made later than 30 calendar days after receiving the formal written grievance.

### **III. Written Decision**

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

1. a description of the health care services that were denied, including, the dates of service and the name of the provider;
2. the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include a clear statement describing the basis for this decision and your ability to request the clinical rationale;
3. a clear statement that the notice constitutes the final adverse determination; and
4. a contact name and telephone number you can contact with questions.

**NOTICE CONCERNING COVERAGE  
LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND  
HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

**COVERAGE**

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, person holding such policies are not protected by this association if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy as issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contractholder;
- (6) employers' plans to the extent they are self-funded (that is not insured by an insurance company, even

if an insurance company administers them);

- (7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The Tennessee Life and Health Insurance Guaranty Association  
1200 First Union Tower  
150 4<sup>th</sup> Avenue North  
Nashville, Tennessee 37219**

**Tennessee Department of Commerce and Insurance  
500 James Robertson Parkway  
Nashville, Tennessee 37243-2433**

## TABLE OF CONTENTS

<b>Name of Provision</b>	<b>Page Number</b>
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Premiums	9050
Definitions	
Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Elimination Period	
Contribution Requirement	
Effective Date	
Termination Date	
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods, Missing Tooth Clause, Cosmetic Clause	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Orthodontic Expense Benefits	9260
Eye Care Expense Benefits	9270
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
General Provisions Continued	9323
Participation Requirements	
Termination of Policy	
Grace Period	

**SCHEDULE OF BENEFITS**  
**OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Employee Electing The Low Plan
Class 2	Employee Electing The High Plan
Class 3	Employee Enrolled In Eye Care Plan

Class Number 1

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

Type 1 Procedures	\$0
Type 2 Procedures - Each Benefit Period	\$50

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%

Maximum Amount - Each Benefit Period \$1,000

Class Number 2

**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

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period \$1,000

**ORTHODONTIC EXPENSE BENEFITS**

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

*You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the **ORTHODONTIC EXPENSE BENEFITS** page for details regarding elimination period(s), limitations and exclusions.*

Class Number 3

### **EYE CARE 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.

When a Participating Provider is used:

Deductible Amount:

Exams - Each Benefit Period	\$10
Frames	\$ 0
Lenses - Each Benefit Period	\$25

When a Non-Participating Provider is used:

Deductible Amount	\$0
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*Please refer to the **EYE CARE EXPENSE BENEFITS** page for details regarding frequency, limitations, and exclusions.*

## PREMIUMS

### TABLE OF MONTHLY PREMIUM RATES

#### Class 1

Dental Care Insurance	\$19.04 per Insured Person
	\$20.84 Spouse Only
	\$32.52 Child(ren) Only
	\$53.36 Spouse & Child(ren)

#### Class 2

Dental Care Insurance	\$22.40 per Insured Person
	\$25.04 Spouse Only
	\$32.76 Child(ren) Only
	\$57.80 Spouse & Child(ren)

#### Class 2

Orthodontic Insurance	\$0.00 per Insured Person
	\$0.00 Spouse Only
	\$3.92 Child(ren) Only
	\$3.92 Spouse & Child(ren)

#### Class 3

Eye Care Insurance	\$6.96 per Insured Person
	\$8.04 Spouse Only
	\$5.20 Child(ren) Only
	\$13.24 Spouse & Child(ren)

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

**PREMIUM DUE DATE.** The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than

monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

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

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

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

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

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

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or
2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

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

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

## DEFINITIONS

**COMPANY** refers to 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.

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

### Class Number 1

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured or the insured's spouse, for the majority of their support, to include:
  - i. natural born children;
  - ii. adopted children, eligible from the date of placement for adoption;
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 24 or older who:
  - i. is Totally Disabled due to mental or physical reasons; 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.

### Class Number 2

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured or the insured's spouse, for the majority of their support, to include:

- i. natural born children;
  - ii. adopted children, eligible from the date of placement for adoption;
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 24 or older who:
- i. is Totally Disabled due to mental or physical reasons; 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.

### Class Number 3

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured or the insured's spouse, for the majority of their support, to include:
  - i. natural born children;
  - ii. adopted children, eligible from the date of placement for adoption;
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 24 or older who:
  - i. is Totally Disabled due to mental or physical reasons; 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.

### All Classes

**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.

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

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

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

## CONDITIONS FOR INSURANCE COVERAGE

### *ELIGIBILITY*

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

#### Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employee electing the low plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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 first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> 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 employee electing the low plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

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

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

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

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

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

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.

### Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employee electing the high plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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 first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> 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 employee electing the high plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

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

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

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

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

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

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.

### Class Number 3

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employee enrolled in eye care plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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 first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> 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 employee enrolled in eye care plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

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

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

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

**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 the first of the month falling on or first following:

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.

### All Classes

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

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

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

### ***TERMINATION DATES***

#### Class Number 1

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

#### Class Number 2

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

#### Class Number 3

**INSUREDS.** The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

#### All Classes

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

## DENTAL EXPENSE BENEFITS

### Class Number 1

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

**PARTICIPATING AND NON-PARTICIPATING PROVIDERS.** The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as determined by us, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as determined by us.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. Your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee.

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

**ALTERNATIVE PROCEDURES.** If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance

for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

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

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

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

1. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
2. for any procedure begun after the insured person's insurance under this contract terminates.
3. to replace lost or stolen appliances.
4. for any treatment which is for cosmetic purposes.
5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
7. 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.
8. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
9. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
10. because of war or any act of war, declared or not.

## Class Number 2

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

**PARTICIPATING AND NON-PARTICIPATING PROVIDERS.** The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

**COVERED EXPENSES.** Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as determined by us, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as determined by us.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. Your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee.

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

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

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so

you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

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

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

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture 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 prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.
2. 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.
3. 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.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. 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.)
7. 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).
8. 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.
9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
11. because of war or any act of war, declared or not.

## TABLE OF DENTAL PROCEDURES

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

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

#### Class Number 1

- 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.

#### Class Number 2

- 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.

#### All Classes

- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Ø Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Ø Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Ø X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

**TYPE 1 PROCEDURES**

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary  
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge  
BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

**ROUTINE ORAL EVALUATION**

D0120 Periodic oral evaluation - established patient.

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

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

**COMPLETE SERIES OR PANORAMIC FILM**

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

**OTHER XRAYS**

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

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

**BITEWING FILMS**

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

**PROPHYLAXIS (CLEANING) AND FLUORIDE**

D1110 Prophylaxis - adult.

D1120 Prophylaxis - child.

D1203 Topical application of fluoride - child.

D1204 Topical application of fluoride - adult.

## TYPE 1 PROCEDURES

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

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

### SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

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

### SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

### APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

## TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary  
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge  
BENEFIT PERIOD - Calendar Year

### For Additional Limitations - See Limitations

#### LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

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.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

#### AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

#### RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

#### STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

## TYPE 2 PROCEDURES

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

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

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

### RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.

D2915 Recement cast or prefabricated post and core.

D2920 Recement crown.

D6092 Recement implant/abutment supported crown.

D6093 Recement implant/abutment supported fixed partial denture.

D6930 Recement fixed partial denture.

### SEDATIVE FILLING

D2940 Sedative filling.

### FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

### PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

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

### DENTURE REPAIR

D5510 Repair broken complete denture base.

D5520 Replace missing or broken teeth - complete denture (each tooth).

D5610 Repair resin denture base.

D5620 Repair cast framework.

D5630 Repair or replace broken clasp.

D5640 Replace broken teeth - per tooth.

### DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).

D5731 Reline complete mandibular denture (chairside).

D5740 Reline maxillary partial denture (chairside).

D5741 Reline mandibular partial denture (chairside).

D5750 Reline complete maxillary denture (laboratory).

D5751 Reline complete mandibular denture (laboratory).

D5760 Reline maxillary partial denture (laboratory).

D5761 Reline mandibular partial denture (laboratory).

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.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

### SURGICAL EXTRACTIONS

## TYPE 2 PROCEDURES

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

### OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Surgical access of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Surgical reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.

## TYPE 2 PROCEDURES

- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

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).
- D7286 Biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

### PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-GENERAL/IV

- D9220 Deep sedation/general anesthesia - first 30 minutes.
- D9221 Deep sedation/general anesthesia - each additional 15 minutes.
- D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
- D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

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.
- D9952 Occlusal adjustment - complete.

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 brush biopsy sample, microscopic examination, preparation and transmission of written report.
- D2951 Pin retention - per tooth, in addition to restoration.

## TYPE 2 PROCEDURES

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

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

Class Number 2

**TYPE 1 PROCEDURES**

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary  
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

**ROUTINE ORAL EVALUATION**

D0120 Periodic oral evaluation - established patient.

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

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

**COMPLETE SERIES OR PANORAMIC FILM**

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

**OTHER XRAYS**

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

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

**BITEWING FILMS**

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

**PROPHYLAXIS (CLEANING) AND FLUORIDE**

D1110 Prophylaxis - adult.

D1120 Prophylaxis - child.

D1203 Topical application of fluoride - child.

D1204 Topical application of fluoride - adult.

## TYPE 1 PROCEDURES

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

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

### SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

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

### SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

### APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

## TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary  
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge  
BENEFIT PERIOD - Calendar Year

### For Additional Limitations - See Limitations

#### LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

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.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

#### AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

#### RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

#### STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

## TYPE 2 PROCEDURES

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

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

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

### RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.

D2915 Recement cast or prefabricated post and core.

D2920 Recement crown.

D6092 Recement implant/abutment supported crown.

D6093 Recement implant/abutment supported fixed partial denture.

D6930 Recement fixed partial denture.

### SEDATIVE FILLING

D2940 Sedative filling.

### FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

### PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

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

### DENTURE REPAIR

D5510 Repair broken complete denture base.

D5520 Replace missing or broken teeth - complete denture (each tooth).

D5610 Repair resin denture base.

D5620 Repair cast framework.

D5630 Repair or replace broken clasp.

D5640 Replace broken teeth - per tooth.

### DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).

D5731 Reline complete mandibular denture (chairside).

D5740 Reline maxillary partial denture (chairside).

D5741 Reline mandibular partial denture (chairside).

D5750 Reline complete maxillary denture (laboratory).

D5751 Reline complete mandibular denture (laboratory).

D5760 Reline maxillary partial denture (laboratory).

D5761 Reline mandibular partial denture (laboratory).

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.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

### SURGICAL EXTRACTIONS

## TYPE 2 PROCEDURES

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

### OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Surgical access of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Surgical reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.

## TYPE 2 PROCEDURES

- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

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).
- D7286 Biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

### PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-GENERAL/IV

- D9220 Deep sedation/general anesthesia - first 30 minutes.
- D9221 Deep sedation/general anesthesia - each additional 15 minutes.
- D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
- D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

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

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

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.
- D9952 Occlusal adjustment - complete.

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 brush biopsy sample, microscopic examination, preparation and transmission of written report.
- D2951 Pin retention - per tooth, in addition to restoration.

## TYPE 2 PROCEDURES

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

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

### TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary  
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge  
BENEFIT PERIOD - Calendar Year

**For Additional Limitations - See Limitations**

#### INLAY RESTORATIONS

- D2510 Inlay - metallic - one surface.
- D2520 Inlay - metallic - two surfaces.
- D2530 Inlay - metallic - three or more surfaces.
- D2610 Inlay - porcelain/ceramic - one surface.
- D2620 Inlay - porcelain/ceramic - two surfaces.
- D2630 Inlay - porcelain/ceramic - three or more surfaces.
- D2650 Inlay - resin-based composite - one surface.
- D2651 Inlay - resin-based composite - two surfaces.
- D2652 Inlay - resin-based composite - three or more surfaces.

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.
- D2543 Onlay - metallic - three surfaces.
- D2544 Onlay - metallic - four or more surfaces.
- D2642 Onlay - porcelain/ceramic - two surfaces.
- D2643 Onlay - porcelain/ceramic - three surfaces.
- D2644 Onlay - porcelain/ceramic - four or more surfaces.
- D2662 Onlay - resin-based composite - two surfaces.
- D2663 Onlay - resin-based composite - three surfaces.
- D2664 Onlay - resin-based composite - four or more surfaces.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

#### CROWNS SINGLE RESTORATIONS

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic substrate.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.

## TYPE 3 PROCEDURES

- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.
- D2792 Crown - full cast noble metal.
- D2794 Crown - titanium.

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

### CORE BUILD-UP

- D2950 Core buildup, including any pins.
- D6973 Core build up for retainer, including any pins.

### POST AND CORE

- D2952 Post and core in addition to crown, indirectly fabricated.
- D2954 Prefabricated post and core in addition to crown.

### FIXED CROWN AND PARTIAL DENTURE REPAIR

- D2980 Crown repair, by report.
- D6980 Fixed partial denture repair, by report.
- D9120 Fixed partial denture sectioning.

### ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.
- D3330 Endodontic therapy, molar.

## TYPE 3 PROCEDURES

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.

D3346 Retreatment of previous root canal therapy - anterior.

D3347 Retreatment of previous root canal therapy - bicuspid.

D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

## SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.

D3421 Apicoectomy/periradicular surgery - bicuspid (first root).

D3425 Apicoectomy/periradicular surgery - molar (first root).

D3426 Apicoectomy/periradicular surgery (each additional root).

## SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4263 Bone replacement graft - first site in quadrant.

D4264 Bone replacement graft - each additional site in quadrant.

D4265 Biologic materials to aid in soft and osseous tissue regeneration.

D4270 Pedicle soft tissue graft procedure.

D4271 Free soft tissue graft procedure (including donor site surgery).

D4273 Subepithelial connective tissue graft procedures, per tooth.

D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).

D4275 Soft tissue allograft.

D4276 Combined connective tissue and double pedicle graft, per tooth.

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

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

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

## CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

## TYPE 3 PROCEDURES

### NON-SURGICAL PERIODONTICS

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

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).

### PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

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

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

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

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

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

### DENTURE ADJUSTMENTS

- D5410 Adjust complete denture - maxillary.
- D5411 Adjust complete denture - mandibular.
- D5421 Adjust partial denture - maxillary.
- D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

## TYPE 3 PROCEDURES

### ADD TOOTH/CLASP TO EXISTING PARTIAL

- D5650 Add tooth to existing partial denture.
- D5660 Add clasp to existing partial denture.

### DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.

### TISSUE CONDITIONING

- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

### PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
- D6094 Abutment supported crown - (titanium).
- D6194 Abutment supported retainer crown for FPD - (titanium).
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.
- D6245 Pontic - porcelain/ceramic.
- D6250 Pontic - resin with high noble metal.
- D6251 Pontic - resin with predominantly base metal.

## TYPE 3 PROCEDURES

- D6252 Pontic - resin with noble metal.
- D6545 Retainer - cast metal for resin bonded fixed prosthesis.
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
- D6600 Inlay - porcelain/ceramic, two surfaces.
- D6601 Inlay - porcelain/ceramic, three or more surfaces.
- D6602 Inlay - cast high noble metal, two surfaces.
- D6603 Inlay - cast high noble metal, three or more surfaces.
- D6604 Inlay - cast predominantly base metal, two surfaces.
- D6605 Inlay - cast predominantly base metal, three or more surfaces.
- D6606 Inlay - cast noble metal, two surfaces.
- D6607 Inlay - cast noble metal, three or more surfaces.
- D6608 Onlay - porcelain/ceramic, two surfaces.
- D6609 Onlay - porcelain/ceramic, three or more surfaces.
- D6610 Onlay - cast high noble metal, two surfaces.
- D6611 Onlay - cast high noble metal, three or more surfaces.
- D6612 Onlay - cast predominantly base metal, two surfaces.
- D6613 Onlay - cast predominantly base metal, three or more surfaces.
- D6614 Onlay - cast noble metal, two surfaces.
- D6615 Onlay - cast noble metal, three or more surfaces.
- D6624 Inlay - titanium.
- D6634 Onlay - titanium.
- D6710 Crown - indirect resin based composite.
- D6720 Crown - resin with high noble metal.
- D6721 Crown - resin with predominantly base metal.
- D6722 Crown - resin with noble metal.
- D6740 Crown - porcelain/ceramic.
- D6750 Crown - porcelain fused to high noble metal.
- D6751 Crown - porcelain fused to predominantly base metal.
- D6752 Crown - porcelain fused to noble metal.
- D6780 Crown - 3/4 cast high noble metal.
- D6781 Crown - 3/4 cast predominantly base metal.
- D6782 Crown - 3/4 cast noble metal.
- D6783 Crown - 3/4 porcelain/ceramic.
- D6790 Crown - full cast high noble metal.
- D6791 Crown - full cast predominantly base metal.
- D6792 Crown - full cast noble metal.
- D6794 Crown - titanium.
- D6940 Stress breaker.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

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

## TYPE 3 PROCEDURES

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

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

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

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

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

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

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

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

## CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.

D6972 Prefabricated post and core in addition to fixed partial denture retainer.

## ORTHODONTIC EXPENSE BENEFITS

### Class Number 2

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

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

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

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

**COVERED EXPENSES.** Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

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

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

**TREATMENT PROGRAM.** Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

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

- a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 19 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

## **EYE CARE EXPENSE BENEFITS**

### Class Number 3

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

#### **AMOUNT PAYABLE**

The Amount Payable for Covered Expenses is the lesser of:

- A. the provider's charge, or
- B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

#### **DEDUCTIBLE AMOUNT**

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

#### **PARTICIPATING AND NON-PARTICIPATING PROVIDERS**

A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

#### **COVERED EXPENSES**

Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

#### **EYE CARE SUPPLIES**

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

#### **REQUEST FOR SERVICES**

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

#### **ASSIGNMENT OF BENEFITS**

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured.

#### **EXTENSION OF BENEFITS**

We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

#### **EXPENSES INCURRED**

An expense is incurred at the time a service is rendered or a supply item furnished.

## LIMITATIONS

This plan has the following limitations.

- 1) This plan does not cover more than one Eye Exam in any 12-month period.
- 2) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.
- 3) This plan does not cover more than one set of Frames in any 24-month period.
- 4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lenses or Frame benefit.
- 5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.
  - a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
  - b. Patients whose vision can be corrected two lines of improvement on the visual activity chart when compared to best standard spectacle lens correction.
  - c. Anisometropia of 3D or more.
  - d. High Ametropia exceeding -10D or +10D in spherical equivalent.
- 6) This plan does not cover Orthoptics or vision training and any associated testing.
- 7) This plan does not cover Plano Lenses.
- 8) This plan does not cover non-prescribed Lenses or sunglasses.
- 9) This plan does not cover two pairs of glasses in lieu of Bifocals.
- 10) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
- 11) This plan does not cover medical or surgical treatment of the eyes or supporting structures.
- 12) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- 13) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

## SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

<i><b>SERVICE</b></i>	<i><b>PLAN MAXIMUM COVERED EXPENSE</b></i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Exam	Covered in Full	Up to \$ 35.00
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered in Full	Up to \$ 25.00
Lined Bifocal Lenses	Covered in Full	Up to \$ 40.00
Lined Trifocal Lenses	Covered in Full	Up to \$ 55.00
Frame	Up to \$100.00	Up to \$ 45.00
Contact Lenses*		
Elective	Up to \$115.00	Up to \$100.00
Medically Necessary	Covered in Full	Up to \$200.00

\*The contact lenses allowance applies to the contact lens exam and lenses.

## COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:
  - a. Any group or blanket insurance policy.
  - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
  - c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.
  - d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
2. "Plan" does **not** include the following:
  - a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.
  - b. Coverages for school type accidents only, including athletic injuries.
3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
  - a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.
  - b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
    - i. the parents are married;
    - ii. the parents are not separated (whether or not they ever have been married); or
    - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental and Eye Care coverage.

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

- c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
  - i. the Plan of the Custodial Parent;
  - ii. the Plan of the spouse of the Custodial Parent;
  - iii. the Plan of the non-Custodial Parent; and then
  - iv. the Plan of the spouse of the non-Custodial Parent.

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

- d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

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

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

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

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

## GENERAL PROVISIONS

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

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

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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

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

**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 \$1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

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

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

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

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

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

## GENERAL PROVISIONS (CONTINUED)

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

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

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

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

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

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

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

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

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

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

The Participation Requirements are as follows:

Percentage of Members-	20%
Percentage of Members-	N/A
Number of Members-	10

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

We may terminate this policy on the earlier of:

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

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

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

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

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

*Application is Hereby Made to*

AMERITAS LIFE INSURANCE CORP.

by: WALKING HORSE TRAINERS ASSOCIATION, INC.

whose main office address is: 1101 N MAIN ST  
SHELBYVILLE, TN 37160-2309

for Group Policy No. 10-35007

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

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

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

WALKING HORSE TRAINERS ASSOCIATION, INC.

(Full or Corporate Name of Applicant)

Dated at \_\_\_\_\_ By \_\_\_\_\_  
(Signature and Title)

On \_\_\_\_\_, 20\_\_ Witness \_\_\_\_\_  
(To be signed by Resident Agent where required by law)

**This copy is to Remain Attached to the Policy**

**WALKING HORSE TRAINER ASSOCIATION**

Sub	Policy	Res St	Employees Only	Employees + Dependents Total Lvs	Effective	Assn Situs	Address 1	Address 2	City	State	Zip5	Zip+
10	35007				20100410	TN	1101 North Main Street	P. O. Box 61	Shelbyville	TN	37162	
		AR	2	5								
		FL	11	28								
		LA	1	3								
		OR	4	10								
		NC	31	78								
		WA	3	8								
		Totals	52	132								

As of 02/23/10