

SERFF Tracking Number: AMFA-127643092 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: Tennessee State Employees Association SERFF Tr Num: AMFA-127643092 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved State Tr Num: 50320

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: TENNESSEE STATE EMPLOYEES ASSOCIATION State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Author: Janis Landon

Disposition Date: 01/03/2012

Date Submitted: 11/22/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 02/03/2012

State Filing Description:

General Information

Project Name: Tennessee State Employees Association

Status of Filing in Domicile: Not Filed

Project Number: Tennessee State Employees Association

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

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 01/03/2012

State Status Changed: 01/03/2012

Deemer Date:

Created By: Janis Landon

Submitted By: Janis Landon

Corresponding Filing Tracking Number:

Filing Description:

RE: Request for Review – Out-of-State Association Group

Tennessee State Employees Association

Dear Sir/Madam:

Ameritas Life Insurance Corp. ("Ameritas Life") is an Arkansas licensed insurer and has recently issued a group policy providing dental benefits to the members of the Tennessee State Employees Association (TSEA), situated in Tennessee. The association may have or potentially have members who are resident of Arkansas.

SERFF Tracking Number: AMFA-127643092 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

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

Therefore, Ameritas Life 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 Life 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 Life represents that the benefits of the policy are reasonable in relation to the premium charged. Enclosed are the required certification forms and the association documents.

TSEA is a non-profit Association that represents the interests and rights of state employee members. TSEA is one of the largest independent state employee organizations in the nation, and one of the most successful at improving salaries, rights and benefits of state employees.

TSEA is a unified group of active and retired state employees from all branches of state government working together toward the goals of better working conditions and improved state services.

Governed by a 19-member board of directors elected by its membership, the Association determines initiatives and goals each year at the annual Representative Assembly. Members are also actively involved at the local level through 47 chapters across the state.

Members are involved in the political process through the Association's political action committee, the Tennessee Employees Action Movement (TEAM). TEAM endorses candidates in gubernatorial and state legislative races, and provides financial and volunteer support in the races of candidates who have worked with the Association to address the concerns of employees. TSEA is a recognized voice for state employees on Capitol Hill. The Association's lobbying efforts during each legislative session have made a significant difference by achieving many improvements in employees' pay, rights and benefits.

TSEA is a powerful advocate for its members. The Association's employee rights staff provides advice, assistance and representation to members regarding job-related problems, assists members with grievances and other situations where rights have been threatened or violated.

The purpose of the Tennessee State Employees Association is to encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee.

TSEA intends to accomplish this purpose by:

- Stimulating the development of a compensation plan and working conditions for state employees which will cause people to:

SERFF Tracking Number: AMFA-127643092 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

1. Seek state employment as a career
 2. Retain a continuing interest in such employment
 3. Generate respect for and loyalty to state service
- Seeking to protect the legal rights for each active employee as they pertain to his/her employment, the civil service status of each position and seeking civil service like rights for those positions which do not have them.
 - Establishing an open channel of communication between state employees as such and the citizens of the state and their elected and appointed representatives
 - Offering a collective-voice input by state employees into the decision-making processes of state government at all levels of responsibility wherever employee interests are involved.
 - Furthering the extension and equitable enforcement of appropriate standards to govern employee selection, appointment, promotion, separation and grievance procedures in the administration of state government.
 - Advancing the enactment and faithful administration of laws and regulations to ensure job security for all qualified state employees.
 - Encouraging necessary legislation and any other essential action to safeguard the interest of both active and retired state employees.
 - Addressing itself to the full and swift solution of any problems not specifically suggested herein which involve the interests of state employees in their relations with either the administrators of state government or the citizenry of the state and its representatives

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 August 4, 2009 for true employer groups. There will be four different plan options.

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

Tennessee State Employees Association
627 Woodland Street
Nashville, TN 37206

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.

Sincerely,

Janis Landon

SERFF Tracking Number: AMFA-127643092 State: Arkansas
 Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
 Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Tennessee State Employees Association
 Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Senior Contract Analyst

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	\$50.00	11/22/2011	53990298

SERFF Tracking Number: AMFA-127643092 State: Arkansas
 Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
 Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Tennessee State Employees Association
 Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/03/2012	01/03/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/22/2011	11/22/2011	Janis Landon	12/29/2011	12/29/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Extension Request Granted	Note To Filer	Donna Lambert	12/21/2011	12/21/2011
Extention requested	Note To Reviewer	Janis Landon	12/20/2011	12/20/2011

SERFF Tracking Number: AMFA-127643092 *State:* Arkansas
Filing Company: Ameritas Life Insurance Corp. *State Tracking Number:* 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Disposition

Disposition Date: 01/03/2012

Implementation Date: 02/03/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMFA-127643092 State: Arkansas
 Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
 Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Tennessee State Employees Association
 Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Constitution and Bylaws	Approved	Yes
Supporting Document	Board of Directors and Chapter Information	Approved	Yes
Supporting Document	Financials	Approved	Yes
Supporting Document	AR Members	Approved	Yes
Supporting Document	Association Information	Approved	Yes
Supporting Document	Group Master Policy sitused in Tennessee	Approved	Yes
Supporting Document	Group Detal Certificates	Approved	Yes
Supporting Document	Articles of Incorporation	Approved	Yes

SERFF Tracking Number: AMFA-127643092 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/22/2011
Submitted Date	11/22/2011
Respond By Date	01/23/2012

Dear Janis Landon,

This will acknowledge receipt of the captioned filing.

I did not find the Articles of Incorporation. Please provide as required by 23-86-106(2)(A)(i).

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: AMFA-127643092 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/29/2011
Submitted Date 12/29/2011

Dear Donna Lambert,

Comments:

Thank you for allowing us to respond to you on this issue.

Response 1

Comments: We have provided the Articles of Incorporation. They may be located under the Articles of Incorporation subfolder located in the Supporting Documentation Tab.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Articles of Incorporation

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you

Sincerely,
Janis Landon

SERFF Tracking Number: AMFA-127643092 *State:* Arkansas
Filing Company: Ameritas Life Insurance Corp. *State Tracking Number:* 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Note To Filer

Created By:

Donna Lambert on 12/21/2011 10:35 AM

Last Edited By:

Donna Lambert

Submitted On:

01/03/2012 08:24 AM

Subject:

Extension Request Granted

Comments:

The response date has been extended an additional 30 days.

SERFF Tracking Number: AMFA-127643092 *State:* Arkansas
Filing Company: Ameritas Life Insurance Corp. *State Tracking Number:* 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Note To Reviewer

Created By:

Janis Landon on 12/20/2011 04:57 PM

Last Edited By:

Donna Lambert

Submitted On:

01/03/2012 08:24 AM

Subject:

Extention requested

Comments:

We are diligently attempting to obtain a copy of TSEA's Articles of Incorporation. We would like to request an extension to allow us to continue to do so.

Thank you

SERFF Tracking Number: AMFA-127643092 State: Arkansas
 Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
 Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Tennessee State Employees Association
 Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/03/2012
Comments:			
Attachment:			
AR Readability .pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	01/03/2012
Comments:	Applications approved by the Department on 09/10/2007 under SERFF Tracking #AMFA-125271106. These applications will be used with an applicant employer or association who is selecting dental and/or eye care coverage for their employees or members.		
Attachments:			
GR 902 7-07.pdf			
GR5882 7-07.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Constitution and Bylaws	Approved	01/03/2012
Comments:			
Attachment:			
TSEA Const and Bylaws 0608.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Board of Directors and Chapter Information	Approved	01/03/2012
Comments:			
Attachments:			
Board Members.pdf			
Chapters.pdf			

SERFF Tracking Number: AMFA-127643092 State: Arkansas
 Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50320
 Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Tennessee State Employees Association
 Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

Item Status: Approved **Status Date:** 01/03/2012
Satisfied - Item: Financials
Comments:
Attachment:
 Financials 063011.pdf

Item Status: Approved **Status Date:** 01/03/2012
Satisfied - Item: AR Members
Comments:
Attachment:
 TSEA Members in AR.pdf

Item Status: Approved **Status Date:** 01/03/2012
Satisfied - Item: Association Information
Comments:
Attachments:
 staff.pdf
 team.pdf
 lobbying.pdf
 TSEA Benefits.pdf
 TSEA marketing on website.pdf
 TSEA Dental Plans.pdf

Item Status: Approved **Status Date:** 01/03/2012
Satisfied - Item: Group Master Policy sitused in Tennessee
Comments:
Attachment:
 350706_TN_POL.pdf

SERFF Tracking Number: AMFA-127643092 *State:* Arkansas
Filing Company: Ameritas Life Insurance Corp. *State Tracking Number:* 50320
Company Tracking Number: TENNESSEE STATE EMPLOYEES ASSOCIATION
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Tennessee State Employees Association
Project Name/Number: Tennessee State Employees Association/Tennessee State Employees Association

		Item Status:	Status Date:
Satisfied - Item:	Group Detal Certificates	Approved	01/03/2012
Comments:			
Attachment:			
AR_CERT_350706.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Articles of Incorporation	Approved	01/03/2012
Comments:			
Attachment:			
TSEA Art of Incorp.pdf			

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

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

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
9000 Policy Rev. 03-08	50, with policy/certificate	Policy Cover
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: **Gail M. Garcia**
TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance
DATE: 10/24/11

 Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life Insurance Co, ou=Group Compliance, email=ggarcia@ameritas.com, c=US
Date: 2011.10.24 12:10:13 -05'00'

application

for group insurance

See reverse side for additional information.



Lincoln, NE

1. Applicant's legal name _____

2. Doing business as _____

3. _____

P.O. Box / ZIP Code _____

Street Address _____

City / State / ZIP _____

Phone No. _____

Fax No. _____

E-mail Address _____

Tax I.D. No. _____

4. What is the nature of your business or industry?

5. Eligibility

Total Number of Eligible Employees _____

Employees in Waiting Period _____

6. Are any classes or locations excluded? Yes No

Are domestic partners included? Yes No

Are retirees included? Yes No
(If yes, please use reverse side for explanation.)

7. Are any subsidiary and/or affiliated companies to be insured? Yes No

(If yes, please use reverse side to list name and location.)

8. How many hours per week equals full time employment? _____

9. Employee Participation

Employer contributes _____% of employee premium.

Tied-to-Medical (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

Non-Contributory (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

Non-Contributory, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

Contributory (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

Voluntary (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. Dependent Participation:

Employer contributes _____% of employee premium.

Tied-to-Medical (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

Non-Contributory (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

Non-Contributory, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

Contributory (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

Voluntary (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. Section 125 Plan

Election Period _____

Plan Year _____

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. **Plan is subject to ERISA (complete question 12.B.)**

Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception
(see DOL Reg. §2510.3-1(j))

B. **Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan.** Yes No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year _____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP _____

Phone No. _____ Plan Fiscal Year _____

Please Note: Applicant remains responsible for ensuring that SPD form provided by Ameritas Life Ins. Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

_____ for those employed on or before the policy effective date.
_____ for those employed after the new policy effective date.
 month(s) calendar days working days

14. Effective Date and Termination Date

Immediate
 First of Month Effective date / End of Month Termination date
 Other _____

15. Premium Payment Mode (In advance)

Monthly Quarterly Semi-Annual Annual
 Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)
If policy effective date is other than first of the month, is a first of the month premium due date desired? Yes No

Billing Options

Home Office Third-Party Administration

Contact Name

Title

Street Address

City / State / ZIP

Phone No. _____ Fax No. _____

E-mail Address

16. The following coverages are applied for:

Employee & Dependents Benefits

Dental Orthodontia Eye Care
 Other _____

Employee Only Benefits

Dental Orthodontia Eye Care
 Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. 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.

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

Coverages: Dental Orthodontia Eye Care
 Other _____

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 6: Exclusions

a. Classes, include reason for exclusion.

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

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

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 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 Georgia, Kansas, Nebraska, Oregon 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 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 _____ State _____ Date _____

Soliciting Agent: Printed Name _____
Signature _____

Signed by (Policyholder Representative): Printed name and title _____

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. Signature _____

Was a binder check received? 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.

application

for association group insurance

See reverse side for additional information.



Lincoln, NE

1. **Applicant's Legal Name** _____

2. _____

P.O. Box / ZIP Code _____

Street Address _____

City / State / ZIP _____

Phone No. _____

Fax No. _____

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 _____

Other _____

4. **Eligibility**

Total number of eligible employees _____

Employees in waiting period _____

5. **Are any Association chapters, classes of members or locations excluded?** Yes No

Are domestic partners included? Yes No

Are retirees included? Yes 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**

_____ for those employed on or before the policy effective date.

_____ 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.)

Contact Name _____

Title _____

Street Address _____

City / State / ZIP _____

Phone No. _____

Fax No. _____

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 _____
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.

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 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 Georgia, Kansas, Nebraska, Oregon 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 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 _____ State _____ Date _____

Soliciting Agent: Printed Name _____ For FL agents only, provide FL license # _____

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.

Signature _____

Signed by (Policyholder Representative): Printed name and title _____

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.

Signature _____

Was a binder check received? 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.

Amended June, 2008

**TENNESSEE STATE EMPLOYEES ASSOCIATION
CONSTITUTION**

ARTICLE I - NAME AND PURPOSE

SECTION 1. Name: The name of this organization shall be the **Tennessee State Employees Association.**

SECTION 2. Purpose and Methods: The purpose of this Association shall be to encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee. This purpose shall be accomplished by:

a. Stimulating the development of a compensation plan and working conditions for state employees which will cause people to:

1. Seek state employment as a career;
2. Retain a continuing interest in such employment; and,
3. Generate respect for and loyalty to the state service;

b. Seeking to protect the legal rights for each active employee as they pertain to his/her employment, the civil service status of each position and seeking civil service-like rights for those positions which do not have them;

c. Establishing an open channel of communication between state employees as such and the citizens of the state and their elected and appointed representatives;

d. Offering a collective-voice input by state employees into the decision-making processes of state government at all levels of responsibility wherever employee interests are involved;

e. Furthering the extension and equitable enforcement of appropriate standards to govern employee selection, appointment, promotion, separation and grievance procedures in the administration of state government;

f. Advancing the enactment and faithful administration of laws and regulations to ensure job security for all qualified state employees;

g. Encouraging necessary legislation and any other essential action to safeguard the interests of both active and retired state employees; and,

h. Addressing itself to the full and swift solution of any problems not specifically suggested herein which involve the interests of state employees in their relations with either the administrators of state government or the citizenry of the state and its representatives.

ARTICLE II - MEMBERSHIP

SECTION 1. Categories: There shall be two (2) membership categories:

a. Regular: Any active employee of the State of Tennessee.

b. Retiree: Any retired employee of the State of Tennessee.

SECTION 2. Obligations: The conditions of membership shall be:

a. Payment of dues in the amount defined by Bylaws Article II - Section 2.

b. Allegiance to the purpose of TSEA as outlined in the Constitution.

ARTICLE III - OFFICERS

SECTION 1. Elected Officers: The elected officers of the Association will be: (1) president, (2) vice president - west region, (3) vice president - middle region, (4) vice president - east region, (5) secretary, and (6) treasurer. Each of the regional vice presidents shall be elected by and from the members of the grand division they are to represent.

SECTION 2. Appointed Officer: An executive director shall be appointed, or terminated, by a two-thirds (2/3) vote of the Board of Directors. He/She shall serve as a non-voting officer of the Board.

SECTION 3. Terms of Office: The terms of office of the president, vice presidents, secretary, and treasurer shall be two (2) years.

ARTICLE IV - BOARD OF DIRECTORS

SECTION 1. Defined:

The Board of Directors shall consist of not more than nineteen (19) members. It shall be the policy-making body of the Association. It shall be comprised of the Executive Committee and twelve (12) district directors. Each district director shall be elected by and from the members of the chapters in each Board district they are to represent.

Each board district may be composed of a single county or of contiguous counties and shall include all chapters within the county or counties. A single chapter may qualify for one or more board seats based on membership. In such case, all members of the chapter shall be eligible to vote for each board seat. The districts will be equitably apportioned according to membership as of December 31, 1994, and each six years thereafter.

Beginning 1995 and each subsequent 6 years thereafter, the President, with the approval of the Board, will appoint a redistricting committee to study and recommend to the Board and the Representative Assembly a plan for 12 Board districts to be used in the Board elections beginning the following year.

The Representative Assembly will vote to ratify the election districts. Board districts will be defined in the Bylaws.

-2-

SECTION 2. May Not Hold Other Association Office:

No member of the Board of Directors may hold any other elected office in the Association at either the state or chapter level.

A Board member who holds an elected, chapter office or one who holds an elected, chapter office when elected to the Board shall be allowed to serve until such time as chapter elections are held and new officers are installed. However, no Board member shall be

allowed to hold both a chapter office and a Board seat past October 1 of the year elected to the Board.

ARTICLE V - EXECUTIVE COMMITTEE

The Executive Committee of the Board of Directors shall consist of the president, the immediate past president, the three (3) vice presidents, the secretary, and the treasurer. The executive director shall serve as an ex-officio member of the Executive Committee.

ARTICLE VI - REPRESENTATIVE ASSEMBLY

SECTION 1. Official Delegates and Chapter Selection:

The Representative Assembly shall be comprised of duly appointed representative delegates, the total number of which shall not exceed ten (10) percent of the total membership. Each chapter shall determine its delegate selection method.

SECTION 2. Allotment and Notification of Delegation Size:

The number of delegates allotted to the chapter shall be based on the membership of that chapter as of December 31 of the previous year. The chapters shall be notified of their delegation size at least ninety (90) days prior to the Representative Assembly.

SECTION 3: Purpose:

The Representative Assembly shall have the power to adopt a budget, establish general policies of the Association, and transact such business of the Association as may be legally brought before it. (See Bylaws Article VI.)

ARTICLE VII - CHAPTERS

SECTION 1. Chapter Charter:

Chapters of the Association may be formed in any county or other approved geographic area whenever fifty (50) or more members of the Association submit a signed petition requesting a charter, subject to the approval of the TSEA Board of Directors.

SECTION 2. Removal:

The charter of the chapter may be removed by two-thirds (2/3) vote of the total members of the TSEA Board of Directors if that chapter ceases to conform with the Constitution and Bylaws of the Association.

-3-

ARTICLE VIII - REGIONAL COUNCILS

SECTION 1. Council Composition:

The Regional Council for each grand division shall be comprised of the members of the TSEA Board of Directors elected from that grand division and the presidents of all chapters chartered within that grand division.

SECTION 2. Council Purpose:

The Regional Council shall act as a channel of communication between the Board of Directors and the chapters within the grand division and shall perform other duties as assigned by the TSEA Board of Directors.

ARTICLE IX - COMMITTEES

SECTION 1. Definition: All appointed bodies of the Association shall be designated as committees.

SECTION 2. Establishment and Discontinuance: The Board of Directors may establish committees and may discontinue them. Committee members shall be selected in accordance with the provisions of the Bylaws.

SECTION 3. Responsibilities: All committees shall be accountable to the Board of Directors. Each committee shall function as charged by the Board.

ARTICLE X - ELECTIONS AND VACANCIES

The president, regional vice presidents, secretary, treasurer, directors of the Board and state employee members of the State Employee Sick Leave Bank Board of Trustees shall be elected and vacant positions filled according to the provisions of the Bylaws, Article X.

ARTICLE XI - SICK LEAVE BANK BOARD OF TRUSTEES

The three (3) state employee representatives on the Board of Trustees of the State Employee Sick Leave Bank shall be Association members nominated from the grand divisions of the state and elected for staggered three year terms.

Members shall be elected by the delegates of the Representative Assembly according to provisions of the Bylaws. (See Bylaws Article X.) The position of Trustee shall not be considered as an office of the Association.

ARTICLE XII - RECORDS

Association records shall be retained according to the provisions of the Bylaws.

-4-

ARTICLE XIII - RULES OF ORDER

Meetings of the Association shall be operated according to the provisions of the Bylaws.

ARTICLE XIV - FISCAL YEAR

The fiscal and administrative year of the Association shall begin July 1 and shall end on June 30.

ARTICLE XV - AMENDMENTS

Any portion of this Constitution may be amended by the Representative Assembly by a two-thirds (2/3) vote of the delegates present and voting provided that the proposed amendment has been submitted in writing to the executive director of the Association by a chapter, or by a petition signed by twenty-five (25) members, or by the Board of Directors of the Association not later than ninety

(90) days prior to the date set for the convening of the Representative Assembly. The executive director shall cause all proposed amendments to be printed in a publication of the Association at least twenty (20) days prior to the meeting of the Representative Assembly. An amendment shall become effective on July 1 following its adoption unless the amendment includes a different specified beginning date. An amendment adopted by the Representative Assembly shall not become effective prior to the date following adjournment of the Assembly.

**TENNESSEE STATE EMPLOYEES ASSOCIATION
BYLAWS**

BYLAWS ARTICLE I - NAME AND PURPOSE

In these Bylaws the Tennessee State Employees Association also may be referred to as the Association or TSEA.

BYLAWS ARTICLE II - MEMBERSHIP

SECTION 1. Rights and Privileges:

a. Regular: Regular members in good standing shall have full rights and privileges.

b. Retiree: Retiree members shall be eligible to participate in Association activities and shall have the same rights and privileges as regular members.

SECTION 2. Dues:

a. Regular: Association dues for regular members of the TSEA shall be .00438 of the prior year's average salary of state employees as computed from information provided by the Department of Finance and Administration. The proceeds realized from .0004 of the established dues factor shall be segregated and designated to TEAM.

No adjustment of Association dues will be made until such time as there is a general salary increase in the salary awarded to the majority of state employees.

b. Retiree: Association dues for retiree members shall be three (3) dollars per month. (6/08)

BYLAWS ARTICLE III - DUTIES OF OFFICERS

SECTION 1. President: The president shall:

a. Serve as the chief executive officer of the Association;

b. Preside at the meetings of the Representative Assembly, Board of Directors, and Executive Committee;

c. Serve as an ex-officio member of all the committees of the Association;

d. Perform those duties assigned by the Constitution and Bylaws, Representative Assembly, Board of Directors, and Executive Committee;

e. Make recommendations to the Board of Directors concerning committee assignments; and,

f. Designate the West or East Regional Vice President as parliamentarian for meetings in the absence of the Middle Vice President.

g. Perform other duties as customarily belong to the office.

SECTION 2. East, Middle and West Regional Vice Presidents:

The regional vice presidents shall:

a. Preside at meetings in the absence of the president in a rotating manner;

b. Serve as chairman of the regional council in the region where elected to serve.

c. Perform those duties assigned by the Constitution and Bylaws, Representative Assembly, Board of Directors and Executive Committee.

d. The Middle Regional Vice President shall be the parliamentarian for meetings using Roberts Rules of Order and any adopted rules consistent with this Constitution and Bylaws.

SECTION 3. Secretary: The secretary shall:

- a. Be responsible for the records and minutes of the Association;
- b. Help prepare reports of the Executive Committee and the Board of Directors to the membership;
- c. Perform those duties assigned by the Constitution and Bylaws, Representative Assembly, Board of Directors, and Executive Committee.

SECTION 4. Treasurer: The treasurer shall:

- a. Supervise the financial activities of the Association;
- b. Be responsible for the accurate safe-keeping, expending, and accounting of Association funds;
- c. Submit to those duties assigned by the Constitution and Bylaws, Representative Assembly, Board of Directors, and Executive Committee.

SECTION 5. Executive Director: The executive director, under the direction of the Board of Directors, shall:

- a. Serve as the chief administrative officer;
- b. Supervise and coordinate the administrative, editorial, public relations, and professional activities of the Association;
- c. Advise and assist officers, Executive Committee, Representative Assembly, and all committees in carrying out the programs of the Association;
- d. Employ staff to fill positions after such positions have been approved by the Board of Directors; and,
- e. Perform those duties assigned by the Constitution and Bylaws.

BYLAWS ARTICLE IV - BOARD OF DIRECTORS

SECTION 1. Qualifications:

- a. All members of the Board shall be members in good standing of the Association.
- b. Any nominee for president of the Association shall have been a member in good standing of TSEA for at least three (3) consecutive years immediately preceding the deadline for receiving nominations. Any nominee for president also shall have served at least one (1) year in an elected capacity at the state or chapter level prior to the deadline for receiving nominations.
- c. Any nominee for an elected position other than president shall have been a member in good standing of the Association for at least the one (1) year immediately preceding the deadline for receiving nominations.

-2-

SECTION 2. Terms of Office: The regular term of office for a Board member shall be two (2) years. Election of the following officers shall be held in even years: president, secretary, treasurer and the six (6) district directors from the even numbered board districts. In odd years the following shall be elected: three (3) regional vice presidents and six (6) district directors from the odd numbered board districts.

SECTION 3. Past President: The succeeded president will serve as

past president, and this provision shall not preclude successive terms as president. The past president shall serve on the Board of Directors until such time as he is succeeded.

SECTION 4. Assuming Office: Board members shall assume office immediately following their election and induction and shall hold office until their successors shall have been named.

SECTION 5. Removal from Office: Any member of the Board of Directors who misses three (3) scheduled meetings of the Board of Directors during a fiscal year may be removed by a two-thirds (2/3) majority vote of the Board of Directors.

SECTION 6. Meetings and Quorum: The Board of Directors shall meet at least eight (8) times annually in regular session and upon call of the president. Only those portions of Board meetings dealing with formal member grievance items, legislative matters, or possible litigation can be held in executive session. All members wishing to address the Board will be allowed to speak at the open Board meeting. The president will allow at least thirty (30) minutes for the total speaking time if there are members who wish to speak. Each member of the Board shall be notified of the time and place of meetings. A majority of the voting membership of the Board shall constitute a quorum.

SECTION 7. Powers and Duties: The powers and duties of the Board shall be:

- a. To serve as the executive body of the Association;
- b. To carry out the work, between meetings of the Representative Assembly, for which the Association is established;
- c. To fix the time and place of the annual statewide meeting of the Representative Assembly;
- d. To employ the executive director who shall serve as the chief administrative officer of the Association and to fix his/her compensation;
- e. To fix bond for the officers and any other employees vested with handling funds of the Association;
- f. To establish policies for the operation of the Association headquarters;
- g. To direct the affairs of the Association and to carry out its policies as determined by the Representative Assembly and this Constitution and Bylaws;

-3-

- h. To oversee the financial operation of the Association;
- i. To transfer funds from one category to another within the budget;
- j. To provide for an annual audit of the Association funds by a certified public accountant;
- k. To make appointments to committees based on the recommendations of the Association's president;
- l. To prepare a proposed agenda, rules of order, and budget for Representative Assembly action;
- m. To present recommendations to the Representative Assembly on any proposed constitutional amendment, policy, program or position of the Association;
- n. To develop objectives and programs for the achievement of stated purpose and to provide for continuing evaluation and

improvement of programs; and,

o. To perform those duties assigned it by the Constitution and Bylaws and by the Representative Assembly.

BYLAWS ARTICLE V - EXECUTIVE COMMITTEE

SECTION 1. Powers and Duties: The Executive Committee shall have the power to act for the Board of Directors on all matters delegated to it by the Board and on those items of Association business that cannot acceptably await the next Board meeting. The Executive Committee shall be responsible to the Board at all times and shall report in writing any actions to the Board at its next regular meeting. The Executive Committee shall have input into the interviewing and hiring of a **membership director**.

SECTION 2. Meetings: The Executive Committee shall meet upon call of the president or upon written request of a majority of the Executive Committee.

SECTION 3. Quorum: A quorum of the Executive Committee shall be four (4) members.

BYLAWS ARTICLE VI - REPRESENTATIVE ASSEMBLY

SECTION 1. Delegates: Each chapter chartered by the Board of Directors shall be entitled to two (2) delegates for the first fifty (50) chapter members and one (1) delegate for each additional fifty (50) members or major fraction thereof. In addition, each chapter president shall be entitled to serve as a chapter delegate. Each chapter shall be entitled to a minimum of four (4) delegates. Each member of the TSEA Board of Directors shall serve as a delegate. No individual may serve as a delegate until membership dues shall have been paid or authorized through payroll deduction. Each chapter delegate must be a member of the chapter he/she is to represent. Delegate credentials shall be issued to any eligible member of the Association who shall be designated by the president and secretary of the member's chapter as having been selected a delegate by that chapter.

-4-

SECTION 2. Meetings: The Representative Assembly shall meet annually at a time and place established by the Board of Directors.

SECTION 3. Quorum: A quorum for convening the business session of the Representative Assembly shall be a majority of those registered as official delegates at said Representative Assembly.

SECTION 4. Voting: In all voting in the Representative Assembly each certified delegate is entitled to one (1) vote. In the case of a chapter having less than a full delegation, proxy votes shall be certified for the entitled number of votes. Proxy votes may be issued. No delegate may have more than his vote and one proxy vote. In case of disputed votes, the Board of Directors shall have the power to act.

SECTION 5. Governing Rules: The Representative Assembly shall operate under the provisions of the Constitution and Bylaws and under such rules of order consistent therewith as may be adopted by it. The most recently revised edition of Robert's Rules of Order

shall govern the meeting in all particulars not otherwise specified.

SECTION 6. Committees: The president shall appoint the committees necessary to assist in conducting the business of the Representative Assembly.

SECTION 7. Actions: When action is taken by the Representative Assembly which supersedes previously adopted Assembly action, all previously established policies, positions, and statements shall be considered to have been simultaneously amended to reflect the most recently adopted action. It shall be the responsibility of the president and executive director to see that all such policies, positions and statements are in conformity with the most recent Representative Assembly action.

BYLAWS ARTICLE VII - CHAPTERS

There are no bylaws relative to Chapters.

BYLAWS ARTICLE VIII - REGIONAL COUNCILS

There are no bylaws relative to Regional Councils.

BYLAWS ARTICLE IX - COMMITTEES

SECTION 1. Appointment: Committee members shall be recommended by the president and approved by the Board of Directors.

SECTION 2. Qualifications: Any member of a committee shall have been a member in good standing of the Tennessee State Employees Association for at least the one (1) year immediately before being appointed to a committee.

-5-

SECTION 3. Representation: Committees as a whole and individually, insofar as possible, shall reflect a representative balance of the various departments of state government, the geographic regions of the state, and the individual chapters across the state. Committee appointments shall be made without discrimination on the basis of gender, race, or religion.

BYLAWS ARTICLE X - ELECTIONS AND VACANCIES

SECTION 1. Election Districts: The membership or the delegates of the Representative Assembly shall elect persons to fill all positions as required by the Constitution in the following manner:

a. The Eastern, Middle and Western Grand Divisions or regions as used by the Association shall conform to the geographic areas officially designated by the State of Tennessee; however, multiple county chapters shall not be divided in order to conform. In such cases, the Board of Directors shall determine the appropriate grand division.

b. The president, secretary and treasurer shall be elected at large by the members of the Association.

c. The three (3) regional vice presidents shall be elected by and from members of the respective grand division - one each from the Eastern, Middle and Western Grand Divisions.

d. Twelve (12) district members of the Board of Directors

shall be elected by and from chapter members of the following 12 board election districts as defined by the Representative Assembly as of July 1, 1995, and each six years thereafter.

Districts consist of the following:

DISTRICT 1 CHAPTERS

Hatchie River (*Haywood, Lauderdale, Tipton*)
Pioneer (*Crockett, Gibson*)
Reelfoot (*Dyer, Lake, Obion*)
WHBC (*Benton, Carroll, Henry, Weakley*)

Cumberland Plateau (*Cumberland, Fentress*)
Morgan (*Morgan*)
Roane (*Roane*)
Tealeaf (*Rhea*)
Upper Cumberland (*Clay, Jackson, Overton, Pickett, Putnam, White*)

DISTRICT 2 CHAPTER

Shelby (*Shelby*)

DISTRICT 3 CHAPTERS

CHAD (*Chester, Decatur, Henderson*)
Fayette (*Fayette*)
Forked Deer (*Madison*)
Southwest (*Hardeman, Hardin, McNairy*)

- 6 -

DISTRICT 9 CHAPTERS

Caney Fork (*Cannon, DeKalb, Grundy, Warren*)
Fall Creek Falls (*Bledsoe, Sequatchie, Van Buren*)
Hamilton (*Hamilton*)
Hiwassee (*Bradley, McMinn, Meigs, Polk*)
Marion (*Marion*)

DISTRICT 4 CHAPTERS

Highland Rim (*Dickson, Houston, Humphreys*)
Sycamore (*Cheatham, Robertson*)
TWS (*Smith, Trousdale, Wilson*)
Volunteer (*Macon, Sumner*)

DISTRICT 4 CHAPTERS (cont.)

Warioto (*Montgomery, Stewart*)

DISTRICT 10 CHAPTERS

Anderson (*Anderson*)
Knox (*Knox*)
Norris Lake (*Claiborne, Union*)
University of Tennessee

DISTRICT 5 CHAPTER

Davidson (*Davidson*)

DISTRICT 6 CHAPTER

Davidson (*Davidson*)

DISTRICT 11 CHAPTERS

Appalachian (*Carter, Johnson, Unicoi, Washington*)
East Tennessee State Univ.
Lakeway (*Grainger, Hamblen, Hancock, Hawkins*)
Northeast (*Sullivan*)

DISTRICT 7 CHAPTERS

David Crockett (*Lawrence*)
Giles/Lincoln (*Giles, Lincoln*)
Maury/Marshall (*Marshall, Maury*)
Rutherford County (*Rutherford*)
South 40 (*Hickman, Lewis, Perry*)
Three Rivers (*Bedford, Coffee, Moore*)
Tims Ford (*Franklin*)
Wayne (*Wayne*)
Williamson (*Williamson*)

DISTRICT 12 CHAPTERS

Foothills (*Blount, Loudon, Monroe*)
French Broad (*Cocke, Jefferson*)
Greene (*Greene*)
Smoky Mountain (*Sevier*)

DISTRICT 8 CHAPTERS

Campbell/Scott (*Campbell, Scott*)

e. The three (3) Trustees for the State Employee Sick Leave Bank shall be elected by delegates of the Representative Assembly from the respective grand division - one each from the East, Middle and West Grand Divisions.

SECTION 2. Nominations:

a. Nominations for positions on the Board of Directors shall be made in writing, be signed by the nominee, and include signatures of 25 TSEA members. The letter of nomination must state the position that is desired and be submitted to the executive director at least sixty (60) days prior to the date set for the mailing of the ballots. Any nominee shall be qualified for the position as required in Bylaws Article IV. The executive director shall cause to be printed a picture and biographical sketch of each candidate in a

publication of the Association that is mailed to each member at least twenty (20) days prior to ballots being mailed.

b. Nominations for positions on the State Employee Sick Leave Bank Board of Trustees shall be made in writing, be signed by the nominee and include signatures of 25 TSEA members. The letter of nomination must state the nominee's TSEA chapter and state department and be submitted to the executive director no later than sixty (60) days prior to the date set for the convening of the Representative Assembly. Any nominee shall be qualified for the position as required in Bylaws Article XI. The executive director shall cause to be printed a picture and biographical sketch of each candidate in a publication of the Association that is mailed to each member at least twenty days (20) prior to the Representative Assembly.

c. All nominations shall be reported to the Board at least forty-five (45) days prior to the election date as established by the Board.

d. No individual may be placed on a ballot for more than one elected position.

SECTION 3. Withdrawals: An announced candidate or nominee may withdraw at any time prior to the closing of nominations for the respective race by notifying the president or executive director in

-7-

writing or personally. Once nominations for a race have been closed, one cannot withdraw from the ballot.

SECTION 4. Voting:

a. The election of executive officers and the Board of Directors shall be held during the month of June each year on the date established by the Board. The membership of the Association shall be given an opportunity to vote for the executive officers and Board members by mail ballot. Ballots shall be mailed to all members at their last known address at least thirty (30) days prior to the election. In the event only one qualified nominee is presented as required in Section 2 of this article, said nominee shall be deemed elected and the position shall not be included on any ballot mailed to members. Candidates' names shall be listed by position in alphabetical order on the ballot. The names of those nominees to be elected by and from each grand division shall appear only on the ballot to be mailed to members in the respective grand division. Any ballot received after the date established by the Board as the election day shall not be counted in the official tabulation.

b. The election of TSEA members to the State Employee Sick Leave Bank Board of Trustees shall be voted upon by secret ballot only by official delegates to the Representative Assembly. The ballot shall be made up of names of all qualified candidates nominated as required in Section 2 of this Article. Candidates' names shall be listed in alphabetical order on the ballot. In the event the name of only one nominee is presented, said nominee shall be elected by voice vote.

c. All positions to be filled by election shall be by plurality vote. In case of a tie vote for any elective position, the Board of Directors as constituted prior to the election shall cast one tie-breaker vote for the nominees involved in the tie.

Such tie-breaker vote shall be determined by a majority vote of the members of the Board.

d. All nominees or their designated representative and any member of the Board may be present at the official tabulation of the ballots.

SECTION 5. Election Committee: An Election Committee shall be appointed by the president from members of the Association and shall be charged with the duties of verifying candidates, conducting any Representative Assembly election, counting the votes and certifying the results. Copies of said certification shall be presented to the Board and to each candidate or designated representative.

SECTION 6. Vacancies:

a. The Board of Directors shall have the power to fill any declared vacancy or any vacancy due to death, resignation from the position, Association membership cancellation or leaving state employment.

- 8 -

1. Any regional Board position filled by a member whose chapter membership changes from the region in which elected to serve shall be declared vacant.

2. Any Board member who misses three (3) meetings in any fiscal year without such absences being approved by the Board as justifiable shall be declared as having resigned and the position declared vacant upon a two-thirds (2/3) vote of the Board.

3. Any member of the Board who is elected to another position that would place said member on the Board shall relinquish the original position upon assuming the duties of the second position and the original position shall be declared vacant.

b. In the event that any executive officer, director, or Sick Leave Bank Board Trustee position shall become vacant, that position shall be filled for the unexpired term by nomination by the President and election by the Board of Directors. If the vacancy is that of the President, the Interim President shall be nominated and elected by and from members of the Board of Directors to fill the unexpired term. Such election shall be by a majority of the members of the Board of Directors.

SECTION 7. Challenges and Recounts: A challenge or a request for a recount must be made in writing to the president or the executive director by a candidate in the race in question within twenty-four (24) hours following the election certification. The president and the executive director shall establish a time, place and procedure for the recount. If a request for recount is made without challenging the election procedures, the results of the recount will be certified and the winner seated. A challenge must include the specific provision of the TSEA Constitution and Bylaws, Standing Rules or policy which was allegedly violated. The Executive Committee shall review all challenges and rule upon them. The decision of the Executive Committee shall be provided in writing to each candidate involved in the challenged election. Any candidate in the challenged election may appeal the decision of the Executive Committee to the Board of Directors by filing a written request to the president or executive director within thirty (30) days of the receipt of the Executive Committee's decision. The decision of the

Board shall be final. For a challenge to merit being sustained, the election being declared void, and a vacancy declared, its validity must be established and clear evidence must show that the outcome of the election could have been significantly altered or reversed. In the event a challenge is sustained and a vacancy is declared, such shall be filled according to Section 6 of this Article.

BYLAWS ARTICLE XI - SICK LEAVE BANK BOARD OF TRUSTEES

SECTION 1. Qualifications:

a. All members of the Sick Leave Bank Board of Trustees representing employees shall be members in good standing of the Association.

- 9 -

b. Any nominee for an employee position on the Board of Trustees shall have been a member in good standing of the Association for at least the one (1) full year immediately preceding the deadline for receiving nominations.

c. Any nominee for a position shall be from a department other than those already represented by an employee representative on the Board of Trustees.

BYLAWS ARTICLE XII - RECORDS

The statute of limitations of the State of Tennessee shall be followed in retaining records which have legal significance.

BYLAWS ARTICLE XIII - RULES OF ORDER

Roberts Rules of Order shall govern all parliamentary procedures not otherwise specified.

BYLAWS ARTICLE XIV - FISCAL YEAR

There are no bylaws relative to Fiscal year.

BYLAWS ARTICLE XV - AMENDMENTS

Any portion of these Bylaws may be amended by the Representative Assembly by a majority vote of the delegates present and voting provided that the proposed amendment has been submitted in writing to the executive director of the Association by a chapter, or by a petition signed by twenty-five (25) members, or by the Board of Directors of the Association not later than ninety (90) days prior to the date set for the convening of the Representative Assembly. The executive director shall cause all proposed amendments to be printed in a publication of the Association at least twenty (20) days prior to the meeting of the Representative Assembly. An amendment shall become effective on July 1 following its adoption unless the amendment includes a different specified beginning date. An amendment adopted by the Representative Assembly shall not become effective prior to the date following adjournment of the Assembly.

ADOPTED SEPTEMBER, 1974
AMENDED JUNE 15, 2002
LAST AMENDED JUNE 14, 2008



Tennessee State Employees Association

To encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee

- [JOIN TODAY!](#)
- [HOME](#)
- [MEMBERS](#)
- [HISTORY](#)
- [LOBBYING](#)
- [BOARD MEMBERS](#)
- [TSEA STAFF](#)
- [TEAM POLITICAL ACTION COMMITTEE](#)
- [FIND A LOCAL CHAPTER](#)
- [MEDIA](#)
- [FAQ](#)
- [SUGGESTED LINKS](#)
- [CONTACT US](#)

Board Members



Philip Morson - *President*

322 Harris Street
 Bolivar, TN 38008
Home: (731) 609-8758
Work: () -
[Philip Morson \(home\)](#)
[Philip.Morson \(work\)](#)



James Ruth - *East TN Vice President*

6265 Woodcrest Drive
 Morristown, TN 37814
Home: (865) 385-7884
Work: (865) 397-0174 x135
[Jim Ruth\(home\)](#)
[James.Ruth \(work\)](#)



Donnie Cole - *Middle TN Vice President*

920 Rock Creek Road
 Estill Springs, TN 37330
Home: (931) 649-2825
Work: (931) 461-7720
Fax:
[Donnie Cole \(work\)](#)



Almous Austin - *West TN Vice President*

1031 Austin Rd.
 Newbern, TN 38059
Home: (731) 627-2431
Work: (731) 253-7070
Fax: (731) 627-9939
[Almous Austin](#)



Jackie Coleman - *Secretary*

2602 Brittany Dr.
 Nashville, TN 37206
Home: (615) 226-0444
Pager: (615) 821-0444
Work: (615) 231-5337
Fax: (615) 228-7284
[Jackie Coleman](#)

< September 2011 >									
				1	2	3			
4	5	6	7	8	9	10			
11	12	13	14	15	16	17			
18	19	20	21	22	23	24			
25	26	27	28	29	30				

Click highlighted dates for important Association information

- [Join TSEA!](#)
- [Member Login](#)
- [Cut Waste, Not Services](#)

View our State Map

Click Here to find out what is happening in Tennessee Government

**Ernest Tisdale - Treasurer**

P O Box 521
 Whiteville, TN 38075-0521
Work: 731-228-2295
Home: 731-254-8453
[Ernest.Tisdale \(work\)](#)

**Bettye Kirkpatrick - District 1 Director**

931 Becton Williams Road
 Ripley, TN 38063
Home: (731) 635-2011
Work: Retired
Cell: (731) 413-7310
[Bettye Kirkpatrick](#)

**Paul Cade - District 2 Director**

5504 Millers Glen Lane
 Memphis, TN 38125
Home: (901) 737-5059
Work: (901) 678-2791
[Paul Cade](#)
[Paul Cade\(work\)](#)

**Betty Davis - District 3 Director**

5505 Old Friendship Rd.
 Finger, TN 38334-1958
Work: 731-228-2000 x2194
Home: 731-608-1895
[Betty Davis \(work\)](#)

**Terrie Goble - District 4 Director**

3249 Oakridge Rd.
 Palmyra, TN 37142
Home: (931) 326-9383
Work: (931) 648-5572
[Terrie.Goble \(work\)](#) (work)
[Terrie Goble](#)

**Martha Wettemann - District 5 Director**

714 Darrow Drive
 Pleasant View, TN 37146
Home: (615) 746-8916
Work: (615) 253-6884
[Martha Wettemann](#)
[Martha Wettemann \(work\)](#)

**Arlene Martin-Norman - District 6 Director**

681 Brewer Dr.
Nashville, TN 37211
Home: (615) 833-5893
Work: (615) 253-0042
[Arlene.Martin-Norman \(work\)](#)
[Arlene Martin-Norman](#)



Vacant - District 7 Director



Tommy Francis - District 8 Director

197 Liberty Road
Wartburg, TN 37887
Home: (865) 776-1146
Work: (423) 346-1300 x1664
[Tommy Francis](#)
[Tommy Francis \(work\)](#)



Steve Thomas - District 9 Director

2706 Pine Dr. NE
Cleveland, TN 37312
Home: (423) 421-1882
Work: (423) 338-5332 ext 109
[Steve Thomas](#)
[stephen.thomas \(work\)](#)



Ms. Betty Hardin - District 10 Director

215 Widow Newman Lane
Knoxville, TN 37924-3418
Work: (865) 594-2458
Home: (865) 932-0273
Fax: (865) 594-6341
[Betty Hardin \(home\)](#)



Bryan Merritt - District 11 Director

107 Old Farm Rd.
Erwin, TN 37650
Work: (423) 743-3166 x24
Cell: (423) 956-4521
[Bryan Merritt \(work\)](#)
[Bryan Merritt](#)



Don Burnette - District 12 Director

3140 Joppa Mountain Road
Powder Springs, TN 37848-7002
Work: 865-397-0174 X314
Home: 865-497-2656

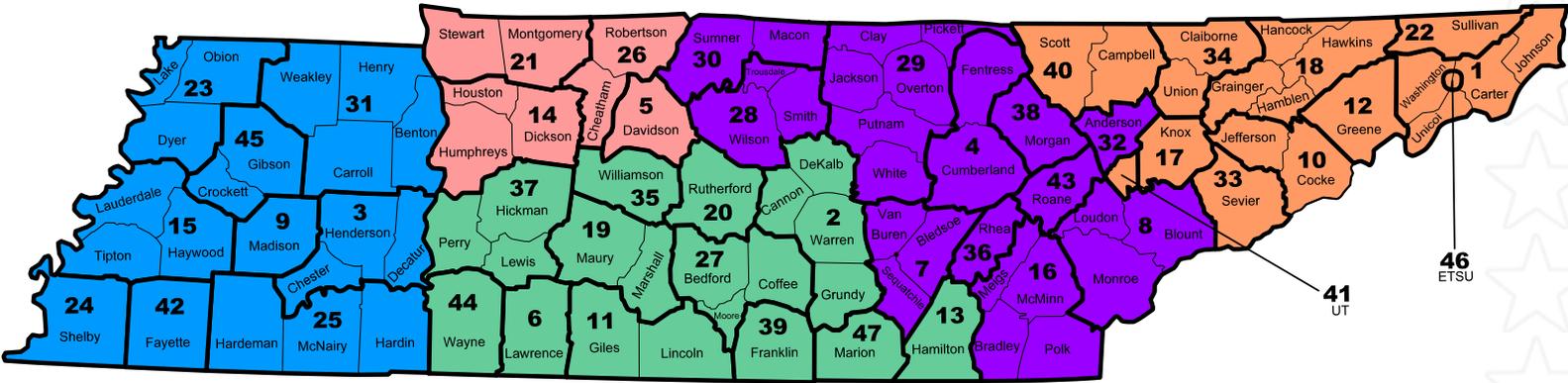
[donald.burnette \(work\)](#)
[Don Burnette\(home\)](#)

© 2008 The Official Web Site of the Tennessee State Employees Association

Site Design and Hosting by: iDesign, inc

TSEA Chapters

Click on your county to find your TSEA Field Representative and their contact information.



Field Representatives

- Lisa Hogue-Moffet, District 1
- Terrell Gregory, District 2
- Gary Pinson, District 3
- Terry Carroll, District 4
- Gayle Williams, District 5

Tennessee State Employees Association
Statement of Activities
For the Twelve Months Ending June 30, 2011

	Actual Year to Date	Budget Year to Date	Variance Year to Date
Revenues			
Dues Income	\$ 2,038,549.83	2,112,480.00	(73,930.17)
Interest Income	277.83	1,000.00	(722.17)
TEAM Administrative Fees	53,724.00	71,724.00	(18,000.00)
Miscellaneous Income	31,055.52	24,500.00	6,555.52
Representative Assembly Income	3,300.27	0.00	3,300.27
Legal Fees Earned	0.00	2,000.00	(2,000.00)
Sales - Logo Merchandise	125.00	0.00	125.00
Fundraising	2,319.06	1,500.00	819.06
Member Benefits Tickets	17,210.47	0.00	17,210.47
Total Revenues	2,146,561.98	2,213,204.00	(66,642.02)
Cost of Sales			
Cost of Sales - Logo Merch	1,847.43	0.00	1,847.43
Fundraising Costs	372.50	0.00	372.50
Member Benefits Tickets Cost	12,443.74	0.00	12,443.74
Total Cost of Sales	14,663.67	0.00	14,663.67
Gross Profit	2,131,898.31	2,213,204.00	(81,305.69)
Expenses			
Salaries & Benefits	1,341,922.58	1,290,000.00	51,922.58
Awards	1,127.01	1,000.00	127.01
Donations	0.00	700.00	(700.00)
Dues & Subscriptions	11,186.93	15,000.00	(3,813.07)
Government Relations	45,076.42	25,000.00	20,076.42
Insurance	43,384.64	58,500.00	(15,115.36)
Legal Fees	24,371.09	100,002.37	(75,631.28)
Maintenance	38,696.77	50,000.00	(11,303.23)
Member/Leader Involvement	150,594.43	143,165.29	7,429.14
Miscellaneous	1,474.94	5,000.00	(3,525.06)
Postage	76,355.07	75,000.00	1,355.07
Printing	102,428.76	86,000.00	16,428.76
Professional Fees	24,901.83	25,000.00	(98.17)
Recruitment	24,430.81	65,000.30	(40,569.49)
Staff Training	25.00	2,000.00	(1,975.00)
Supplies	15,826.08	20,001.33	(4,175.25)
Taxes	19,493.95	22,000.00	(2,506.05)
Telephone	21,472.46	27,000.00	(5,527.54)
Temporary Services	6,731.60	70,000.00	(63,268.40)
Travel, Board & President	43,808.34	45,000.00	(1,191.66)
Travel, Staff	56,261.61	60,000.00	(3,738.39)
Utilities & Housing	23,054.81	27,000.00	(3,945.19)
Depreciation	45,000.00	0.00	45,000.00
Total Expenses	2,117,625.13	2,212,369.29	(94,744.16)
Net Income	\$ 14,273.18	834.71	13,438.47

Tennessee State Employees Association
Statement of Financial Position
June 30, 2011

ASSETS

Current Assets

Cash - Current Funds	\$ 292,612.73
Cash - Chapter Funds	17,268.63
Cash - Crisis Fund	168,373.73

Total Cash **478,255.09**

Accounts Receivable	161,553.03
Inventory	16,227.78
Prepaid Expense	22,426.24

Total Current Assets **678,462.14**

Property and Equipment

Furniture, Autos, & Equipment	1,635,717.75
Accumulated Depreciation	(904,179.92)

Total Property and Equipment **731,537.83**

Total Assets **\$ 1,409,999.97**

LIABILITIES AND NET ASSETS

Current Liabilities

Accounts Payable	\$ 97,470.59
Accrued Leave Payable	143,703.74
FUTA Tax Payable	(1,206.09)
State Payroll Tax Payable	(0.39)
SUTA Payable	(3,667.58)
Pension - TCRS Payable	4,195.74
Employee TEAM Payable	38.66
Employee ECP2	1,152.86

Total Current Liabilities **241,687.53**

Total Liabilities **241,687.53**

Net Assets

Fund Balance - Unrestricted	705,112.95
Fund Balance - Current	448,926.31
Net Income	14,273.18

Total Net Assets **1,168,312.44**

Total Liabilities & Net Assets **\$ 1,409,999.97**

AR TSEA Members

Tennessee State Employees Association						
Arkansas Members						
Title	First Name	Last Name	Home Address	Home City	Home State	Home Zip
Ms.	Rika	Hudson	407 Birdie Dr Apt 5	Marion	AR	72364-1654
Mr.	James	Hudson	152 Morningside Dr	Marion	AR	72364-3019
Ms.	Gwynn	Kersey	PO Box 1462	Marion	AR	72364-1462
Mr.	Jonathan	Thompson	704 N Roselawn Dr	West Memphis	AR	72301-1948
Ms.	Erica	Thorn	413 Bridge Drive Apt. 4	Marion	AR	72364-8716
Ms.	Kendra	Moore	503 Oxford St	West Memphis	AR	72301-4123
Mr.	David	Mouser	8779 Mopac Rd	Brinkley	AR	72021-9364
Mr.	Michael	Pufahl	139 Alpe Ln	Crawfordsville	AR	72327-2017
Ms.	Jacqueline	Stewart	PO Box 414	West Memphis	AR	72303-0414
Ms.	Charneka	Gage	611 River Oaks Dr	Marion	AR	72364-9048
Ms.	Eunice	Hall	PO Box 2452	West Memphis	AR	72303-2452
Ms.	Karen	Kirkwood	103 Woodard St	Forrest City	AR	72335-7832
Ms.	Margaret	Ray	107 Leawood Ct	Jonesboro	AR	72401-5958

AR TSEA Members



Tennessee State Employees Association

To encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee

- JOIN TODAY!
- HOME
- MEMBERS
- HISTORY
- LOBBYING
- BOARD MEMBERS
- TSEA STAFF
- TEAM POLITICAL ACTION COMMITTEE
- FIND A LOCAL CHAPTER
- MEDIA
- FAQ
- SUGGESTED LINKS
- CONTACT US

Staff

How to Contact TSEA

Telephone:
(615) 256-4533
(800) 251-TSEA (8732)

Fax:
(615) 242-6329

Address:
627 Woodland Street
Nashville, TN 37206

Please send Member Contact Information Changes to linda.darden@tseonline.org or junie.rolens@tseonline.org or mail to the address above.

Our Staff



Robert O'Connell - Executive Director

robert.a.oconnell@tseonline.org



Susan Atwell Wells - Membership Director

susan.atwell@tseonline.org



Sarah Adair - Government Affairs Director

sarah.adair@tseonline.org

John Cahill - Accountant II

john.cahill@tseonline.org

< September 2011 >									
				1	2	3			
4	5	6	7	8	9	10			
11	12	13	14	15	16	17			
18	19	20	21	22	23	24			
25	26	27	28	29	30				

Click highlighted dates for important Association information

- Join TSEA!
- Member Login
- Cut Waste, Not Services

View our State Map

Click Here to find out what is happening in Tennessee Government



Tim Clo - Accountant I

tim.clo@tseonline.org



Chris Dauphin - Communications Manager

chris.dauphin@tseonline.org



Jonathan Stephens - Staff Attorney

jonathan.stephens@tseonline.org



Jo Ann Davis-Davis - Employee Rights Manager

joann.davis-davis@tseonline.org



Joyce Foley - Employee Rights Representative

joyce.foley@tseonline.org



Susan O'Bryan - Administrative Assistant for Employee Rights



susan.obryan@tseaonline.org



Gwen Tuttle - *Employee Compensation and Benefits Manager*

gwen.tuttle@tseaonline.org



Gayle Robb - *Employee Compensation and Benefits Representative*

gayle.robbs@tseaonline.org



Lisa Hogue-Moffett - *Field Representative District 1*

lamtsea08@yahoo.com



Terrell Gregory - *Field Representative District 2*

terrell.gregory@tseaonline.org



Gary Pinson - *Field Representative District 3*

gary.pinson@tseaonline.org

Terry Carroll - *Field Representative District 4*



terry.carroll@tseonline.org



**Gayle Williams - Field
Representative District 5**

gayle.williams@tseonline.org



**LaTanya McAdoo - Executive
Administrative Assistant**

latanya.mcadoo@tseonline.org



**Linda Cartwright-Darden -
Administrative Assistant for
Membership**

linda.darden@tseonline.org



Junie Rolens - Receptionist

junie.rolens@tseonline.org

© 2008 The Official Web Site of the Tennessee State Employees Association

Site Design and Hosting by: iDesign, inc



Tennessee State Employees Association

To encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee

- [JOIN TODAY!](#)
- [HOME](#)
- [MEMBERS](#)
- [HISTORY](#)
- [LOBBYING](#)
- [BOARD MEMBERS](#)
- [TSEA STAFF](#)
- [TEAM POLITICAL ACTION COMMITTEE](#)
- [FIND A LOCAL CHAPTER](#)
- [MEDIA](#)
- [FAQ](#)
- [SUGGESTED LINKS](#)
- [CONTACT US](#)

TEAM Administrative Committee

TSEA's Endorsed Candidates

The Tennessee Employees Action Movement (TEAM) is TSEA's political action arm. Through TEAM, TSEA members are active participants in the political process. TEAM takes an active role in seeking the election of the best candidates for governor, the state Senate, and the state House — those who value state employees and support improved working conditions. TEAM makes endorsements and provides financial contributions for such campaigns.

TEAM is governed by a nine-member administrative committee with three members elected from each of the state's three regions. The TEAM Administrative Committee directs objectives, policies and procedures.

East Region:



Terry C. Anderson - Vice Chair

1877 Sluder Road
 Shady Valley, TN 37688
Home: (423) 739-9021
Work: (423) 727-7387
[Terry C. Anderson](#)



Brian Merritt

107 Old Farm Rd.
 Erwin, TN 37650
Mobile: (423) 956-4521
[Bryan Merritt](#)



Jane Callahan

2364 Timber Trace Pl NW
 Cleveland, TN 37311
Home: (423) 255-2693
Work: (423) 478-0300 ex1128
[Jane Callahan](#) (work)
[Jane Callahan](#) (home)

Middle Region:



Pat Bowman

P.O. Box 544
 Columbia, TN 38402-0544
Home: (931) 379-7206
Work: (931) 540-2600
[Pat Bowman](#) (work)
[Pat Bowman](#)(home)

< September 2011 >									
				1	2	3			
4	5	6	7	8	9	10			
11	12	13	14	15	16	17			
18	19	20	21	22	23	24			
25	26	27	28	29	30				

Click highlighted dates for important Association information

- [Join TSEA!](#)
- [Member Login](#)
- [Cut Waste, Not Services](#)

View our State Map

Click Here
to find out what is happening in Tennessee Government



Jacquelyn F. Coleman - Secretary

2602 Brittany Drive
 Nashville, TN 37206
Work: (615) 231-5337
[Jacquelyn F. Coleman](#)



Tom Osborne - Treasurer

2008 Overhill Drive
 Nashville, TN 37215
Home: (615) 297-4031
Work: (615) 313-5367
[Tom Osborne](#)

West Region:



James Braswell - Chair

4275 Canadaville Loop
 Eads, TN 38028-9998
Home: (901) 853-4466
[James Braswell](#)



Bob Buss

5579 Melvin Road
 Memphis, TN 38120
Home: (901) 761-9879 (Retired)



Tom Haynes

4890 Shifri Ave
 Memphis, TN 38117
Home: (901) 761-9795

[Back to top](#)

TSEA's Endorsed Candidates

Senate

Name	District #	Web Site	Email
------	------------	----------	-------

House of Representatives

Name	District #	Web Site	Email
------	------------	----------	-------

[Back to top](#)

© 2008 The Official Web Site of the Tennessee State Employees Association
Site Design and Hosting by: iDesign, inc



Tennessee State Employees Association

To encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee

JOIN TODAY!

HOME

MEMBERS

HISTORY

LOBBYING

BOARD MEMBERS

TSEA STAFF

TEAM POLITICAL ACTION COMMITTEE

FIND A LOCAL CHAPTER

MEDIA

FAQ

SUGGESTED LINKS

CONTACT US

TSEA Lobbying

[Legislative Accomplishments](#) | [Comprehensive Pay Plan](#) | [Without TSEA](#)

Lobbying

During the legislative session, the TSEA lobbying team is hard at work on state employee issues at Capitol Hill. A glance at TSEA's legislative accomplishments over just the past 20 years shows just how effective those lobbying efforts are. TSEA's legislative record is one of the best on Capitol Hill.

TSEA drafts and lobbies legislation to improve state employee pay, benefits and working conditions; to provide fair employment standards and grievance procedures; to ensure job security; and to improve retirement benefits. TSEA's lobbying team then works with legislators to turn that legislation into law.

2010 Legislative Accomplishments:

- During one of Tennessee's most difficult years economically in all of its history, facing massive layoffs, TSEA was successful in negotiating sufficient funds into the state budget - passed by both the Tennessee Senate and House and signed into law by the Governor - to safeguard, for one year, 559 of the many state jobs originally slated for layoff in the Governor's proposed budget.
- Negotiated with the Tennessee Board of Regents to provide support staff involved in a RIF the same 90-day notice as other state employees.
- Secured and had signed into law the right of TSEA's Board of Directors to take up to 12 administrative leave days per year to attend board meetings and conduct the Association's business.
- The \$50/month matching contribution to state employees' 401(k) accounts was continued.
- Prevented a 5% state employee salary cut.
- Limited the private sector's expansion of 150-bed "transitional facilities" - for persons presently incarcerated in Tennessee within one year of their release dates - to 150 state-wide and a maximum of four facilities, total.
- Helped secure legislation to enact a recession stipend for state employees (contingent upon sales tax collections exceeding predictions by \$50 million). Although tax collections came up short, TSEA continued to fight into the next legislative session to secure the stipend, based on tax collections that were - at the time - improving.

2009 Legislative Accomplishments:

- Faced with unprecedented tax revenue shortages, TSEA was able to postpone some of the planned layoffs and negotiate stronger rights for state employees with passage of legislation that gives more flexibility to the Administration when layoffs occur. This legislation retained grievance rights and 'bumping and retreating' rights as well as expanded the ability of employees to transfer to positions where they meet the job category criteria.
- Successfully passed legislation requiring employees' longevity check be separated from their regular pay check, unless the employee elects not to receive a separate longevity check.
- Successfully passed legislation allowing state and higher education employees to participate in a retiree dental plan upon retirement effective January 1, 2010.
- The Association retained the \$50 match to 401k.
- A severance package was negotiated for all state employees laid off after April 1, 2009 that includes \$3,200 cash and two (2) years of college tuition.
- The Employee Transit Card Program, also known as the Swipe and Ride program, was retained for the Nashville Metro area and expanded to include rail service. This benefit also now extends to the Memphis Metro area.

[Back to top](#)

Comprehensive Pay Plan

Included in the appropriations act is "a sum sufficient for the sole purpose of developing a proposed comprehensive pay plan. The proposed pay plan **shall** include provisions providing for periodic adjustment of individual employee compensation in a manner that would appropriately

< September 2011 >									
				1	2	3			
4	5	6	7	8	9	10			
11	12	13	14	15	16	17			
18	19	20	21	22	23	24			
25	26	27	28	29	30				

Click highlighted dates for important Association information

Join TSEA!

Member Login

**Cut Waste,
Not Services**

View our State Map

Click Here to find out what is happening in Tennessee Government

move state employees through their salary ranges and, thereby, would avoid future salary compression problems. In developing the plan, the department **shall** consult with the Tennessee State Employees Association and other stakeholders.”

[Back to top](#)

Without TSEA, these would not exist:

- Protected the safety and privacy rights of state employees with vital legislation restricting public access to personal information contained in personnel files of employees.
- Protection during mergers, consolidations and reductions-in-force
- Longevity pay
- Retiree insurance with retiree having 30 years of service paying only 20% of premium
- Grievance rights and representation without reprisal
- Medicare supplement with employer contribution toward premium
- First State to match employee contribution to 401(k)
- Sick Leave Bank with employee representation
- Bereavement Leave
- 25% discount for children of active and retired state employees to attend state colleges, universities, and technical schools
- Tuition-free course per term for state employees at state colleges, universities and technical schools
- Employees on disability retirement maintain state insurance
- Whistleblower Protection
- TSEA Representative on State Insurance Committee
- Compounded retirement COLA
- Appeals rights on evaluation process and final evaluation results
- Legal right to communicate with legislators
- Use of sick leave for family member illness
- Pay when required to work more than 90 days above your classification
- Elimination of Social Security and driver's license numbers from personnel files
- Privatization of prison system blocked
- Upgrades and classification compensation
- 50% year-round discount for all state employees on camping fees charged in state park system
- Reorganization cannot result in loss of civil service rights, compensation or benefits
- 90 day notice before lay off
- Blocked privatization of Tourism
- Stopped merger of MHDD with Department of Health
- Extension of TCRS credit for military service
- Protection from unjust disciplinary actions
- Purchase of prior service available on installment plan

TSEA makes the difference, but there is more to do! We invite you to [join](#) and make our voice even stronger

[Back to top](#)

© 2008 The Official Web Site of the Tennessee State Employees Association

Site Design and Hosting by: iDesign, inc



Tennessee State Employees Association

To encourage the development and maintenance of an effective and efficient workforce for the state government in Tennessee

- JOIN TODAY!
- HOME
- MEMBERS
- HISTORY
- LOBBYING
- BOARD MEMBERS
- TSEA STAFF
- TEAM POLITICAL ACTION COMMITTEE
- FIND A LOCAL CHAPTER
- MEDIA
- FAQ
- SUGGESTED LINKS
- CONTACT US

Join TSEA

Membership Benefits

How to Contact TSEA

Telephone:
 (615) 256-4533
 (800) 251-TSEA (8732)

Fax:
 (615) 242-6329

Address:
 627 Woodland Street
 Nashville, TN 37206

Why You Should Join TSEA!

Many people claim to want smaller government, but those same people want more services and faster response. When the rhetoric is over, the bottom line is that state employees feel the pressure.

Before TSEA, the state employee had no unified voice. Unity is strength and there is strength in numbers. Membership numbers create strength and power. Become part of the Power that speaks in a unified voice for all state employees. Show others that you really care and join NOW!

Download Application (PDF)

To join TSEA click on the above link, print, complete, sign and mail your application to:
 Tennessee State Employees Association
 627 Woodland Street
 Nashville, TN 37206

You will need Acrobat Reader to view and print your TSEA Application. If you do not have Acrobat Reader, [visit Adobe Acrobat Reader's Website to download a free copy.](#)

Membership Benefits

With membership comes privilege. As a TSEA member you will have access to our Advantage program. This program offers discounts on services, products and entertainment to all members across the state. We also have a merchant friend program for local chapter level discounts for our members to enjoy that are close to home. The Advantage discounts are listed under the member's only section and information about the merchant friends program can be found periodically in the Co-Worker or by calling the TSEA office at (800) 251-8732. Below is a quick list of the types of discounts gained with your TSEA membership.

- AD&D Insurance
- Additional Life Insurance
- Auto & Homeowners Insurance
- Critical Care Coverage
- CompBenefits Vision Care
- Computer purchase thru payroll deduction
- DHS Credit Union
- Disability Income Protection
- Dell Computer purchase
- Entertainment Discounts at Theme Parks, Vacation destinations, Tennessee attractions and Zoos
- Hotel/Motel Discounts
- Jim Reed Chevrolet car purchases
- Long Term Care Coverage

<		September 2011						>	
				1	2	3			
4	5	6	7	8	9	10			
11	12	13	14	15	16	17			
18	19	20	21	22	23	24			
25	26	27	28	29	30				

Click highlighted dates for important Association information

Join TSEA!

Member Login

Cut Waste, Not Services

View our State Map

Click Here to find out what is happening in Tennessee Government

- [Movie Ticket Discounts](#)
- [Rental Car Discounts](#)
- [Short and Long Term Disability Coverage](#)

Don't let the Advantage of membership pass you by. Your future is bright with TSEA and membership discounts makes it even brighter.

[Back to top](#)

© 2008 The Official Web Site of the Tennessee State Employees Association

Site Design and Hosting by: iDesign, inc

September 19, 2011

New Dental Plan just for TSEA Members!

TSEA has a brand new Dental Plan just for its members! Enrollment begins October 1st, 2011. Call **1-800-880-6542** for more information.



A few highlights of TSEA's New Dental Plan:

-Annual routine exams and cleanings are covered

-No waiting periods

-Freedom to choose any dentist

-4 Plans to choose from

-Available to active members and retirees

-Members can switch between plans each year

-Members can enroll any time

-Hearing benefit included

-Over 1300 PPO providers to choose from

Download the Plan Design Summary, the Covered Procedure Summary, and the Features/Benefits of the plan

here: <http://bit.ly/n3aUm8>



TENNESSEE STATE EMPLOYEES ASSOCIATION

NEW DENTAL PLAN JUST FOR TSEA MEMBERS!!



- * Annual routine exams and cleanings are covered
- * No waiting periods
- * Freedom to choose any dentist
- * 4 Plans to choose from
- * Available to active members **and retirees**
- * Members can switch between plans each year
- * Members can enroll any time
- * Hearing benefit included
- * Over 1300 PPO providers to choose from

Enrollment Begins Oct 1, 2011.
Call 1-800-880-6542 for more information.

Tennessee State Employees Association
Plan Design Summary



Dental Summary

Proposed Effective Date: 10/1/2011

	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan
Coinsurance				
Type 1	MCE	MCE	MCE	MCE
Type 2	MCE	MCE	MCE	MCE
Type 3	NA	MCE	MCE	MCE
Deductible	\$50/Calendar Year	\$50/Calendar Year	\$50/Calendar Year	\$50/Calendar Year
	Waived Type 1	Waived Type 1	Waived Type 1	Waived Type 1
	No Family Maximum	No Family Maximum	No Family Maximum	No Family Maximum
Maximum (per person)	\$750/Calendar Year	\$1,000/Calendar Year	\$1,250/Calendar Year	\$1,500/Calendar Year
PPO	Passive PPO	Passive PPO	Passive PPO	Passive PPO
Allowance	MCE	MCE	MCE	MCE
Type 1				
Type 2	MCE	MCE	MCE	MCE
Type 3	None	MCE	MCE	MCE
Dental Rewards®	Included	Included	Included	Included
Waiting Period	None	None	None	None

Monthly Rates

Member	\$14.60	\$19.24	\$24.04	\$30.16
Member + Spouse	\$29.68	\$39.32	\$49.16	\$61.68
Member + Children	\$35.50	\$42.56	\$54.12	\$69.08
Member + Spouse & Children	\$50.58	\$62.64	\$79.24	\$100.60

Rates are guaranteed for 12 months following the effective date listed above.
Rates include: home address mailing of ID cards.

Employee Participation Requirements

Eligible Members: 15,000

10 lives Voluntary	10 lives Voluntary	10 lives Voluntary	10 lives Voluntary
-----------------------	-----------------------	-----------------------	-----------------------

	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan
Plan Design Summary	MCE/MCE \$50/Calendar Year Waived Type 1 No Family Maximum \$750	MCE/MCE/MCE \$50/Calendar Year Waived Type 1 No Family Maximum \$1,000	MCE/MCE/MCE \$50/Calendar Year Waived Type 1 No Family Maximum \$1,250	MCE/MCE/MCE \$50/Calendar Year Waived Type 1 No Family Maximum \$1,500
Type 1 Procedure (Frequency)	<ul style="list-style-type: none"> Routine Exam (1 in 6 months) Bitewing X-rays (1 in 12 months) Full Mouth/Panoramic X-rays (1 in 5 years) Periapical X-rays Cleaning (1 in 6 months) Fluoride for Children 13 and under (1 in 12 months) 	<ul style="list-style-type: none"> Routine Exam (1 in 6 months) Bitewing X-rays (1 in 12 months) Full Mouth/Panoramic X-rays (1 in 5 years) Periapical X-rays Cleaning (1 in 6 months) Fluoride for Children 13 and under (1 in 12 months) 	<ul style="list-style-type: none"> Routine Exam (1 in 6 months) Bitewing X-rays (1 in 12 months) Full Mouth/Panoramic X-rays (1 in 5 years) Periapical X-rays Cleaning (1 in 6 months) Fluoride for Children 13 and under (1 in 12 months) 	<ul style="list-style-type: none"> Routine Exam (1 in 6 months) Bitewing X-rays (1 in 12 months) Full Mouth/Panoramic X-rays (1 in 5 years) Periapical X-rays Cleaning (1 in 6 months) Fluoride for Children 13 and under (1 in 12 months)
Type 2 Procedure (Frequency)	<ul style="list-style-type: none"> Sealants (age 13 and under) Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Denture Repair Simple Extractions 	<ul style="list-style-type: none"> Sealants (age 13 and under) Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Denture Repair Simple Extractions 	<ul style="list-style-type: none"> Sealants (age 13 and under) Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Denture Repair Simple Extractions 	<ul style="list-style-type: none"> Sealants (age 13 and under) Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Denture Repair Simple Extractions
Type 3 Procedure (Frequency)	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Space Maintainers Onlays Crowns (1 in 10 years per tooth) Crown Repair Endodontics (surgical) Periodontics (surgical) Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) Complex Extractions Anesthesia 	<ul style="list-style-type: none"> Space Maintainers Onlays Crowns (1 in 10 years per tooth) Crown Repair Endodontics (surgical) Periodontics (surgical) Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) Complex Extractions Anesthesia 	<ul style="list-style-type: none"> Space Maintainers Onlays Crowns (1 in 10 years per tooth) Crown Repair Endodontics (surgical) Periodontics (surgical) Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) Complex Extractions Anesthesia

Current Dental Terminology © American Dental Association.

*Maximum Covered Expense is the maximum amount considered per procedure.

Hearing Care Summary—included in rates and as part of the plan for all enrollees

SoundCare SM	
Coinsurance	
Annual Hearing Exam	100%
Hearing Aid	50%
Hearing Aid Maintenance	100%
Deductible	
Annual Hearing Exam	\$0
Hearing Aid	\$0
Hearing Aid Maintenance	\$0
Maximum (per benefit period)	
Annual Hearing Exam	Up to \$75
Hearing Aids (for both ears)	
Year One	Up to \$200
Year Two	Up to \$600
Year Three	Up to \$800
Hearing Aid Maintenance	Up to \$40

SoundCareSM Hearing Health Benefits

Life's getting louder.SM Thanks to the cranked-up volume of modern life, hearing loss has become one of the most common chronic health problems in the U.S. It afflicts more than 30 million of us - about 10% of the population has a significant hearing loss - and the number is growing. Today's Baby Boomers have the most active and noisy lifestyle of any previous generation. And hearing loss is occurring at younger and younger ages, partly because of electronic devices that flood our society.

In addition to the obvious culprits we're sticking in our ears - portable media players, cell phone earpieces, gaming headsets - here's a look at common noises that affect hearing, and the amount of time it can take for hearing loss to occur:

- stadium football game: two and a half hours
- tractor: 37 minutes
- hand drill: 23 minutes
- snowmobile: 15 minutes
- leaf blower, smoke alarm, chain saw, airplane cabin: a minute and a half
- rock concert, ambulance: 9 seconds

An Important Addition To Your Benefits Package

Employers of choice know the value of offering a competitive benefits package that demonstrates concern for the well-being of employees and their families. People usually mention sight and hearing as the two most important senses. Regular hearing screenings are a valuable but often overlooked habit for good health, because they alert people to hearing changes early and allow them to take protective measures before problems become serious. Treating hearing loss not only improves quality of life, it can improve employees' ability to communicate effectively on the job. Fortunately, most of the common forms of hearing loss including noise-induced hearing loss are treatable, primarily through the use of hearing aids. Sadly, less than 25% of people who can benefit are treated, often because of concerns about price.

Dental Rewards®

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental PPO network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.



A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL AND HEARING CARE INSURANCE POLICY

The Policyholder	TENNESSEE STATE EMPLOYEES ASSOCIATION	Policy Number	10-350706
State of Delivery	Tennessee	Plan Effective Date	December 1, 2011
Premium Due Date 1st of each month.		Renewal Date	December 1

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.

Corporate Secretary

President

Specimen

**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 UNDER THE TENNESSEE 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 Insurance 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 the insured persons who live in the 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 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 or describe all of the conditions and limitations relating to coverage. This summary does not 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, an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty 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 was 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 Guaranty 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).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

\$300,000 for policies and contracts of all types, except as described in the next point

\$500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

Life insurance death benefits - \$300,000

Life insurance cash surrender value - \$100,000

Present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000

Present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000

Health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000

Health insurance benefits for companies declared insolvent on or after January 1, 2010:

\$100,000 for limited benefits and supplemental health coverages

\$300,000 for disability and long term care insurance

\$500,000 for basic hospital, medical and surgical insurance or major medical insurance

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.

Tennessee Life and Health Insurance Guaranty Association

**1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219**

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

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

Name of Provision	Page Number
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Increased Maximum Benefit	9042
Premiums	9050
Definitions	
Late Entrant, Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Elimination Period	
Contribution Requirement	
Effective Date	
Termination Date	
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods, Missing Tooth Clause, Cosmetic Clause, Late Entrant	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Hearing Care Expense Benefits	9290
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	Eligible Member Electing The Silver Plan
Class 2	Eligible Member Electing The Gold Plan
Class 3	Eligible Member Electing The Platinum Plan
Class 4	Eligible Member Electing The Bronze 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
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

Dental expenses incurred by an individual on or after January 1, 2011, but before December 1, 2011, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to December 1, 2011; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,000

HEARING CARE EXPENSE BENEFITS

Deductible Amount: \$0

Coinsurance Percentage:

Exams	100%***
Hearing Aids	50%
Hearing Aid Maintenance	100%***

***refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):

1st 12 month Period	\$100
2nd 12 month Period	\$300

3rd 12 month Period or thereafter

\$400

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy **BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION**. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

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

Dental expenses incurred by an individual on or after January 1, 2011, but before December 1, 2011, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to December 1, 2011; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,250

HEARING CARE EXPENSE BENEFITS

Deductible Amount: \$0

Coinsurance Percentage:

Exams	100%***
Hearing Aids	50%
Hearing Aid Maintenance	100%***

***refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):	
1st 12 month Period	\$100
2nd 12 month Period	\$300
3rd 12 month Period or thereafter	\$400

The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured’s initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured’s new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy **BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION**. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

Class Number 3

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

Dental expenses incurred by an individual on or after January 1, 2011, but before December 1, 2011, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to December 1, 2011; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,500

HEARING CARE EXPENSE BENEFITS

Deductible Amount: \$0

Coinsurance Percentage:

Exams 100%***

Hearing Aids 50%

Hearing Aid Maintenance 100%***

***refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):

1st 12 month Period \$100

2nd 12 month Period \$300

3rd 12 month Period or thereafter \$400

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

Class Number 4

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

Dental expenses incurred by an individual on or after January 1, 2011, but before December 1, 2011, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to December 1, 2011; and

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

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	\$750

HEARING CARE EXPENSE BENEFITS

Deductible Amount: \$0

Coinsurance Percentage:	
Exams	100%***
Hearing Aids	50%
Hearing Aid Maintenance	100%***

***refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):	
1st 12 month Period	\$100
2nd 12 month Period	\$300
3rd 12 month Period or thereafter	\$400

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

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

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

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

- a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

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

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

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

Class Number 2

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

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

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

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

- a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

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

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

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

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

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

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

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

- a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

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

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

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

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

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

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

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

- a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

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

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

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

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Class 1

Dental Care Insurance	\$18.24 per Insured Person
	\$19.08 Spouse Only
	\$22.82 Child(ren) Only
	\$41.90 Spouse & Child(ren)

Class 2

Dental Care Insurance	\$23.04 per Insured Person
	\$24.12 Spouse Only
	\$29.58 Child(ren) Only
	\$53.70 Spouse & Child(ren)

Class 3

Dental Care Insurance	\$29.16 per Insured Person
	\$29.99 Spouse Only
	\$38.42 Child(ren) Only
	\$68.41 Spouse & Child(ren)

Class 4

Dental Care Insurance	\$13.60 per Insured Person
	\$14.08 Spouse Only
	\$20.40 Child(ren) Only
	\$34.48 Spouse & Child(ren)

Classes 01,02,03,04

Hearing Care Insurance	\$1.00 per Insured Person
	\$1.00 Spouse Only
	\$0.50 Child(ren) Only

\$1.50 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.

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

Class Number 1

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured, the insured's spouse or the Insured's Domestic Partner 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 or Domestic Partner.

- b. each unmarried child less than 24 years of age who are dependent upon the Insured, the insured's spouse or the Insured's Domestic Partner 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 or Domestic Partner.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured, the insured's spouse or the Insured's Domestic Partner 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 4

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried child less than 24 years of age who are dependent upon the Insured, the insured's spouse or the Insured's Domestic Partner 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.

Class Number 1

LATE ENTRANT refers to any person:

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

Class Number 2

LATE ENTRANT refers to any person:

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

Class Number 3

LATE ENTRANT refers to any person:

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

Class Number 4

LATE ENTRANT refers to any person:

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

All Classes

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 eligible member electing the silver plan working a minimum number of hours per week as required by the Policyholder. 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 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible member electing the silver plan working a minimum number of hours per week as required by the Policyholder 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.

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

Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible member electing the gold plan working a minimum number of hours per week as required by the Policyholder. 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 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible member electing the gold plan working a minimum number of hours per week as required by the

Policyholder 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.

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

Class Number 3

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible member electing the platinum plan working a minimum number of hours per week as required by the Policyholder. 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 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible member electing the platinum plan working a minimum number of hours per week as required by the Policyholder 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.

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

Class Number 4

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible member electing the bronze plan working a minimum number of hours per week as required by the Policyholder. 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 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible member electing the bronze plan working a minimum number of hours per week as required by the Policyholder 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.

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

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."

Class Number 4

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 Maximum Covered Expense as determined by us.

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

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

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the insured person is covered on December 1, 2011. For those Insureds covered on December 1, 2011, see b.
 - b. Limitation a. will be waived for those Insureds whose coverage was effective on December 1, 2011 and
 - i. the person has the tooth extracted while insured under the prior contract; and
 - ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and
 - iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.
3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, 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.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. 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 Maximum Covered Expense as determined by us.

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

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is

amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the insured person is covered on December 1, 2011. For those Insureds covered on December 1, 2011, see b.
 - b. Limitation a. will be waived for those Insureds whose coverage was effective on December 1, 2011 and
 - i. the person has the tooth extracted while insured under the prior contract; and
 - ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and
 - iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.
3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, 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.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not.

Class Number 3

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

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the insured person is covered on December 1, 2011. For those Insureds covered on December 1, 2011, see b.
 - b. Limitation a. will be waived for those Insureds whose coverage was effective on December 1, 2011 and
 - i. the person has the tooth extracted while insured under the prior contract; and
 - ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and
 - iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, 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.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. because of war or any act of war, declared or not.

Class Number 4

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

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

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

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. 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.

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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- 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

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- 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 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- 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 4

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- 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

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- 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).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- B/R means By Report.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$23.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$18.00
D0150 Comprehensive oral evaluation - new or established patient.	\$36.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$36.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none">• Coverage is limited to 1 of each of these procedures per 1 provider.• In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).• D0120, D0145, also contribute(s) to this limitation.• If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.	
ROUTINE EVALUATION: D0120, D0145	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 6 month(s).• D0150, D0180, also contribute(s) to this limitation.• Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$76.00
D0330 Panoramic film.	\$61.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 5 year(s).	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$14.00
D0230 Intraoral - periapical each additional film.	\$11.00
D0240 Intraoral - occlusal film.	\$19.00
D0250 Extraoral - first film.	\$24.00
D0260 Extraoral - each additional film.	\$19.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none">• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
BITEWING FILMS	
D0270 Bitewing - single film.	\$12.00
D0272 Bitewings - two films.	\$21.00
D0273 Bitewings - three films.	\$26.00
D0274 Bitewings - four films.	\$33.00
D0277 Vertical bitewings - 7 to 8 films.	\$50.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 12 month(s).• D0277, also contribute(s) to this limitation.• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none">• Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. 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

TYPE 1 PROCEDURES

	Maximum Covered Expense
D1110 Prophylaxis - adult.	\$50.00
D1120 Prophylaxis - child.	\$35.00
D1203 Topical application of fluoride - child.	\$19.00
D1204 Topical application of fluoride - adult.	\$19.00
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	\$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$32.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$32.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$39.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$76.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$76.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$24.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$25.00
SEALANT: D1351, D1352	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • Benefits are considered for persons age 13 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$55.00
D2150 Amalgam - two surfaces, primary or permanent.	\$70.00
D2160 Amalgam - three surfaces, primary or permanent.	\$84.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$101.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • 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.	\$67.00
D2331 Resin-based composite - two surfaces, anterior.	\$84.00
D2332 Resin-based composite - three surfaces, anterior.	\$105.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$116.00
D2391 Resin-based composite - one surface, posterior.	\$73.00
D2392 Resin-based composite - two surfaces, posterior.	\$93.00
D2393 Resin-based composite - three surfaces, posterior.	\$116.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$128.00
D2410 Gold foil - one surface.	\$55.00
D2420 Gold foil - two surfaces.	\$70.00
D2430 Gold foil - three surfaces.	\$84.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • 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. 	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$142.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$119.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$127.00
D2932	Prefabricated resin crown.	\$142.00
D2933	Prefabricated stainless steel crown with resin window.	\$142.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$142.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	\$44.00
D2915	Recement cast or prefabricated post and core.	\$22.00
D2920	Recement crown.	\$43.00
D6092	Recement implant/abutment supported crown.	\$43.00
D6093	Recement implant/abutment supported fixed partial denture.	\$43.00
D6930	Recement fixed partial denture.	\$60.00

SEDATIVE FILLING

D2940	Protective restoration.	\$40.00
-------	-------------------------	---------

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$74.00
D3221	Pulpal debridement, primary and permanent teeth.	\$74.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$112.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$99.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$86.00
D3333	Internal root repair of perforation defects.	\$122.00
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	\$122.00
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).	\$83.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).	\$241.00
D3430	Retrograde filling - per root.	\$95.00
D3450	Root amputation - per root.	\$226.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$192.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$339.00
D3320	Endodontic therapy, bicuspid tooth.	\$400.00
D3330	Endodontic therapy, molar.	\$523.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$200.00
D3346	Retreatment of previous root canal therapy - anterior.	\$423.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$487.00
D3348	Retreatment of previous root canal therapy - molar.	\$604.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$114.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$57.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$83.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$68.00
-------	--	---------

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$70.00
-------	--------------------------	---------

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$70.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$58.00
D5610	Repair resin denture base.	\$69.00
D5620	Repair cast framework.	\$82.00
D5630	Repair or replace broken clasp.	\$85.00
D5640	Replace broken teeth - per tooth.	\$61.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$128.00
D5731	Reline complete mandibular denture (chairside).	\$127.00
D5740	Reline maxillary partial denture (chairside).	\$115.00
D5741	Reline mandibular partial denture (chairside).	\$116.00
D5750	Reline complete maxillary denture (laboratory).	\$191.00
D5751	Reline complete mandibular denture (laboratory).	\$187.00
D5760	Reline maxillary partial denture (laboratory).	\$191.00
D5761	Reline mandibular partial denture (laboratory).	\$192.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$61.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$61.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$290.00
D7261	Primary closure of a sinus perforation.	\$290.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$175.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$175.00
D7280	Surgical access of an unerupted tooth.	\$271.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$195.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$82.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$102.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$51.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$129.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$65.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$187.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$465.00
D7410	Excision of benign lesion up to 1.25 cm.	\$185.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$237.00
D7412	Excision of benign lesion, complicated.	\$261.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$250.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$183.00
D7415	Excision of malignant lesion, complicated.	\$202.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$250.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$183.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$56.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$165.00
D7472	Removal of torus palatinus.	\$165.00
D7473	Removal of torus mandibularis.	\$165.00
D7485	Surgical reduction of osseous tuberosity.	\$269.00
D7490	Radical resection of maxilla or mandible.	\$250.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$83.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$95.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$76.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$209.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$209.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$275.00
D7910	Suture of recent small wounds up to 5 cm.	\$37.00
D7911	Complicated suture - up to 5 cm.	\$41.00
D7912	Complicated suture - greater than 5 cm.	\$60.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$199.00
D7963	Frenuloplasty.	\$248.00
D7970	Excision of hyperplastic tissue - per arch.	\$153.00
D7972	Surgical reduction of fibrous tuberosity.	\$244.00
D7980	Sialolithotomy.	\$229.00
D7983	Closure of salivary fistula.	\$73.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$248.00
D7286	Biopsy of oral tissue - soft.	\$134.00
D7287	Exfoliative cytological sample collection.	\$67.00
D7288	Brush biopsy - transepithelial sample collection.	\$67.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$46.00
-------	--	---------

TYPE 2 PROCEDURES

Maximum Covered
Expense

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$47.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$32.00
D9440	Office visit - after regularly scheduled hours.	\$57.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$35.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$44.00
D9952	Occlusal adjustment - complete.	\$221.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$39.00
D2951	Pin retention - per tooth, in addition to restoration.	\$21.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$67.00

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
SPACE MAINTAINERS	
D1510 Space maintainer - fixed - unilateral.	\$93.00
D1515 Space maintainer - fixed - bilateral.	\$153.00
D1520 Space maintainer - removable - unilateral.	\$146.00
D1525 Space maintainer - removable - bilateral.	\$178.00
D1550 Re-cementation of space maintainer.	\$19.00
D1555 Removal of fixed space maintainer.	\$26.00
SPACE MAINTAINER: D1510, D1515, D1520, D1525	
<ul style="list-style-type: none"> • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date. 	
INLAY RESTORATIONS	
D2510 Inlay - metallic - one surface.	\$229.00
D2520 Inlay - metallic - two surfaces.	\$273.00
D2530 Inlay - metallic - three or more surfaces.	\$293.00
D2610 Inlay - porcelain/ceramic - one surface.	\$252.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$274.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$301.00
D2650 Inlay - resin-based composite - one surface.	\$262.00
D2651 Inlay - resin-based composite - two surfaces.	\$258.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$267.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> • Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury. 	
ONLAY RESTORATIONS	
D2542 Onlay - metallic - two surfaces.	\$297.00
D2543 Onlay - metallic - three surfaces.	\$331.00
D2544 Onlay - metallic - four or more surfaces.	\$344.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$297.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$332.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$342.00
D2662 Onlay - resin-based composite - two surfaces.	\$278.00
D2663 Onlay - resin-based composite - three surfaces.	\$287.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$304.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$130.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2712	Crown - 3/4 resin-based composite (indirect).	\$321.00
D2720	Crown - resin with high noble metal.	\$331.00
D2721	Crown - resin with predominantly base metal.	\$252.00
D2722	Crown - resin with noble metal.	\$310.00
D2740	Crown - porcelain/ceramic substrate.	\$357.00
D2750	Crown - porcelain fused to high noble metal.	\$347.00
D2751	Crown - porcelain fused to predominantly base metal.	\$298.00
D2752	Crown - porcelain fused to noble metal.	\$319.00
D2780	Crown - 3/4 cast high noble metal.	\$330.00
D2781	Crown - 3/4 cast predominantly base metal.	\$287.00
D2782	Crown - 3/4 cast noble metal.	\$300.00
D2783	Crown - 3/4 porcelain/ceramic.	\$357.00
D2790	Crown - full cast high noble metal.	\$330.00
D2791	Crown - full cast predominantly base metal.	\$287.00
D2792	Crown - full cast noble metal.	\$300.00
D2794	Crown - titanium.	\$330.00
	CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	
	<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
	CORE BUILD-UP	
D2950	Core buildup, including any pins.	\$72.00
D6973	Core build up for retainer, including any pins.	\$72.00
	CORE BUILDUP: D2950, D6973	
	<ul style="list-style-type: none"> • A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss. 	
	POST AND CORE	
D2952	Post and core in addition to crown, indirectly fabricated.	\$114.00
D2954	Prefabricated post and core in addition to crown.	\$95.00
	FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980	Crown repair, by report.	\$58.00
D6980	Fixed partial denture repair, by report.	\$64.00
D9120	Fixed partial denture sectioning.	\$64.00
	SURGICAL ENDODONTICS	
D3410	Apicoectomy/periradicular surgery - anterior.	\$214.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$246.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$266.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$95.00
	SURGICAL PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$135.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$68.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$186.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$93.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$340.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$170.00
D4263	Bone replacement graft - first site in quadrant.	\$111.00
D4264	Bone replacement graft - each additional site in quadrant.	\$84.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$56.00
D4270	Pedicle soft tissue graft procedure.	\$251.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$265.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$310.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$149.00
D4275	Soft tissue allograft.	\$265.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$310.00
	BONE GRAFTS: D4263, D4264, D4265	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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.	\$205.00
	PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)	
D5110	Complete denture - maxillary.	\$370.00
D5120	Complete denture - mandibular.	\$358.00
D5130	Immediate denture - maxillary.	\$400.00
D5140	Immediate denture - mandibular.	\$387.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$266.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$308.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$428.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$428.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$266.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$308.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$229.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$266.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$308.00
D5810	Interim complete denture (maxillary).	\$163.00
D5811	Interim complete denture (mandibular).	\$172.00
D5820	Interim partial denture (maxillary).	\$144.00
D5821	Interim partial denture (mandibular).	\$151.00
D5860	Overdenture - complete, by report.	\$370.00
D5861	Overdenture - partial, by report.	\$428.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$370.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$428.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$370.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$428.00
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078	
• Replacement is limited to 1 of any of these procedures per 10 year(s).	
• Frequency is waived for accidental injury.	
• Allowances include adjustments within 6 months after placement date. Procedures 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 10 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.	\$21.00
D5411 Adjust complete denture - mandibular.	\$20.00
D5421 Adjust partial denture - maxillary.	\$22.00
D5422 Adjust partial denture - mandibular.	\$21.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422	
• Coverage is limited to dates of service more than 6 months after placement date.	
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$48.00
D5660 Add clasp to existing partial denture.	\$56.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$135.00
D5711 Rebase complete mandibular denture.	\$142.00
D5720 Rebase maxillary partial denture.	\$128.00
D5721 Rebase mandibular partial denture.	\$136.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$38.00
D5851 Tissue conditioning, mandibular.	\$40.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$308.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$336.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$336.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$308.00
D6062 Abutment supported cast metal crown (high noble metal).	\$336.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$336.00
D6064 Abutment supported cast metal crown (noble metal).	\$364.00
D6065 Implant supported porcelain/ceramic crown.	\$308.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$336.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$336.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$308.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$336.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$336.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$308.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$336.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$336.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$364.00
D6075 Implant supported retainer for ceramic FPD.	\$308.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$336.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$336.00
D6094 Abutment supported crown - (titanium).	\$336.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$336.00
D6205 Pontic - indirect resin based composite.	\$278.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6210	Pontic - cast high noble metal.	\$336.00
D6211	Pontic - cast predominantly base metal.	\$336.00
D6212	Pontic - cast noble metal.	\$364.00
D6214	Pontic - titanium.	\$336.00
D6240	Pontic - porcelain fused to high noble metal.	\$336.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$336.00
D6242	Pontic - porcelain fused to noble metal.	\$308.00
D6245	Pontic - porcelain/ceramic.	\$308.00
D6250	Pontic - resin with high noble metal.	\$336.00
D6251	Pontic - resin with predominantly base metal.	\$308.00
D6252	Pontic - resin with noble metal.	\$364.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$112.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$112.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$274.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$302.00
D6602	Inlay - cast high noble metal, two surfaces.	\$247.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$271.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$213.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$234.00
D6606	Inlay - cast noble metal, two surfaces.	\$224.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$247.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$297.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$326.00
D6610	Onlay - cast high noble metal, two surfaces.	\$271.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$298.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$234.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$258.00
D6614	Onlay - cast noble metal, two surfaces.	\$247.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$271.00
D6624	Inlay - titanium.	\$271.00
D6634	Onlay - titanium.	\$298.00
D6710	Crown - indirect resin based composite.	\$278.00
D6720	Crown - resin with high noble metal.	\$336.00
D6721	Crown - resin with predominantly base metal.	\$174.00
D6722	Crown - resin with noble metal.	\$280.00
D6740	Crown - porcelain/ceramic.	\$308.00
D6750	Crown - porcelain fused to high noble metal.	\$364.00
D6751	Crown - porcelain fused to predominantly base metal.	\$336.00
D6752	Crown - porcelain fused to noble metal.	\$308.00
D6780	Crown - 3/4 cast high noble metal.	\$364.00
D6781	Crown - 3/4 cast predominantly base metal.	\$336.00
D6782	Crown - 3/4 cast noble metal.	\$308.00
D6783	Crown - 3/4 porcelain/ceramic.	\$308.00
D6790	Crown - full cast high noble metal.	\$336.00
D6791	Crown - full cast predominantly base metal.	\$336.00
D6792	Crown - full cast noble metal.	\$308.00
D6794	Crown - titanium.	\$336.00
D6940	Stress breaker.	\$93.00

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

Maximum Covered
Expense

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

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- 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 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$101.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	\$101.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	\$72.00
-------	--	---------

TYPE 3 PROCEDURES

	Maximum Covered Expense
D7220 Removal of impacted tooth - soft tissue.	\$90.00
D7230 Removal of impacted tooth - partially bony.	\$120.00
D7240 Removal of impacted tooth - completely bony.	\$140.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$160.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$75.00
D7251 Coronectomy-intentional partial tooth removal.	\$140.00
APPLIANCE THERAPY	
D8210 Removable appliance therapy.	\$140.00
D8220 Fixed appliance therapy.	\$140.00
APPLIANCE THERAPY: D8210, D8220	
• Coverage is limited to the correction of thumb-sucking.	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$108.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$35.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$71.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$17.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
• Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.	

Class Number 2

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$28.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$22.00
D0150 Comprehensive oral evaluation - new or established patient.	\$43.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$43.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none">• Coverage is limited to 1 of each of these procedures per 1 provider.• In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).• D0120, D0145, also contribute(s) to this limitation.• If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.	
ROUTINE EVALUATION: D0120, D0145	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 6 month(s).• D0150, D0180, also contribute(s) to this limitation.• Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$91.00
D0330 Panoramic film.	\$73.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 5 year(s).	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$17.00
D0230 Intraoral - periapical each additional film.	\$13.00
D0240 Intraoral - occlusal film.	\$23.00
D0250 Extraoral - first film.	\$29.00
D0260 Extraoral - each additional film.	\$23.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none">• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
BITEWING FILMS	
D0270 Bitewing - single film.	\$14.00
D0272 Bitewings - two films.	\$26.00
D0273 Bitewings - three films.	\$31.00
D0274 Bitewings - four films.	\$40.00
D0277 Vertical bitewings - 7 to 8 films.	\$60.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 12 month(s).• D0277, also contribute(s) to this limitation.• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none">• Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. 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

TYPE 1 PROCEDURES

	Maximum Covered Expense
D1110 Prophylaxis - adult.	\$60.00
D1120 Prophylaxis - child.	\$42.00
D1203 Topical application of fluoride - child.	\$23.00
D1204 Topical application of fluoride - adult.	\$23.00
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	\$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$38.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$38.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$45.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$90.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$90.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$28.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$29.00
SEALANT: D1351, D1352	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • Benefits are considered for persons age 13 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$65.00
D2150 Amalgam - two surfaces, primary or permanent.	\$82.00
D2160 Amalgam - three surfaces, primary or permanent.	\$100.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$119.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • 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.	\$79.00
D2331 Resin-based composite - two surfaces, anterior.	\$100.00
D2332 Resin-based composite - three surfaces, anterior.	\$125.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$138.00
D2391 Resin-based composite - one surface, posterior.	\$87.00
D2392 Resin-based composite - two surfaces, posterior.	\$109.00
D2393 Resin-based composite - three surfaces, posterior.	\$138.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$152.00
D2410 Gold foil - one surface.	\$65.00
D2420 Gold foil - two surfaces.	\$82.00
D2430 Gold foil - three surfaces.	\$100.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • 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. 	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$168.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$141.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$149.00
D2932	Prefabricated resin crown.	\$168.00
D2933	Prefabricated stainless steel crown with resin window.	\$168.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$168.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	\$52.00
D2915	Recement cast or prefabricated post and core.	\$26.00
D2920	Recement crown.	\$51.00
D6092	Recement implant/abutment supported crown.	\$51.00
D6093	Recement implant/abutment supported fixed partial denture.	\$51.00
D6930	Recement fixed partial denture.	\$70.00

SEDATIVE FILLING

D2940	Protective restoration.	\$48.00
-------	-------------------------	---------

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$88.00
D3221	Pulpal debridement, primary and permanent teeth.	\$88.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$132.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$117.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$102.00
D3333	Internal root repair of perforation defects.	\$144.00
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$144.00
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	\$97.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$285.00
D3430	Retrograde filling - per root.	\$113.00
D3450	Root amputation - per root.	\$268.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$226.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$401.00
D3320	Endodontic therapy, bicuspid tooth.	\$472.00
D3330	Endodontic therapy, molar.	\$619.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$236.00
D3346	Retreatment of previous root canal therapy - anterior.	\$499.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$575.00
D3348	Retreatment of previous root canal therapy - molar.	\$714.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$134.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$67.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$99.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$80.00
-------	--	---------

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$82.00
-------	--------------------------	---------

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$82.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$68.00
D5610	Repair resin denture base.	\$81.00
D5620	Repair cast framework.	\$96.00
D5630	Repair or replace broken clasp.	\$101.00
D5640	Replace broken teeth - per tooth.	\$73.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$152.00
D5731	Reline complete mandibular denture (chairside).	\$151.00
D5740	Reline maxillary partial denture (chairside).	\$135.00
D5741	Reline mandibular partial denture (chairside).	\$136.00
D5750	Reline complete maxillary denture (laboratory).	\$225.00
D5751	Reline complete mandibular denture (laboratory).	\$221.00
D5760	Reline maxillary partial denture (laboratory).	\$225.00
D5761	Reline mandibular partial denture (laboratory).	\$226.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$73.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$73.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$342.00
D7261	Primary closure of a sinus perforation.	\$342.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$207.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$207.00
D7280	Surgical access of an unerupted tooth.	\$321.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$231.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$96.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$120.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$61.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$153.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$77.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$221.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$549.00
D7410	Excision of benign lesion up to 1.25 cm.	\$219.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$281.00
D7412	Excision of benign lesion, complicated.	\$309.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$296.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$217.00
D7415	Excision of malignant lesion, complicated.	\$238.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$296.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$217.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$219.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$281.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$219.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$281.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$66.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$195.00
D7472	Removal of torus palatinus.	\$195.00
D7473	Removal of torus mandibularis.	\$195.00
D7485	Surgical reduction of osseous tuberosity.	\$317.00
D7490	Radical resection of maxilla or mandible.	\$296.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$97.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$113.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$90.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$247.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$247.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$325.00
D7910	Suture of recent small wounds up to 5 cm.	\$43.00
D7911	Complicated suture - up to 5 cm.	\$49.00
D7912	Complicated suture - greater than 5 cm.	\$70.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$235.00
D7963	Frenuloplasty.	\$294.00
D7970	Excision of hyperplastic tissue - per arch.	\$181.00
D7972	Surgical reduction of fibrous tuberosity.	\$288.00
D7980	Sialolithotomy.	\$271.00
D7983	Closure of salivary fistula.	\$87.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$294.00
D7286	Biopsy of oral tissue - soft.	\$158.00
D7287	Exfoliative cytological sample collection.	\$79.00
D7288	Brush biopsy - transepithelial sample collection.	\$79.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$54.00
-------	--	---------

TYPE 2 PROCEDURES

Maximum Covered
Expense

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$55.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$38.00
D9440	Office visit - after regularly scheduled hours.	\$67.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$41.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$52.00
D9952	Occlusal adjustment - complete.	\$261.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$45.00
D2951	Pin retention - per tooth, in addition to restoration.	\$25.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$79.00

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
SPACE MAINTAINERS	
D1510 Space maintainer - fixed - unilateral.	\$113.00
D1515 Space maintainer - fixed - bilateral.	\$186.00
D1520 Space maintainer - removable - unilateral.	\$177.00
D1525 Space maintainer - removable - bilateral.	\$216.00
D1550 Re-cementation of space maintainer.	\$23.00
D1555 Removal of fixed space maintainer.	\$32.00
SPACE MAINTAINER: D1510, D1515, D1520, D1525	
<ul style="list-style-type: none"> • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date. 	
INLAY RESTORATIONS	
D2510 Inlay - metallic - one surface.	\$278.00
D2520 Inlay - metallic - two surfaces.	\$332.00
D2530 Inlay - metallic - three or more surfaces.	\$357.00
D2610 Inlay - porcelain/ceramic - one surface.	\$307.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$334.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$366.00
D2650 Inlay - resin-based composite - one surface.	\$319.00
D2651 Inlay - resin-based composite - two surfaces.	\$314.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$325.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> • Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury. 	
ONLAY RESTORATIONS	
D2542 Onlay - metallic - two surfaces.	\$361.00
D2543 Onlay - metallic - three surfaces.	\$402.00
D2544 Onlay - metallic - four or more surfaces.	\$419.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$361.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$404.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$416.00
D2662 Onlay - resin-based composite - two surfaces.	\$338.00
D2663 Onlay - resin-based composite - three surfaces.	\$349.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$370.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$158.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2712	Crown - 3/4 resin-based composite (indirect).	\$391.00
D2720	Crown - resin with high noble metal.	\$402.00
D2721	Crown - resin with predominantly base metal.	\$307.00
D2722	Crown - resin with noble metal.	\$377.00
D2740	Crown - porcelain/ceramic substrate.	\$435.00
D2750	Crown - porcelain fused to high noble metal.	\$422.00
D2751	Crown - porcelain fused to predominantly base metal.	\$362.00
D2752	Crown - porcelain fused to noble metal.	\$388.00
D2780	Crown - 3/4 cast high noble metal.	\$402.00
D2781	Crown - 3/4 cast predominantly base metal.	\$349.00
D2782	Crown - 3/4 cast noble metal.	\$365.00
D2783	Crown - 3/4 porcelain/ceramic.	\$435.00
D2790	Crown - full cast high noble metal.	\$402.00
D2791	Crown - full cast predominantly base metal.	\$349.00
D2792	Crown - full cast noble metal.	\$365.00
D2794	Crown - titanium.	\$402.00
	CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	
	<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
	CORE BUILD-UP	
D2950	Core buildup, including any pins.	\$87.00
D6973	Core build up for retainer, including any pins.	\$87.00
	CORE BUILDUP: D2950, D6973	
	<ul style="list-style-type: none"> • A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss. 	
	POST AND CORE	
D2952	Post and core in addition to crown, indirectly fabricated.	\$139.00
D2954	Prefabricated post and core in addition to crown.	\$116.00
	FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980	Crown repair, by report.	\$70.00
D6980	Fixed partial denture repair, by report.	\$78.00
D9120	Fixed partial denture sectioning.	\$78.00
	SURGICAL ENDODONTICS	
D3410	Apicoectomy/periradicular surgery - anterior.	\$260.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$299.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$324.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$116.00
	SURGICAL PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$164.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$83.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$226.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$113.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$414.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$207.00
D4263	Bone replacement graft - first site in quadrant.	\$135.00
D4264	Bone replacement graft - each additional site in quadrant.	\$102.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$68.00
D4270	Pedicle soft tissue graft procedure.	\$305.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$323.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$377.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$181.00
D4275	Soft tissue allograft.	\$323.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$377.00
	BONE GRAFTS: D4263, D4264, D4265	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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.	\$249.00
	PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)	
D5110	Complete denture - maxillary.	\$450.00
D5120	Complete denture - mandibular.	\$436.00
D5130	Immediate denture - maxillary.	\$487.00
D5140	Immediate denture - mandibular.	\$471.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$323.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$375.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$521.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$521.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$323.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$375.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$279.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$323.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$375.00
D5810	Interim complete denture (maxillary).	\$199.00
D5811	Interim complete denture (mandibular).	\$209.00
D5820	Interim partial denture (maxillary).	\$175.00
D5821	Interim partial denture (mandibular).	\$184.00
D5860	Overdenture - complete, by report.	\$450.00
D5861	Overdenture - partial, by report.	\$521.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$450.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$521.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$450.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$521.00
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078	
• Replacement is limited to 1 of any of these procedures per 10 year(s).	
• Frequency is waived for accidental injury.	
• Allowances include adjustments within 6 months after placement date. Procedures 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 10 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.	\$25.00
D5411 Adjust complete denture - mandibular.	\$24.00
D5421 Adjust partial denture - maxillary.	\$27.00
D5422 Adjust partial denture - mandibular.	\$25.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422	
• Coverage is limited to dates of service more than 6 months after placement date.	
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$58.00
D5660 Add clasp to existing partial denture.	\$68.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$164.00
D5711 Rebase complete mandibular denture.	\$173.00
D5720 Rebase maxillary partial denture.	\$156.00
D5721 Rebase mandibular partial denture.	\$165.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$46.00
D5851 Tissue conditioning, mandibular.	\$49.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$375.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$409.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$409.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$375.00
D6062 Abutment supported cast metal crown (high noble metal).	\$409.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$409.00
D6064 Abutment supported cast metal crown (noble metal).	\$443.00
D6065 Implant supported porcelain/ceramic crown.	\$375.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$409.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$409.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$375.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$409.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$409.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$375.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$409.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$409.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$443.00
D6075 Implant supported retainer for ceramic FPD.	\$375.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$409.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$409.00
D6094 Abutment supported crown - (titanium).	\$409.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$409.00
D6205 Pontic - indirect resin based composite.	\$338.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6210	Pontic - cast high noble metal.	\$409.00
D6211	Pontic - cast predominantly base metal.	\$409.00
D6212	Pontic - cast noble metal.	\$443.00
D6214	Pontic - titanium.	\$409.00
D6240	Pontic - porcelain fused to high noble metal.	\$409.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$409.00
D6242	Pontic - porcelain fused to noble metal.	\$375.00
D6245	Pontic - porcelain/ceramic.	\$375.00
D6250	Pontic - resin with high noble metal.	\$409.00
D6251	Pontic - resin with predominantly base metal.	\$375.00
D6252	Pontic - resin with noble metal.	\$443.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$136.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$136.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$334.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$367.00
D6602	Inlay - cast high noble metal, two surfaces.	\$300.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$330.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$259.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$285.00
D6606	Inlay - cast noble metal, two surfaces.	\$273.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$300.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$361.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$397.00
D6610	Onlay - cast high noble metal, two surfaces.	\$330.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$363.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$285.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$314.00
D6614	Onlay - cast noble metal, two surfaces.	\$300.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$330.00
D6624	Inlay - titanium.	\$330.00
D6634	Onlay - titanium.	\$363.00
D6710	Crown - indirect resin based composite.	\$338.00
D6720	Crown - resin with high noble metal.	\$409.00
D6721	Crown - resin with predominantly base metal.	\$212.00
D6722	Crown - resin with noble metal.	\$341.00
D6740	Crown - porcelain/ceramic.	\$375.00
D6750	Crown - porcelain fused to high noble metal.	\$443.00
D6751	Crown - porcelain fused to predominantly base metal.	\$409.00
D6752	Crown - porcelain fused to noble metal.	\$375.00
D6780	Crown - 3/4 cast high noble metal.	\$443.00
D6781	Crown - 3/4 cast predominantly base metal.	\$409.00
D6782	Crown - 3/4 cast noble metal.	\$375.00
D6783	Crown - 3/4 porcelain/ceramic.	\$375.00
D6790	Crown - full cast high noble metal.	\$409.00
D6791	Crown - full cast predominantly base metal.	\$409.00
D6792	Crown - full cast noble metal.	\$375.00
D6794	Crown - titanium.	\$409.00
D6940	Stress breaker.	\$113.00

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

Maximum Covered
Expense

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

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- 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 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$123.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	\$123.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	\$88.00
-------	--	---------

TYPE 3 PROCEDURES

	Maximum Covered Expense
D7220 Removal of impacted tooth - soft tissue.	\$110.00
D7230 Removal of impacted tooth - partially bony.	\$146.00
D7240 Removal of impacted tooth - completely bony.	\$171.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$194.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$91.00
D7251 Coronectomy-intentional partial tooth removal.	\$171.00
APPLIANCE THERAPY	
D8210 Removable appliance therapy.	\$171.00
D8220 Fixed appliance therapy.	\$171.00
APPLIANCE THERAPY: D8210, D8220	
<ul style="list-style-type: none">Coverage is limited to the correction of thumb-sucking.	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$131.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$43.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$87.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$21.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none">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.	

Class Number 3

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$33.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$25.00
D0150 Comprehensive oral evaluation - new or established patient.	\$51.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$51.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none">• Coverage is limited to 1 of each of these procedures per 1 provider.• In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).• D0120, D0145, also contribute(s) to this limitation.• If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.	
ROUTINE EVALUATION: D0120, D0145	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 6 month(s).• D0150, D0180, also contribute(s) to this limitation.• Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$106.00
D0330 Panoramic film.	\$85.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 5 year(s).	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$19.00
D0230 Intraoral - periapical each additional film.	\$15.00
D0240 Intraoral - occlusal film.	\$27.00
D0250 Extraoral - first film.	\$34.00
D0260 Extraoral - each additional film.	\$27.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none">• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
BITEWING FILMS	
D0270 Bitewing - single film.	\$16.00
D0272 Bitewings - two films.	\$30.00
D0273 Bitewings - three films.	\$36.00
D0274 Bitewings - four films.	\$46.00
D0277 Vertical bitewings - 7 to 8 films.	\$70.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 12 month(s).• D0277, also contribute(s) to this limitation.• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none">• Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. 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

TYPE 1 PROCEDURES

	Maximum Covered Expense
D1110 Prophylaxis - adult.	\$70.00
D1120 Prophylaxis - child.	\$49.00
D1203 Topical application of fluoride - child.	\$27.00
D1204 Topical application of fluoride - adult.	\$27.00
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	\$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$47.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$47.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$56.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$111.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$111.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$35.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$36.00
SEALANT: D1351, D1352	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • Benefits are considered for persons age 13 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$80.00
D2150 Amalgam - two surfaces, primary or permanent.	\$101.00
D2160 Amalgam - three surfaces, primary or permanent.	\$123.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$147.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • 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.	\$97.00
D2331 Resin-based composite - two surfaces, anterior.	\$123.00
D2332 Resin-based composite - three surfaces, anterior.	\$153.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$169.00
D2391 Resin-based composite - one surface, posterior.	\$107.00
D2392 Resin-based composite - two surfaces, posterior.	\$135.00
D2393 Resin-based composite - three surfaces, posterior.	\$169.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$187.00
D2410 Gold foil - one surface.	\$80.00
D2420 Gold foil - two surfaces.	\$101.00
D2430 Gold foil - three surfaces.	\$123.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • 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. 	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$207.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$173.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$184.00
D2932	Prefabricated resin crown.	\$207.00
D2933	Prefabricated stainless steel crown with resin window.	\$207.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$207.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	\$64.00
D2915	Recement cast or prefabricated post and core.	\$32.00
D2920	Recement crown.	\$63.00
D6092	Recement implant/abutment supported crown.	\$63.00
D6093	Recement implant/abutment supported fixed partial denture.	\$63.00
D6930	Recement fixed partial denture.	\$87.00

SEDATIVE FILLING

D2940	Protective restoration.	\$59.00
-------	-------------------------	---------

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$108.00
D3221	Pulpal debridement, primary and permanent teeth.	\$108.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$163.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$144.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$125.00
D3333	Internal root repair of perforation defects.	\$177.00
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	\$177.00
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).	\$120.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).	\$351.00
D3430	Retrograde filling - per root.	\$139.00
D3450	Root amputation - per root.	\$329.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$279.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$493.00
D3320	Endodontic therapy, bicuspid tooth.	\$581.00
D3330	Endodontic therapy, molar.	\$761.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$291.00
D3346	Retreatment of previous root canal therapy - anterior.	\$615.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$708.00
D3348	Retreatment of previous root canal therapy - molar.	\$879.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$165.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$83.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$121.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$99.00
-------	--	---------

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$101.00
-------	--------------------------	----------

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$101.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$84.00
D5610	Repair resin denture base.	\$100.00
D5620	Repair cast framework.	\$119.00
D5630	Repair or replace broken clasp.	\$124.00
D5640	Replace broken teeth - per tooth.	\$89.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$187.00
D5731	Reline complete mandibular denture (chairside).	\$185.00
D5740	Reline maxillary partial denture (chairside).	\$167.00
D5741	Reline mandibular partial denture (chairside).	\$168.00
D5750	Reline complete maxillary denture (laboratory).	\$277.00
D5751	Reline complete mandibular denture (laboratory).	\$272.00
D5760	Reline maxillary partial denture (laboratory).	\$277.00
D5761	Reline mandibular partial denture (laboratory).	\$279.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$89.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$89.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$421.00
D7261	Primary closure of a sinus perforation.	\$421.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$255.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$255.00
D7280	Surgical access of an unerupted tooth.	\$395.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$284.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$119.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$148.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$75.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$188.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$95.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$272.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$676.00
D7410	Excision of benign lesion up to 1.25 cm.	\$269.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$345.00
D7412	Excision of benign lesion, complicated.	\$380.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$364.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$267.00
D7415	Excision of malignant lesion, complicated.	\$293.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$364.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$267.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$269.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$345.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$269.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$345.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$81.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$240.00
D7472	Removal of torus palatinus.	\$240.00
D7473	Removal of torus mandibularis.	\$240.00
D7485	Surgical reduction of osseous tuberosity.	\$391.00
D7490	Radical resection of maxilla or mandible.	\$364.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$120.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$139.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$111.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$304.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$304.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$400.00
D7910	Suture of recent small wounds up to 5 cm.	\$53.00
D7911	Complicated suture - up to 5 cm.	\$60.00
D7912	Complicated suture - greater than 5 cm.	\$87.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$289.00
D7963	Frenuloplasty.	\$361.00
D7970	Excision of hyperplastic tissue - per arch.	\$223.00
D7972	Surgical reduction of fibrous tuberosity.	\$355.00
D7980	Sialolithotomy.	\$333.00
D7983	Closure of salivary fistula.	\$107.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$361.00
D7286	Biopsy of oral tissue - soft.	\$195.00
D7287	Exfoliative cytological sample collection.	\$97.00
D7288	Brush biopsy - transepithelial sample collection.	\$97.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$67.00
-------	--	---------

TYPE 2 PROCEDURES

Maximum Covered
Expense

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$68.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$47.00
D9440	Office visit - after regularly scheduled hours.	\$83.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$51.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$64.00
D9952	Occlusal adjustment - complete.	\$321.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$56.00
D2951	Pin retention - per tooth, in addition to restoration.	\$31.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$97.00

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
SPACE MAINTAINERS	
D1510 Space maintainer - fixed - unilateral.	\$133.00
D1515 Space maintainer - fixed - bilateral.	\$219.00
D1520 Space maintainer - removable - unilateral.	\$209.00
D1525 Space maintainer - removable - bilateral.	\$255.00
D1550 Re-cementation of space maintainer.	\$27.00
D1555 Removal of fixed space maintainer.	\$38.00
SPACE MAINTAINER: D1510, D1515, D1520, D1525	
<ul style="list-style-type: none"> • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date. 	
INLAY RESTORATIONS	
D2510 Inlay - metallic - one surface.	\$328.00
D2520 Inlay - metallic - two surfaces.	\$391.00
D2530 Inlay - metallic - three or more surfaces.	\$420.00
D2610 Inlay - porcelain/ceramic - one surface.	\$362.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$393.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$431.00
D2650 Inlay - resin-based composite - one surface.	\$375.00
D2651 Inlay - resin-based composite - two surfaces.	\$371.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$383.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> • Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury. 	
ONLAY RESTORATIONS	
D2542 Onlay - metallic - two surfaces.	\$425.00
D2543 Onlay - metallic - three surfaces.	\$474.00
D2544 Onlay - metallic - four or more surfaces.	\$493.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$425.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$476.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$490.00
D2662 Onlay - resin-based composite - two surfaces.	\$399.00
D2663 Onlay - resin-based composite - three surfaces.	\$411.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$436.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$186.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2712	Crown - 3/4 resin-based composite (indirect).	\$461.00
D2720	Crown - resin with high noble metal.	\$474.00
D2721	Crown - resin with predominantly base metal.	\$362.00
D2722	Crown - resin with noble metal.	\$444.00
D2740	Crown - porcelain/ceramic substrate.	\$512.00
D2750	Crown - porcelain fused to high noble metal.	\$497.00
D2751	Crown - porcelain fused to predominantly base metal.	\$427.00
D2752	Crown - porcelain fused to noble metal.	\$457.00
D2780	Crown - 3/4 cast high noble metal.	\$473.00
D2781	Crown - 3/4 cast predominantly base metal.	\$411.00
D2782	Crown - 3/4 cast noble metal.	\$430.00
D2783	Crown - 3/4 porcelain/ceramic.	\$512.00
D2790	Crown - full cast high noble metal.	\$473.00
D2791	Crown - full cast predominantly base metal.	\$411.00
D2792	Crown - full cast noble metal.	\$430.00
D2794	Crown - titanium.	\$473.00
	CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	
	<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
	CORE BUILD-UP	
D2950	Core buildup, including any pins.	\$103.00
D6973	Core build up for retainer, including any pins.	\$103.00
	CORE BUILDUP: D2950, D6973	
	<ul style="list-style-type: none"> • A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss. 	
	POST AND CORE	
D2952	Post and core in addition to crown, indirectly fabricated.	\$164.00
D2954	Prefabricated post and core in addition to crown.	\$137.00
	FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980	Crown repair, by report.	\$83.00
D6980	Fixed partial denture repair, by report.	\$92.00
D9120	Fixed partial denture sectioning.	\$92.00
	SURGICAL ENDODONTICS	
D3410	Apicoectomy/periradicular surgery - anterior.	\$306.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$353.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$382.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$137.00
	SURGICAL PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$194.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$97.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$266.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$133.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$488.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$244.00
D4263	Bone replacement graft - first site in quadrant.	\$159.00
D4264	Bone replacement graft - each additional site in quadrant.	\$120.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$80.00
D4270	Pedicle soft tissue graft procedure.	\$359.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$380.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$444.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$214.00
D4275	Soft tissue allograft.	\$380.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$444.00
	BONE GRAFTS: D4263, D4264, D4265	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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.	\$293.00
	PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)	
D5110	Complete denture - maxillary.	\$530.00
D5120	Complete denture - mandibular.	\$514.00
D5130	Immediate denture - maxillary.	\$574.00
D5140	Immediate denture - mandibular.	\$555.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$381.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$441.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$614.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$614.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$381.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$441.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$329.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$381.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$441.00
D5810	Interim complete denture (maxillary).	\$234.00
D5811	Interim complete denture (mandibular).	\$247.00
D5820	Interim partial denture (maxillary).	\$206.00
D5821	Interim partial denture (mandibular).	\$216.00
D5860	Overdenture - complete, by report.	\$530.00
D5861	Overdenture - partial, by report.	\$614.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$530.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$614.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$530.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$614.00
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078	
• Replacement is limited to 1 of any of these procedures per 10 year(s).	
• Frequency is waived for accidental injury.	
• Allowances include adjustments within 6 months after placement date. Procedures 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 10 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.	\$30.00
D5411 Adjust complete denture - mandibular.	\$28.00
D5421 Adjust partial denture - maxillary.	\$31.00
D5422 Adjust partial denture - mandibular.	\$30.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422	
• Coverage is limited to dates of service more than 6 months after placement date.	
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$68.00
D5660 Add clasp to existing partial denture.	\$80.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$193.00
D5711 Rebase complete mandibular denture.	\$204.00
D5720 Rebase maxillary partial denture.	\$184.00
D5721 Rebase mandibular partial denture.	\$194.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$54.00
D5851 Tissue conditioning, mandibular.	\$58.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$442.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$482.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$482.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$442.00
D6062 Abutment supported cast metal crown (high noble metal).	\$482.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$482.00
D6064 Abutment supported cast metal crown (noble metal).	\$522.00
D6065 Implant supported porcelain/ceramic crown.	\$442.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$482.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$482.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$442.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$482.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$482.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$442.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$482.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$482.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$522.00
D6075 Implant supported retainer for ceramic FPD.	\$442.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$482.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$482.00
D6094 Abutment supported crown - (titanium).	\$482.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$482.00
D6205 Pontic - indirect resin based composite.	\$398.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6210	Pontic - cast high noble metal.	\$482.00
D6211	Pontic - cast predominantly base metal.	\$482.00
D6212	Pontic - cast noble metal.	\$522.00
D6214	Pontic - titanium.	\$482.00
D6240	Pontic - porcelain fused to high noble metal.	\$482.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$482.00
D6242	Pontic - porcelain fused to noble metal.	\$442.00
D6245	Pontic - porcelain/ceramic.	\$442.00
D6250	Pontic - resin with high noble metal.	\$482.00
D6251	Pontic - resin with predominantly base metal.	\$442.00
D6252	Pontic - resin with noble metal.	\$522.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$161.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$161.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$393.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$432.00
D6602	Inlay - cast high noble metal, two surfaces.	\$354.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$389.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$305.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$336.00
D6606	Inlay - cast noble metal, two surfaces.	\$321.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$354.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$425.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$468.00
D6610	Onlay - cast high noble metal, two surfaces.	\$389.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$428.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$336.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$370.00
D6614	Onlay - cast noble metal, two surfaces.	\$354.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$389.00
D6624	Inlay - titanium.	\$389.00
D6634	Onlay - titanium.	\$428.00
D6710	Crown - indirect resin based composite.	\$398.00
D6720	Crown - resin with high noble metal.	\$482.00
D6721	Crown - resin with predominantly base metal.	\$250.00
D6722	Crown - resin with noble metal.	\$402.00
D6740	Crown - porcelain/ceramic.	\$442.00
D6750	Crown - porcelain fused to high noble metal.	\$522.00
D6751	Crown - porcelain fused to predominantly base metal.	\$482.00
D6752	Crown - porcelain fused to noble metal.	\$442.00
D6780	Crown - 3/4 cast high noble metal.	\$522.00
D6781	Crown - 3/4 cast predominantly base metal.	\$482.00
D6782	Crown - 3/4 cast noble metal.	\$442.00
D6783	Crown - 3/4 porcelain/ceramic.	\$442.00
D6790	Crown - full cast high noble metal.	\$482.00
D6791	Crown - full cast predominantly base metal.	\$482.00
D6792	Crown - full cast noble metal.	\$442.00
D6794	Crown - titanium.	\$482.00
D6940	Stress breaker.	\$133.00

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

Maximum Covered
Expense

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

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- 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 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$145.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	\$145.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	\$104.00
-------	--	----------

TYPE 3 PROCEDURES

	Maximum Covered Expense
D7220 Removal of impacted tooth - soft tissue.	\$129.00
D7230 Removal of impacted tooth - partially bony.	\$172.00
D7240 Removal of impacted tooth - completely bony.	\$201.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$229.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$108.00
D7251 Coronectomy-intentional partial tooth removal.	\$201.00
APPLIANCE THERAPY	
D8210 Removable appliance therapy.	\$201.00
D8220 Fixed appliance therapy.	\$201.00
APPLIANCE THERAPY: D8210, D8220	
<ul style="list-style-type: none">Coverage is limited to the correction of thumb-sucking.	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$154.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$51.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$102.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$25.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none">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.	

Class Number 4

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$23.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$18.00
D0150 Comprehensive oral evaluation - new or established patient.	\$36.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$36.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none">• Coverage is limited to 1 of each of these procedures per 1 provider.• In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).• D0120, D0145, also contribute(s) to this limitation.• If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.	
ROUTINE EVALUATION: D0120, D0145	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 6 month(s).• D0150, D0180, also contribute(s) to this limitation.• Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$76.00
D0330 Panoramic film.	\$61.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 5 year(s).	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$14.00
D0230 Intraoral - periapical each additional film.	\$11.00
D0240 Intraoral - occlusal film.	\$19.00
D0250 Extraoral - first film.	\$24.00
D0260 Extraoral - each additional film.	\$19.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none">• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
BITEWING FILMS	
D0270 Bitewing - single film.	\$12.00
D0272 Bitewings - two films.	\$21.00
D0273 Bitewings - three films.	\$26.00
D0274 Bitewings - four films.	\$33.00
D0277 Vertical bitewings - 7 to 8 films.	\$50.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 12 month(s).• D0277, also contribute(s) to this limitation.• The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none">• Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. 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

TYPE 1 PROCEDURES

	Maximum Covered Expense
D1110 Prophylaxis - adult.	\$50.00
D1120 Prophylaxis - child.	\$35.00
D1203 Topical application of fluoride - child.	\$19.00
D1204 Topical application of fluoride - adult.	\$19.00
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	\$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$32.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$32.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$39.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$76.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$76.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$24.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$25.00
SEALANT: D1351, D1352	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • Benefits are considered for persons age 13 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$55.00
D2150 Amalgam - two surfaces, primary or permanent.	\$70.00
D2160 Amalgam - three surfaces, primary or permanent.	\$84.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$101.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • 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.	\$67.00
D2331 Resin-based composite - two surfaces, anterior.	\$84.00
D2332 Resin-based composite - three surfaces, anterior.	\$105.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$116.00
D2391 Resin-based composite - one surface, posterior.	\$73.00
D2392 Resin-based composite - two surfaces, posterior.	\$93.00
D2393 Resin-based composite - three surfaces, posterior.	\$116.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$128.00
D2410 Gold foil - one surface.	\$55.00
D2420 Gold foil - two surfaces.	\$70.00
D2430 Gold foil - three surfaces.	\$84.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • 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. 	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$142.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$119.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$127.00
D2932	Prefabricated resin crown.	\$142.00
D2933	Prefabricated stainless steel crown with resin window.	\$142.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$142.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	\$44.00
D2915	Recement cast or prefabricated post and core.	\$22.00
D2920	Recement crown.	\$43.00
D6092	Recement implant/abutment supported crown.	\$43.00
D6093	Recement implant/abutment supported fixed partial denture.	\$43.00
D6930	Recement fixed partial denture.	\$60.00

SEDATIVE FILLING

D2940	Protective restoration.	\$40.00
-------	-------------------------	---------

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$74.00
D3221	Pulpal debridement, primary and permanent teeth.	\$74.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$112.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$99.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$86.00
D3333	Internal root repair of perforation defects.	\$122.00
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	\$122.00
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).	\$83.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).	\$241.00
D3430	Retrograde filling - per root.	\$95.00
D3450	Root amputation - per root.	\$226.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$192.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$339.00
D3320	Endodontic therapy, bicuspid tooth.	\$400.00
D3330	Endodontic therapy, molar.	\$523.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$200.00
D3346	Retreatment of previous root canal therapy - anterior.	\$423.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$487.00
D3348	Retreatment of previous root canal therapy - molar.	\$604.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$114.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$57.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$83.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$68.00
-------	--	---------

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$70.00
-------	--------------------------	---------

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$70.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$58.00
D5610	Repair resin denture base.	\$69.00
D5620	Repair cast framework.	\$82.00
D5630	Repair or replace broken clasp.	\$85.00
D5640	Replace broken teeth - per tooth.	\$61.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$128.00
D5731	Reline complete mandibular denture (chairside).	\$127.00
D5740	Reline maxillary partial denture (chairside).	\$115.00
D5741	Reline mandibular partial denture (chairside).	\$116.00
D5750	Reline complete maxillary denture (laboratory).	\$191.00
D5751	Reline complete mandibular denture (laboratory).	\$187.00
D5760	Reline maxillary partial denture (laboratory).	\$191.00
D5761	Reline mandibular partial denture (laboratory).	\$192.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$61.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$61.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$290.00
D7261	Primary closure of a sinus perforation.	\$290.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$175.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$175.00
D7280	Surgical access of an unerupted tooth.	\$271.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$195.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$82.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$102.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$51.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$129.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$65.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$187.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$465.00
D7410	Excision of benign lesion up to 1.25 cm.	\$185.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$237.00
D7412	Excision of benign lesion, complicated.	\$261.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$250.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$183.00
D7415	Excision of malignant lesion, complicated.	\$202.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$250.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$183.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$56.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$165.00
D7472	Removal of torus palatinus.	\$165.00
D7473	Removal of torus mandibularis.	\$165.00
D7485	Surgical reduction of osseous tuberosity.	\$269.00
D7490	Radical resection of maxilla or mandible.	\$250.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$83.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$95.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$76.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$209.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$209.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$275.00
D7910	Suture of recent small wounds up to 5 cm.	\$37.00
D7911	Complicated suture - up to 5 cm.	\$41.00
D7912	Complicated suture - greater than 5 cm.	\$60.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$199.00
D7963	Frenuloplasty.	\$248.00
D7970	Excision of hyperplastic tissue - per arch.	\$153.00
D7972	Surgical reduction of fibrous tuberosity.	\$244.00
D7980	Sialolithotomy.	\$229.00
D7983	Closure of salivary fistula.	\$73.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$248.00
D7286	Biopsy of oral tissue - soft.	\$134.00
D7287	Exfoliative cytological sample collection.	\$67.00
D7288	Brush biopsy - transepithelial sample collection.	\$67.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$46.00
-------	--	---------

TYPE 2 PROCEDURES

Maximum Covered
Expense

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$47.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$32.00
D9440	Office visit - after regularly scheduled hours.	\$57.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$35.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$44.00
D9952	Occlusal adjustment - complete.	\$221.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$39.00
D2951	Pin retention - per tooth, in addition to restoration.	\$21.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$67.00

DESENSITIZATION: D9911

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

HEARING CARE EXPENSE BENEFITS

Class Number 1

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the actual charge for services or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or 45 days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.
2. any examination performed or supply furnished after the Insured's coverage under this section ceases.
3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:

- a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and
 - b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
 - c. at least 3 years has passed since placement of the previous hearing aid.
5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
 6. hearing care services or supplies in the first 12 months that a person is insured if the person is a Late Entrant, except hearing examinations. After this 12 month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.
 7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
 8. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
 9. any procedure not shown in the Schedule of Hearing Care Services.
 10. any treatment which is for cosmetic purposes.
 11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
 12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
 13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
 14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
 15. a hearing aid dispensed without the direction and supervision of a provider licensed to perform hearing aid examinations and/or hearing aid dispensing.
 16. because of war or any act of war, declared or not.
 17. removal of foreign bodies or ear wax from the ear or any part of the ear.

SCHEDULE OF HEARING CARE SERVICES

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to \$75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to \$40 per Benefit Period

Class Number 2

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the actual charge for services or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered

Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or 45 days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.
2. any examination performed or supply furnished after the Insured's coverage under this section ceases.
3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
 - a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and
 - b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
 - c. at least 3 years has passed since placement of the previous hearing aid.
5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
6. hearing care services or supplies in the first 12 months that a person is insured if the person is a Late Entrant, except hearing examinations. After this 12 month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.
7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
8. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
9. any procedure not shown in the Schedule of Hearing Care Services.

10. any treatment which is for cosmetic purposes.
11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
15. a hearing aid dispensed without the direction and supervision of a provider licensed to perform hearing aid examinations and/or hearing aid dispensing.
16. because of war or any act of war, declared or not.
17. removal of foreign bodies or ear wax from the ear or any part of the ear.

SCHEDULE OF HEARING CARE SERVICES

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to \$75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to \$40 per Benefit Period

Class Number 3

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the actual charge for services or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered

Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or 45 days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.
2. any examination performed or supply furnished after the Insured's coverage under this section ceases.
3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
 - a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and
 - b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
 - c. at least 3 years has passed since placement of the previous hearing aid.
5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
6. hearing care services or supplies in the first 12 months that a person is insured if the person is a Late Entrant, except hearing examinations. After this 12 month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.
7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
8. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
9. any procedure not shown in the Schedule of Hearing Care Services.

10. any treatment which is for cosmetic purposes.
11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
15. a hearing aid dispensed without the direction and supervision of a provider licensed to perform hearing aid examinations and/or hearing aid dispensing.
16. because of war or any act of war, declared or not.
17. removal of foreign bodies or ear wax from the ear or any part of the ear.

SCHEDULE OF HEARING CARE SERVICES

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to \$75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to \$40 per Benefit Period

Class Number 4

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the actual charge for services or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered

Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or 45 days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.
2. any examination performed or supply furnished after the Insured's coverage under this section ceases.
3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
 - a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and
 - b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
 - c. at least 3 years has passed since placement of the previous hearing aid.
5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
6. hearing care services or supplies in the first 12 months that a person is insured if the person is a Late Entrant, except hearing examinations. After this 12 month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.
7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
8. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
9. any procedure not shown in the Schedule of Hearing Care Services.

10. any treatment which is for cosmetic purposes.
11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
15. a hearing aid dispensed without the direction and supervision of a provider licensed to perform hearing aid examinations and/or hearing aid dispensing.
16. because of war or any act of war, declared or not.
17. removal of foreign bodies or ear wax from the ear or any part of the ear.

SCHEDULE OF HEARING CARE SERVICES

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to \$75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to \$40 per Benefit Period

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, trustee 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 Hearing 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 Hearing 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%
Number of Members-	91

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

We may terminate this policy on the earlier of:

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

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

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

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

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

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

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

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:
Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental and Hearing Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental and Hearing Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.



A STOCK COMPANY
LINCOLN, NEBRASKA

**CERTIFICATE
GROUP DENTAL AND HEARING CARE INSURANCE**

The Policyholder **TENNESSEE STATE EMPLOYEES ASSOCIATION**

Policy Number **10-350706** **Insured Person** **PAT Q. SPECIMEN**

Plan Effective Date **December 1, 2011** **Certificate Effective Date** **December 1, 2011**
Refer to Exceptions on 9070.

Class Number 1

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

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

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

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

JoAnn M Martin

President

IMPORTANT INFORMATION TO POLICYHOLDERS

This notice provides information regarding your right to request information about your coverage with us.

You Have the Right to Request

- Information about your plan provisions, benefits, and exclusions by category of service and provider;
- A description of how you can get an estimate of your benefits prior to receiving treatment
- The name, number, type, specialty, and geographic location of participating providers; and
- Criteria we use to evaluate providers for network participation.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: MAYER, THOMAS, WILLIAM*
Address: 325 CEDAR ST STE 800 SAINT PAUL, MN 55101-1012
Telephone Number: 651-649-3503

Name of Agent: DIRECT BENEFITS INC
Address: 325 CEDAR ST STE 800 SAINT PAUL, MN 55101-1012
Telephone Number: 800-620-5010

If you have been unable to contact or obtain satisfaction from the company or the agent, or we fail to provide you with reasonable and adequate service, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

Name of Provision	Page Number
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Increased Maximum Benefit	9042
Definitions	
Late Entrant, Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Elimination Period	
Contribution Requirement	
Effective Date	
Termination Date	
Dental Expense Benefits	9219
Alternate Benefit provision	
Limitations, including Elimination Periods, Missing Tooth Clause, Cosmetic Clause, Late Entrant	
Table of Dental Procedures	9232
Covered Procedures, Frequencies, Criteria	
Hearing Care Expense Benefits	9290
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
ERISA Information and Notice of Your Rights	ERISA Notice

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Eligible Member Electing The Silver Plan

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

Dental expenses incurred by an individual on or after January 1, 2011, but before December 1, 2011, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to December 1, 2011; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period \$1,000

HEARING CARE EXPENSE BENEFITS

Deductible Amount: \$0

Coinsurance Percentage:

Exams	100%***
Hearing Aids	50%
Hearing Aid Maintenance	100%***

***refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

Hearing Aid Maximum Amount (per ear):

1st 12 month Period	\$100
2nd 12 month Period	\$300
3rd 12 month Period or thereafter	\$400

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is

important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy **BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION**. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	\$250
PPO Bonus – Each Benefit Period	\$100
Benefit Threshold Per Insured Person – Each Benefit Period	\$500
Maximum Carry Over Amount	\$1,000

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

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

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

- a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and
- b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and
- c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

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

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

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

DEFINITIONS

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

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

INSURED refers to a person:

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

DOMESTIC PARTNER. Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried child less than 24 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner, is legally responsible, including:
 - i. natural born children;
 - ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.
 - iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.
 - iv. 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 as defined below; and
 - ii. becomes Totally Disabled while insured as a dependent under b. above.

We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof following our request and for notifying us when such dependency and disability has terminated.

TOTAL DISABILITY describes the Insured's Dependent as:

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

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

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

LATE ENTRANT refers to any person:

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible member electing the silver plan working a minimum number of hours per week as required by the Policyholder. 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 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible member electing the silver plan working a minimum number of hours per week as required by the Policyholder 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.

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

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

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

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

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the 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."

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

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

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

COVERAGE FOR GENERAL ANESTHESIA. Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or
3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

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 dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

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

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the insured person is covered on December 1, 2011. For those Insureds covered on December 1, 2011, see b.
 - b. Limitation a. will be waived for those Insureds whose coverage was effective on December 1, 2011 and
 - i. the person has the tooth extracted while insured under the prior contract; and
 - ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and
 - iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.
3. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. to replace lost or stolen appliances.
6. for any treatment which is for cosmetic purposes.
7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, 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.
10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. 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.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- 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.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- 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).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- B/R means By Report.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation - established patient.	\$23.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$18.00
D0150 Comprehensive oral evaluation - new or established patient.	\$36.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$36.00
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none"> • Coverage is limited to 1 of each of these procedures per 1 provider. • In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s). • D0120, D0145, also contribute(s) to this limitation. • If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ROUTINE EVALUATION: D0120, D0145	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D0150, D0180, also contribute(s) to this limitation. • Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under. 	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$76.00
D0330 Panoramic film.	\$61.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 5 year(s). 	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$14.00
D0230 Intraoral - periapical each additional film.	\$11.00
D0240 Intraoral - occlusal film.	\$19.00
D0250 Extraoral - first film.	\$24.00
D0260 Extraoral - each additional film.	\$19.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none"> • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
BITEWING FILMS	
D0270 Bitewing - single film.	\$12.00
D0272 Bitewings - two films.	\$21.00
D0273 Bitewings - three films.	\$26.00
D0274 Bitewings - four films.	\$33.00
D0277 Vertical bitewings - 7 to 8 films.	\$50.00
BITEWING FILMS: D0270, D0272, D0273, D0274	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • D0277, also contribute(s) to this limitation. • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
VERTICAL BITEWING FILM: D0277	
<ul style="list-style-type: none"> • Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. 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.	\$50.00
D1120 Prophylaxis - child.	\$35.00
D1203 Topical application of fluoride - child.	\$19.00

TYPE 1 PROCEDURES

	Maximum Covered Expense
D1204 Topical application of fluoride - adult.	\$19.00
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	\$19.00
FLUORIDE: D1203, D1204, D1206	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 12 month(s).• Benefits are considered for persons age 13 and under.• An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.	
PROPHYLAXIS: D1110, D1120	
<ul style="list-style-type: none">• Coverage is limited to 1 of any of these procedures per 6 month(s).• D4910, also contribute(s) to this limitation.• An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.	

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$32.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$32.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$39.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$76.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$76.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
SEALANT	
D1351 Sealant - per tooth.	\$24.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$25.00
SEALANT: D1351, D1352	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • Benefits are considered for persons age 13 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$55.00
D2150 Amalgam - two surfaces, primary or permanent.	\$70.00
D2160 Amalgam - three surfaces, primary or permanent.	\$84.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$101.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • 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.	\$67.00
D2331 Resin-based composite - two surfaces, anterior.	\$84.00
D2332 Resin-based composite - three surfaces, anterior.	\$105.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$116.00
D2391 Resin-based composite - one surface, posterior.	\$73.00
D2392 Resin-based composite - two surfaces, posterior.	\$93.00
D2393 Resin-based composite - three surfaces, posterior.	\$116.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$128.00
D2410 Gold foil - one surface.	\$55.00
D2420 Gold foil - two surfaces.	\$70.00
D2430 Gold foil - three surfaces.	\$84.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • 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. 	

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.	\$142.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$119.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$127.00
D2932	Prefabricated resin crown.	\$142.00
D2933	Prefabricated stainless steel crown with resin window.	\$142.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$142.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	\$44.00
D2915	Recement cast or prefabricated post and core.	\$22.00
D2920	Recement crown.	\$43.00
D6092	Recement implant/abutment supported crown.	\$43.00
D6093	Recement implant/abutment supported fixed partial denture.	\$43.00
D6930	Recement fixed partial denture.	\$60.00

SEDATIVE FILLING

D2940	Protective restoration.	\$40.00
-------	-------------------------	---------

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$74.00
D3221	Pulpal debridement, primary and permanent teeth.	\$74.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$112.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$99.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$86.00
D3333	Internal root repair of perforation defects.	\$122.00
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	\$122.00
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).	\$83.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).	\$241.00
D3430	Retrograde filling - per root.	\$95.00
D3450	Root amputation - per root.	\$226.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$192.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	\$339.00
D3320	Endodontic therapy, bicuspid tooth.	\$400.00
D3330	Endodontic therapy, molar.	\$523.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$200.00
D3346	Retreatment of previous root canal therapy - anterior.	\$423.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$487.00
D3348	Retreatment of previous root canal therapy - molar.	\$604.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

TYPE 2 PROCEDURES

Maximum Covered
Expense

- 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.

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$114.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$57.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$83.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$68.00
-------	--	---------

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	\$70.00
-------	--------------------------	---------

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$70.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$58.00
D5610	Repair resin denture base.	\$69.00
D5620	Repair cast framework.	\$82.00
D5630	Repair or replace broken clasp.	\$85.00
D5640	Replace broken teeth - per tooth.	\$61.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	\$128.00
D5731	Reline complete mandibular denture (chairside).	\$127.00
D5740	Reline maxillary partial denture (chairside).	\$115.00
D5741	Reline mandibular partial denture (chairside).	\$116.00
D5750	Reline complete maxillary denture (laboratory).	\$191.00
D5751	Reline complete mandibular denture (laboratory).	\$187.00
D5760	Reline maxillary partial denture (laboratory).	\$191.00
D5761	Reline mandibular partial denture (laboratory).	\$192.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	\$61.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$61.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$290.00
D7261	Primary closure of a sinus perforation.	\$290.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$175.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$175.00
D7280	Surgical access of an unerupted tooth.	\$271.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$195.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$82.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$102.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$51.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$129.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$65.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$187.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$465.00
D7410	Excision of benign lesion up to 1.25 cm.	\$185.00
D7411	Excision of benign lesion greater than 1.25 cm.	\$237.00
D7412	Excision of benign lesion, complicated.	\$261.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$250.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$183.00
D7415	Excision of malignant lesion, complicated.	\$202.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$250.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$183.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$185.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$237.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	\$56.00
D7471	Removal of lateral exostosis (maxilla or mandible).	\$165.00
D7472	Removal of torus palatinus.	\$165.00
D7473	Removal of torus mandibularis.	\$165.00
D7485	Surgical reduction of osseous tuberosity.	\$269.00
D7490	Radical resection of maxilla or mandible.	\$250.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	\$83.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	\$95.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$76.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	\$209.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$209.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$275.00
D7910	Suture of recent small wounds up to 5 cm.	\$37.00
D7911	Complicated suture - up to 5 cm.	\$41.00
D7912	Complicated suture - greater than 5 cm.	\$60.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	\$199.00
D7963	Frenuloplasty.	\$248.00
D7970	Excision of hyperplastic tissue - per arch.	\$153.00
D7972	Surgical reduction of fibrous tuberosity.	\$244.00
D7980	Sialolithotomy.	\$229.00
D7983	Closure of salivary fistula.	\$73.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	\$248.00
D7286	Biopsy of oral tissue - soft.	\$134.00
D7287	Exfoliative cytological sample collection.	\$67.00
D7288	Brush biopsy - transepithelial sample collection.	\$67.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	\$46.00
-------	--	---------

TYPE 2 PROCEDURES

Maximum Covered
Expense

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$47.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	\$32.00
D9440	Office visit - after regularly scheduled hours.	\$57.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	\$35.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	\$44.00
D9952	Occlusal adjustment - complete.	\$221.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$39.00
D2951	Pin retention - per tooth, in addition to restoration.	\$21.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$67.00

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
SPACE MAINTAINERS	
D1510 Space maintainer - fixed - unilateral.	\$93.00
D1515 Space maintainer - fixed - bilateral.	\$153.00
D1520 Space maintainer - removable - unilateral.	\$146.00
D1525 Space maintainer - removable - bilateral.	\$178.00
D1550 Re-cementation of space maintainer.	\$19.00
D1555 Removal of fixed space maintainer.	\$26.00
SPACE MAINTAINER: D1510, D1515, D1520, D1525	
<ul style="list-style-type: none"> • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date. 	
INLAY RESTORATIONS	
D2510 Inlay - metallic - one surface.	\$229.00
D2520 Inlay - metallic - two surfaces.	\$273.00
D2530 Inlay - metallic - three or more surfaces.	\$293.00
D2610 Inlay - porcelain/ceramic - one surface.	\$252.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$274.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$301.00
D2650 Inlay - resin-based composite - one surface.	\$262.00
D2651 Inlay - resin-based composite - two surfaces.	\$258.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$267.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> • Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury. 	
ONLAY RESTORATIONS	
D2542 Onlay - metallic - two surfaces.	\$297.00
D2543 Onlay - metallic - three surfaces.	\$331.00
D2544 Onlay - metallic - four or more surfaces.	\$344.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$297.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$332.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$342.00
D2662 Onlay - resin-based composite - two surfaces.	\$278.00
D2663 Onlay - resin-based composite - three surfaces.	\$287.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$304.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
CROWNS SINGLE RESTORATIONS	
D2710 Crown - resin-based composite (indirect).	\$130.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2712	Crown - 3/4 resin-based composite (indirect).	\$321.00
D2720	Crown - resin with high noble metal.	\$331.00
D2721	Crown - resin with predominantly base metal.	\$252.00
D2722	Crown - resin with noble metal.	\$310.00
D2740	Crown - porcelain/ceramic substrate.	\$357.00
D2750	Crown - porcelain fused to high noble metal.	\$347.00
D2751	Crown - porcelain fused to predominantly base metal.	\$298.00
D2752	Crown - porcelain fused to noble metal.	\$319.00
D2780	Crown - 3/4 cast high noble metal.	\$330.00
D2781	Crown - 3/4 cast predominantly base metal.	\$287.00
D2782	Crown - 3/4 cast noble metal.	\$300.00
D2783	Crown - 3/4 porcelain/ceramic.	\$357.00
D2790	Crown - full cast high noble metal.	\$330.00
D2791	Crown - full cast predominantly base metal.	\$287.00
D2792	Crown - full cast noble metal.	\$300.00
D2794	Crown - titanium.	\$330.00
	CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	
	<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 10 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. • Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. 	
	CORE BUILD-UP	
D2950	Core buildup, including any pins.	\$72.00
D6973	Core build up for retainer, including any pins.	\$72.00
	CORE BUILDUP: D2950, D6973	
	<ul style="list-style-type: none"> • A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss. 	
	POST AND CORE	
D2952	Post and core in addition to crown, indirectly fabricated.	\$114.00
D2954	Prefabricated post and core in addition to crown.	\$95.00
	FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980	Crown repair, by report.	\$58.00
D6980	Fixed partial denture repair, by report.	\$64.00
D9120	Fixed partial denture sectioning.	\$64.00
	SURGICAL ENDODONTICS	
D3410	Apicoectomy/periradicular surgery - anterior.	\$214.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$246.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$266.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$95.00
	SURGICAL PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$135.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$68.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$186.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$93.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$340.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$170.00
D4263	Bone replacement graft - first site in quadrant.	\$111.00
D4264	Bone replacement graft - each additional site in quadrant.	\$84.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$56.00
D4270	Pedicle soft tissue graft procedure.	\$251.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$265.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$310.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$149.00
D4275	Soft tissue allograft.	\$265.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$310.00
	BONE GRAFTS: D4263, D4264, D4265	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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	
	<ul style="list-style-type: none"> • 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.	\$205.00
	PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)	
D5110	Complete denture - maxillary.	\$370.00
D5120	Complete denture - mandibular.	\$358.00
D5130	Immediate denture - maxillary.	\$400.00
D5140	Immediate denture - mandibular.	\$387.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$266.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$308.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$428.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$428.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$266.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$308.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$229.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$266.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$308.00
D5810	Interim complete denture (maxillary).	\$163.00
D5811	Interim complete denture (mandibular).	\$172.00
D5820	Interim partial denture (maxillary).	\$144.00
D5821	Interim partial denture (mandibular).	\$151.00
D5860	Overdenture - complete, by report.	\$370.00
D5861	Overdenture - partial, by report.	\$428.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$370.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$428.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$370.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$428.00
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078	
• Replacement is limited to 1 of any of these procedures per 10 year(s).	
• Frequency is waived for accidental injury.	
• Allowances include adjustments within 6 months after placement date. Procedures 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 10 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.	\$21.00
D5411 Adjust complete denture - mandibular.	\$20.00
D5421 Adjust partial denture - maxillary.	\$22.00
D5422 Adjust partial denture - mandibular.	\$21.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422	
• Coverage is limited to dates of service more than 6 months after placement date.	
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$48.00
D5660 Add clasp to existing partial denture.	\$56.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$135.00
D5711 Rebase complete mandibular denture.	\$142.00
D5720 Rebase maxillary partial denture.	\$128.00
D5721 Rebase mandibular partial denture.	\$136.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$38.00
D5851 Tissue conditioning, mandibular.	\$40.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$308.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$336.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$336.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$308.00
D6062 Abutment supported cast metal crown (high noble metal).	\$336.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$336.00
D6064 Abutment supported cast metal crown (noble metal).	\$364.00
D6065 Implant supported porcelain/ceramic crown.	\$308.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$336.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$336.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$308.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$336.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$336.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$308.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$336.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$336.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$364.00
D6075 Implant supported retainer for ceramic FPD.	\$308.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$336.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$336.00
D6094 Abutment supported crown - (titanium).	\$336.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$336.00
D6205 Pontic - indirect resin based composite.	\$278.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6210	Pontic - cast high noble metal.	\$336.00
D6211	Pontic - cast predominantly base metal.	\$336.00
D6212	Pontic - cast noble metal.	\$364.00
D6214	Pontic - titanium.	\$336.00
D6240	Pontic - porcelain fused to high noble metal.	\$336.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$336.00
D6242	Pontic - porcelain fused to noble metal.	\$308.00
D6245	Pontic - porcelain/ceramic.	\$308.00
D6250	Pontic - resin with high noble metal.	\$336.00
D6251	Pontic - resin with predominantly base metal.	\$308.00
D6252	Pontic - resin with noble metal.	\$364.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$112.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$112.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$274.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$302.00
D6602	Inlay - cast high noble metal, two surfaces.	\$247.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$271.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$213.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$234.00
D6606	Inlay - cast noble metal, two surfaces.	\$224.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$247.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$297.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$326.00
D6610	Onlay - cast high noble metal, two surfaces.	\$271.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$298.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$234.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$258.00
D6614	Onlay - cast noble metal, two surfaces.	\$247.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$271.00
D6624	Inlay - titanium.	\$271.00
D6634	Onlay - titanium.	\$298.00
D6710	Crown - indirect resin based composite.	\$278.00
D6720	Crown - resin with high noble metal.	\$336.00
D6721	Crown - resin with predominantly base metal.	\$174.00
D6722	Crown - resin with noble metal.	\$280.00
D6740	Crown - porcelain/ceramic.	\$308.00
D6750	Crown - porcelain fused to high noble metal.	\$364.00
D6751	Crown - porcelain fused to predominantly base metal.	\$336.00
D6752	Crown - porcelain fused to noble metal.	\$308.00
D6780	Crown - 3/4 cast high noble metal.	\$364.00
D6781	Crown - 3/4 cast predominantly base metal.	\$336.00
D6782	Crown - 3/4 cast noble metal.	\$308.00
D6783	Crown - 3/4 porcelain/ceramic.	\$308.00
D6790	Crown - full cast high noble metal.	\$336.00
D6791	Crown - full cast predominantly base metal.	\$336.00
D6792	Crown - full cast noble metal.	\$308.00
D6794	Crown - titanium.	\$336.00
D6940	Stress breaker.	\$93.00

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

TYPE 3 PROCEDURES

Maximum Covered
Expense

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

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- 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 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$101.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	\$101.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	\$72.00
-------	--	---------

TYPE 3 PROCEDURES

	Maximum Covered Expense
D7220 Removal of impacted tooth - soft tissue.	\$90.00
D7230 Removal of impacted tooth - partially bony.	\$120.00
D7240 Removal of impacted tooth - completely bony.	\$140.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$160.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$75.00
D7251 Coronectomy-intentional partial tooth removal.	\$140.00
APPLIANCE THERAPY	
D8210 Removable appliance therapy.	\$140.00
D8220 Fixed appliance therapy.	\$140.00
APPLIANCE THERAPY: D8210, D8220	
• Coverage is limited to the correction of thumb-sucking.	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$108.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$35.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$71.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$17.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
• Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.	

HEARING CARE EXPENSE BENEFITS

If an Insured under this section incurs Covered Expenses, we will consider benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

- a. the actual charge for services or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Hearing Care Services, adjusted as described below in Covered Expenses.

DEDUCTIBLE AMOUNT. The Deductible Amount, if applicable, shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

COVERED EXPENSES. Covered Expenses means the expenses incurred by an Insured for the procedures shown in the Schedule of Hearing Care Services up to the Maximum Covered Expense shown for each procedure, reduced by any applicable Deductible Amount. This amount is then multiplied by the Coinsurance Percentage, with the resulting amount being the Covered Expense, provided that in no event will the Covered Expense exceed the Maximum Amount as shown in the Schedule of Benefits. Incurred expenses will be considered Covered Expenses only to the extent that they are incurred for procedures provided by a physician, audiologist, or other hearing health care professional acting within the scope of his or her license. These expenses are subject to the "Limitations" listed below.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply is furnished. When it pertains to a Hearing Aid an expense is incurred on the date the Hearing Aid is placed. Benefits for Covered Expenses of Hearing Aids will be paid on the latter of the date the Hearing Aid Purchase Agreement is signed or 45 days from the placement of the hearing aid. No benefits are payable for a Hearing Aid returned for a refund.

The Coordination of Benefit Provision, if any, in the Policy/Certificate does not apply to this Section. This plan is not intended to replace mandatory worksite programs designed to satisfy OSHA hearing conservation programs.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. examinations performed or supplies furnished before the Insured was covered under this section.
2. any examination performed or supply furnished after the Insured's coverage under this section ceases.
3. any hearing examination or supply required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
4. replacement of hearing aids except once every 5 years from the date of placement of the hearing aid. This replacement interval is waived and 50% of the Covered Expense that would be otherwise payable will be considered if all of the following conditions are met:
 - a. the Insured person is diagnosed with a significant deterioration of hearing since placement of the previous hearing aid, and

- b. a statement from the Provider is furnished indicating that the hearing aid being replaced cannot be modified to correct the loss, and
 - c. at least 3 years has passed since placement of the previous hearing aid.
5. medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
 6. hearing care services or supplies in the first 12 months that a person is insured if the person is a Late Entrant, except hearing examinations. After this 12 month period, the Maximum Amount Payable per Insured Person will begin at the 1st 12 Month Period as shown in the Schedule of Benefits.
 7. which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
 8. charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
 9. any procedure not shown in the Schedule of Hearing Care Services.
 10. any treatment which is for cosmetic purposes.
 11. assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
 12. charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
 13. services or supplies which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
 14. charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
 15. a hearing aid dispensed without the direction and supervision of a provider licensed to perform hearing aid examinations and/or hearing aid dispensing.
 16. because of war or any act of war, declared or not.
 17. removal of foreign bodies or ear wax from the ear or any part of the ear.

SCHEDULE OF HEARING CARE SERVICES

The following is a complete list of hearing care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	MAXIMUM COVERED EXPENSE
COMPREHENSIVE HEARING EXAMINATION May consist of the following: case history; external examination of the ear, otoscopy, audiometric testing, audiogram, otoacoustic emissions (OAEs) testing, pure tone audiometry, speech audiometry, mobility of ear drum (tympanometry), and measurement of pressure in the middle ear.	Up to \$75 per Benefit Period
HEARING AIDS A hearing device for the treatment of a defined, measurable hearing loss as prescribed by a licensed provider within the scope of that license.	See Hearing Aid Maximum Amount on the Schedule of Benefits
HEARING AID MAINTENANCE Including but not limited to, batteries, replacement tubing, repair of hearing aid, hearing aid fittings, and maintenance contracts for hearing aids, etc.	Up to \$40 per Benefit Period

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, trustee 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 Hearing 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 Hearing 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.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

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 \$5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

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

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

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

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

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

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

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



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

TSEA - ATTN: JOHN CAHILL
627 WOODLAND ST.
NASHVILLE, TN 37206

Request Type: Certified Copies
Request #: 54695

Issuance Date: 12/21/2011
Copies Requested: 1

Document Receipt

Receipt #: 583449 Filing Fee: \$20.00
Payment-Check/MO - TSEA - ATTN: JOHN CAHILL, NASHVILLE, TN \$20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **TENNESSEE STATE EMPLOYEES ASSOCIATION, INCORPORATED**, Control # 85416 was formed or qualified to do business in the State of Tennessee on 09/04/1974. **TENNESSEE STATE EMPLOYEES ASSOCIATION, INCORPORATED** has a home jurisdiction of Davidson County and is currently in an Active status.

Tre Hargett
Secretary of State

Processed By: Kristen McClellan

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

<u>Reference #</u>	<u>Date Filed</u>	<u>Filing Description</u>
BO30P0681	09/04/1974	Initial Filing
165 00283	06/25/1980	Registered Agent Change (by Entity)
220 00760	07/16/1981	Articles of Amendment
220 00761	07/16/1981	Registered Agent Change (by Entity)
458 01005	01/19/1984	Registered Agent Change (by Entity)
3426-3274	12/29/1997	CMS Annual Report Update
6166-0432	12/07/2007	2007 Annual Report (Due 10/01/2007)
6533-0769	05/08/2009	Registered Agent Change (by Entity)
6560-2409	07/01/2009	Amended and Restated Formation Documents
6609-1189	10/06/2009	2009 Annual Report (Due 10/01/2009)

CHARTER
OF
TENNESSEE STATE EMPLOYEES ASSOCIATION

The undersigned natural persons, having capacity to contract and acting as the incorporators of a corporation under the Tennessee General Corporation Act, adopt the following charter for such corporation:

1. The name of the corporation is Tennessee State Employees Association, Incorporated.
2. The duration of the corporation is perpetual.
3. The address of the principal office of the corporation in the State of Tennessee shall be P.O. Box 2828, Nashville, Davidson Co Tennessee, 37219.
4. The corporation is not for profit.
5. The purpose or purposes for which the corporation is organized are:
 - (a). to improve the standard of service rendered by state employees.
 - (b). to maintain and improve the benefits enjoyed by state employees.
 - (c). to protect the members of this association and to encourage and support the proper administration of the state laws, rules and regulations.
 - (d). to secure such benefits as may be legally available to the individual members of this association.
6. This corporation is to have members.
7. No part of the earnings of this corporation may inure to the benefit of any private shareholder, member or individual.

7. No part of the earnings of this corporation may inure to the benefit of any private shareholder, member or individual.

8. Upon dissolution of this corporation, the net assets remaining after payment of or provision for all debts shall be distributed or conveyed to some corporation or other organization,

4 AM 10 17

not for profit, which is organized for charitable purposes compatible with the purposes of this organization.

Dated this the Twenty-Seventh day of August, 1974.

Charles R. Dodson

1722 Almayville Rd
Murfreesboro TN 37130

Craig Smith

1402 Clifton Ln. Nashville, Tenn. 37215

Juliet Griffin

3013 Wellington Ave, Nashville,
TN 37210

INCORPORATORS

I, JOE C. CARR, Secretary of State, do certify that this Charter, with certificate attached, the foregoing of which is a true copy, was this day registered and certified to by me.

This the 4th day of September, 1974

JOE C. CARR,
SECRETARY OF STATE

FEE: \$ 10.00

FILED
SECRETARY OF STATE
1980 JUN 25 PM 1:19

DESIGNATION, REVOCATION OR CHANGE
OF
REGISTERED AGENT
OF

Tennessee State Employees Association, Incorporated

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of Section 48-1201 of the Tennessee General Corporation Act, the undersigned foreign or domestic corporation or the incorporator or incorporators of a domestic corporation being organized under the Act submit the following statement for the purpose of designating, revoking or changing, as the case may be, the registered agent for the corporation in the state of Tennessee:

1. The name of the corporation is Tennessee State Employees Association,
Incorporated

The address of the corporation is 410 Capitol Hill Building Nashville,
Tennessee 37219

If a foreign corporation, state or country of incorporation _____

2. The name and street address of its registered agent in the State of Tennessee shall be
Marilyn Edwards; 410 Capitol Hill Building, Nashville, Tennessee 37219

Dated June 25, 19 80

Tennessee State Employees Association, Incorporated

Name of Corporation

By Charles R. [Signature] Executive Director
(Title)

(Incorporator
or incorporators,
if corporation is
being organized)

1981 JUL 16 AM 11:40

100-100000
100-100000
100-100000

DESIGNATION, REVOCATION OR CHANGE
OF
REGISTERED AGENT
OF

Tennessee State Employees Association, Incorporated

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of Section 48-1201 of the Tennessee General Corporation Act, the undersigned foreign or domestic corporation or the incorporator or incorporators of a domestic corporation being organized under the Act submit the following statement for the purpose of designating, revoking or changing, as the case may be, the registered agent for the corporation in the state of Tennessee:

1. The name of the corporation is Tennessee State Employees Association, Incorporated

The address of the corporation is 627 Woodland Street, Nashville, Tennessee 37206

If a foreign corporation, state or country of incorporation _____

2. The name and street address of its registered agent in the State of Tennessee shall be
Marilyn Edwards, TSEA, 627 Woodland Street, Nashville, TN 37206

Dated July 8, 1981

Tennessee State Employees Association, Incorporated
a corporation of Tennessee

By Sandra (Signature) Office Manager
(Title)

(Incorporator
or incorporators,
if corporation is
being organized)

FILED
SECRETARY OF STATE

ARTICLES OF AMENDMENT TO THE

CHARTER

1934 JUL 16 AM 11:40

Tennessee State Employees Association, Incorporated

Pursuant to the provisions of the Tennessee State Employees Association
General Corporation Act, the undersigned hereby certifies that the
following articles of amendment to its charter:

1. The name of the corporation is:

Tennessee State Employees Association, Incorporated

*2. The amendment adopted is (insert Amendment):

Change the address of the corporation to:

Tennessee State Employees Association
627 Woodland Street
Nashville, TN 37206

3. The amendment was duly adopted (at a meeting) ~~(by the unanimous~~
~~written consent)~~ of the ~~(shareholders)~~ ~~(members)~~ on December 6, 1981
(Strike inapplicable words)

4. If a corporation for profit, the manner, if not set forth in such
amendment, in which any exchange, readjustment or cancellation of issued
shares provided for in the amendment shall be effected is as follows:
non-profit corporation

5. If the amendment is not to be effective until these articles are
filed by the Secretary of State, the date it will be effective is
_____, 19____ (not later than thirty (30) days after such filing)

Dated: July 8, 1981

Tennessee State Employees Association, Incorporated
Secretary of State

By: *Sandra Johnson*

FILED
SECRETARY OF STATE
1984 JAN 19 AM 9:32

48-1201-13

CHANGE OF REGISTERED AGENT
OF

TENNESSEE STATE EMPLOYEES ASSOCIATION, INCORPORATED

TO: Secretary of State of Tennessee

Pursuant to the provisions of Section 48-1201 of the Tennessee General Corporation Act, the undersigned domestic corporation submits the following statement for the purpose of changing the registered agent for the corporation in the State of Tennessee;

1. The name of the corporation is Tennessee State Employees Association, Incorporated.
2. The name and street address of its registered agent in the State of Tennessee shall be Larry D. Woods, 121 Seventeenth Avenue South, Nashville, Davidson County, Tennessee 37203.

DATED: January 3, 1984

TENNESSEE STATE EMPLOYEES ASSOCIATION, INC.

BY: Anne Carr
Anne Carr, Executive Director

**CORPORATION ANNUAL REPORT
STATE OF TENNESSEE
SECRETARY OF STATE
SUITE 1800, JAMES K. POLK BUILDING
NASHVILLE, TN, 37243-0246**

2,372 2607
3414 1550
2426 2274

591055

AMOUNT DUE - \$20.00

CURRENT FISCAL YEAR CLOSING MONTH: 05 IF DIFFERENT,
CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 10/01/97

(1) SECRETARY OF STATE CONTROL NUMBER: 0085416

OR FEDERAL EMPLOYER IDENTIFICATION NUMBER: _____

(2A) NAME AND MAILING ADDRESS OF CORPORATION:

(2B) STATE OR COUNTRY OF INCORPORATION
TENNESSEE

53467
**TENNESSEE STATE EMPLOYEES ASSOCIATION,
INCORPORATED
627 WOODLAND STREET**

(2C) ADD OR CHANGE MAILING ADDRESS:

NASHVILLE, TN 37206
██

D 09/04/1974 NON-PROFIT

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
627 WOODLAND STREET, NASHVILLE, TN 37206
B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

**** BLOCKS 4A AND 4B MUST BE COMPLETED OR THE ANNUAL REPORT WILL BE RETURNED ****

(4) A. NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS.
(ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT			
SECRETARY	<i>See Attached</i>		

B. BOARD OF DIRECTORS (NAME, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) SAME AS ABOVE NONE

OR LISTED BELOW:	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
	<i>See Attached</i>		

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:

LARRY D WOODS
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
121 SEVENTEENTH, NASHVILLE, TN 37203

(6) INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.
(BLOCK 5A AND/OR 5B.) THERE IS AN ADDITIONAL \$20.00 FEE REQUIRED FOR CHANGES MADE TO THIS INFORMATION.

A. CHANGE OF REGISTERED AGENT:

B. CHANGE OF REGISTERED OFFICE: P.O. Box 24727, 621 Second Ave. N Nashville TN 37202-4727
STREET CITY STATE ZIP CODE + 4 COUNTY

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED. IF BLANK OR CHANGE, PLEASE CHECK APPROPRIATE BOX:

PUBLIC MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX UNLESS OTHERWISE INDICATED. RELIGIOUS

(8) SIGNATURE: *Judy Wahlstrom, President*

(9) DATE: 9/22/97

(10) TYPE PRINT NAME OF SIGNER: Judy Wahlstrom

(11) TITLE OF SIGNER: President

**** THIS REPORT MUST BE DATED AND SIGNED ****

ISEA BOARD OF DIRECTORS 1997 - 1998

PRESIDENT

Judy Wahlstrom (500)
841 Argle Avenue
Madison, TN 37115
WK: (615) 532-4018
HM: (615) 868-0931
NT:

EAST VICE-PRESIDENT

Alex Smith (501)
3412 So. Fountaincrest Drive
Knoxville, TN 37918 5926
WK: (423) 594-9182
HM: (423) 922-8469
NT: 8

MIDDLE VICE-PRESIDENT

Ted Thaler (502)
928 Neuhoft Lane
Nashville, TN 37205
WK: (615) 532-6593
HM: (615) 352-4125
NT: 8

WEST VICE PRESIDENT

Bob Buas (503)
1396 Weymouth
Memphis, TN 38108
WK: (901) 543-7130
HM: (901) 324-3999
NT: 8

SECRETARY

Nicki Lucas (504)
6648 Willow Brook Dr.
Bartlett, TN 38135
WK: (901) 320-7505
HM: (901) 382-0083
NT:

TREASURER

Tom Osborne (505)
4314 Dale Avenue
Nashville, TN 37204
WK: (615) 313-5367
HM: (615) 297-2268
NT: 8

DISTRICT 1 DIRECTOR

Almous Austin (506)
1039 Austin Road
Newbern, TN 38059-4607
WK: (901) 253-7070
HM: (901) 627-2431
NT: 8

DISTRICT 2 DIRECTOR

Tom Haynes (507)
4890 Shiff Avenue
Memphis, TN 38117
WK: (901) 575-8801
HM: (901) 761-9795
NT: 8

DISTRICT 3 DIRECTOR

Philip Morson (508)
1915 Levy Lane
Bolivar, TN 38008
WK: (901) 658-5141
HM: (901) 658-4900
NT: 8

DISTRICT 4 DIRECTOR

Ronny Hoffman (509)
4658 Old Clarksville Pk
Clarksville, TN 37043
WK: (615) 648-5572
HM: (615) 362-3034
NT:

DISTRICT 5 DIRECTOR

Anne F. Marlin (510)
1704 Sweetbriar Avenue
Nashville, TN 37212
WK: (615) 741-2729
HM: (615) 385-3466
NT:

DISTRICT 6 DIRECTOR

Jeannie Bellephant (511)
3924 Calumet Drive
Antioch, TN 37013
WK: (615) 532-4763
HM: (615) 361-8150
NT:

DISTRICT 7 DIRECTOR

Paula Shaw (512)
3 Vera Lane
Leoma, TN 38468
WK: (615) 852-2157
HM: (615) 852-2137
NT:

DISTRICT 8 DIRECTOR

Jean Young (513)
P. O. Box 399
Jamestown, TN 38556
WK: (615) 525-1110
HM: (615) 879-8814 or (615) 528-6143
NT: 8

DISTRICT 9 DIRECTOR

Pats Thurman (514)
113-B Shearer Street
Soddy Daisy, TN 37379
WK: (423) 634-8936
HM: (423) 332-7454
NT: 8

DISTRICT 10 DIRECTOR

Wills Colson (515)
1140 Baker Avenue
Knoxville, TN 37920
WK: () RETIRED
HM: (423) 577-1917
NT:

DISTRICT 11 DIRECTOR

Janice Buchanan (516)
108 Rainbolt Lane
Elizabethton, TN 37643
WK: (423) 727-7387
HM: (423) 542-3144
NT:

DISTRICT 12 DIRECTOR

Patty Ratcliff (517)
1525 Green Acres Dr.
Newport, TN 37821
WK: (423) 623-1291
HM: (423) 625-4933
NT:

IMM. PAST PRESIDENT

Tom Spillman (518)
309 Wauford Drive
Nashville, TN 37211
WK: (615) 741-5954
HM: (615) 834-8843
NT: 8-540-1954

08/21/97

SECRETARY OF STATE

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:
 \$20, if no changes are made in block #6 to the registered agent/office, or
 \$40, if any changes are made in block #6 to the registered agent/office.

TENNESSEE SECRETARY OF STATE
 Attn: Annual Report
 312 Eighth Ave. N. 6th Floor
 William R. Snodgrass Tower
 Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: JUNE

THIS REPORT IS DUE ON OR BEFORE: 10/01/2007

(1) SECRETARY OF STATE CONTROL NUMBER: 0085416

(2A) NAME AND MAILING ADDRESS OF RECORD:

TENNESSEE STATE EMPLOYEES ASSOCIATION, INCORPORATED
 PO BOX 24727
 NASHVILLE, TN, 37202-4727

(2B) STATE OR COUNTRY OF INCORPORATION:

TENNESSEE

(2C) ADD OR CHANGE MAILING ADDRESS:

627 WOODLAND ST
 NASHVILLE, TN, 37206

(3) A. PRINCIPAL ADDRESS OF RECORD: 627 WOODLAND STREET, NASHVILLE, TN 37206-0000

B. CHANGE OF PRINCIPAL ADDRESS: NO CHANGE

Street City State Zip Code +4

(4) NAME AND BUSINESS ADDRESS INCLUDING ZIP CODE OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS

Title	Name	Business Address	City, State Zip Code +4
PRESIDENT	ZOYLE JONES	627 WOODLAND ST	NASHVILLE, TN 37206
SECRETARY	JACKIE COLEMAN	627 WOODLAND ST	NASHVILLE, TN 37206

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE.)

NONE, OR LISTED BELOW

Name	Business Address	City, State, Zip Code +4
ZOYLE JONES	627 WOODLAND ST	NASHVILLE, TN 37206
JAMES RUTH	627 WOODLAND ST	NASHVILLE, TN 37206
PHILIP MORSON	627 WOODLAND ST	NASHVILLE, TN 37206
ALMOUS AUSTIN	627 WOODLAND ST	NASHVILLE, TN 37206
ERNEST TISDALE	627 WOODLAND ST	NASHVILLE, TN 37206
CHRISTINE CHAMBERS	627 WOODLAND ST	NASHVILLE, TN 37206
GARY ANDERSON	627 WOODLAND ST	NASHVILLE, TN 37206
STEPHEN THOMAS	627 WOODLAND ST	NASHVILLE, TN 37206
DONALD BURNETTE	627 WOODLAND ST	NASHVILLE, TN 37206
JACKIE COLEMAN	627 WOODLAND ST	NASHVILLE, TN 37206
TOM SPILLMAM	627 WOODLAND ST	NASHVILLE, TN 37206
ANN MCGUIRE	627 WOODLAND ST	NASHVILLE, TN 37206
TOM HAYNES	627 WOODLAND ST	NASHVILLE, TN 37206
TERRIE V. GOBLE	627 WOODLAND ST	NASHVILLE, TN 37206
ARELENE MARTIN-NORMAN	627 WOODLAND ST	NASHVILLE, TN 37206
ELIZABETH SWAFFORD	627 WOODLAND ST	NASHVILLE, TN 37206
CRAIG LARIMER	627 WOODLAND ST	NASHVILLE, TN 37206
BETTY HARDIN	627 WOODLAND ST	NASHVILLE, TN 37206

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS: LARRY D WOODS

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS: 631 SECOND AVE N, PO BOX 24727, NASHVILLE, TN 37202-4724

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE

(i.) CHANGE OF REGISTERED AGENT:

(ii.) CHANGE OF REGISTERED OFFICE:

(County)

RECEIVED
 STATE OF TENNESSEE
 2007 DEC -7 9M 3:25
 RILEY DANIELL
 SECRETARY OF STATE

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **MUTUAL**

TENNESSEE RELIGIOUS CORPORATION: NO

(8) SIGNATURE ELECTRONIC

(9) DATE: 12/7/2007

(10) TYPE PRINT NAME OF SIGNER ALLISON HEARING

(11) TITLE OF FILER: ACCOUNTANT

6166.0432

CONFIRMATION NUMBER: 100000673

6166.0433

State of Tennessee



Department of State

Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHANGE OF REGISTERED
AGENT/OFFICE
(BY CORPORATION)

RECEIVED
STATE OF TENNESSEE
For Office Use Only

2009 MAY -8 PM 1:47

THE COMPTON
SECRETARY OF STATE

6533.0769

Pursuant to the provisions of Section 48-15-102 or 48-25-108 of the Tennessee Business Corporation Act or Section 48-55-102 or 48-65-108 of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The name of the corporation is TENNESSEE STATE EMPLOYEES ASSOCIATION
INCORPORATED

2. The street address of its current registered office is 627 Woodland Street
Nashville, Tennessee 37206

3. If the current registered office is to be changed, the street address of the new registered office, the zip code of such office, and the county in which the office is located is _____

4. The name of the current registered agent is Larry D. Woods

5. If the current registered agent is to be changed, the name of the new registered agent is
Robert A. O'Connell

6. After the change(s), the street addresses of the registered office and the business office of the registered agent will be identical.

4/30/09
Signature Date
Executive Dir TSEA
Signer's Capacity

Tennessee State Employees Association, Inc.
Name of Corporation
[Signature]
Signature
Jim Tucker
Name (typed or printed)

AMENDED AND RESTATED CHARTER

OF

TENNESSEE STATE EMPLOYEES ASSOCIATION, INCORPORATED

RECEIVED
STATE OF TENNESSEE

2009 JUL -1 AM 11:26

TRE HARGETT
SECRETARY OF STATE

Pursuant to the provisions of T.C.A. §48-51-101, et seq. (the Tennessee Nonprofit Corporation Act), the undersigned not-for-profit corporation adopts the following Amended and Restated Charter:

1. The name of the corporation is Tennessee State Employees Association, Incorporated.
2. This corporation is a public benefit corporation.
3. The address of the registered office of the corporation is 627 Woodland Street, Nashville, Tennessee 37206.
4. The name of the registered agent is Robert A. O'Connell. His address is the same as that of the registered office, listed above.
5. The corporation is not-for-profit.
6. The corporation has members.
7. A Representative Assembly of the membership of the corporation shall be constituted as per the corporation's By-Laws and shall exercise such power and in such manner as shall be set out in the corporation's By-Laws, or as otherwise provided by law. Such Representative Assembly shall meet annually and conduct business, as per the corporation's By-Laws.
8. A Board of Directors of the corporation shall be constituted as per the corporation's By-Laws and shall exercise such power and in such manner as shall be set out in the corporation's By-Laws, or as otherwise provided by law.
9. This charter may be amended and/or restated by action of the members in Representative Assembly.

6560.2409

RECEIVED
STATE OF TENNESSEE

2009 JUL -1 AM 11: 26

WARGETT
SECRETARY OF STATE

10. The corporation's By-Laws may be amended or repealed by the members of the Representative Assembly.
11. The purposes of the corporation shall be those set out in its By-Laws.
12. Upon dissolution of the corporation, its net assets after payment of all debts, shall be distributed to a nonprofit corporation(s), organized for purpose(s) compatible with the purposes of this organization.
13. All members of the Board of Directors shall be immune from liability to the corporation or its members for monetary damages for breach of fiduciary duty as a director, excepting that such immunity shall not extend to any breach of the director's duty of loyalty to the corporation or its members, or to acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, or liability for unlawful distributions, under TCA §48-58-304.
14. This Amended and Restated Charter does not contain any amendment to the charter requiring approval by anyone other than the corporation's members, in Representative Assembly.

6560.2410

THIS AMENDED AND RESTATED CHARTER WAS ADOPTED BY THE MEMBERS OF THE TENNESSEE STATE EMPLOYEES ASSOCIATION IN REPRESENTATIVE ASSEMBLY, ON THE 6th DAY OF JUNE, 2009.

By: Philip H. Norson
PRESIDENT
TENNESSEE STATE EMPLOYEES ASSOCIATION

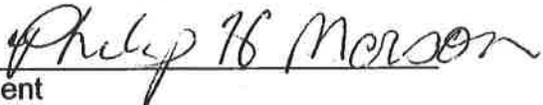
RECEIVED
STATE OF TENNESSEE

AMENDMENT AND
CHARTER RESTATEMENT CERTIFICATION - 1 AM 11:26

TRE HARGETT
SECRETARY OF STATE

1. The accompanying charter amendment and restatement for the Tennessee State Employees Association required approval by its members, in Representative Assembly, which was obtained on June 6, 2009. The approval of no other persons(s) was required.
2. The information required by TCA §48-60-105 is contained in the Amended and Restated Charter submitted herewith.

SO CERTIFIED ON THIS 23 day of June, 2009



President
Tennessee State Employees Association

6560.2411

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:

\$20, if no changes are made in block #6 to the registered agent/office, or
 \$40, if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
 Attn: Annual Report
 312 Rosa L. Parks Avenue, 6th Floor
 William R. Snodgrass Tower
 Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 06

THIS REPORT IS DUE ON OR BEFORE: 10/01/09

(1) SECRETARY OF STATE CONTROL Number: 0085416

(2A.) NAME AND MAILING ADDRESS OF CORPORATION

**TENNESSEE STATE EMPLOYEES ASSOCIATION,
 INCORPORATED
 627 WOODLAND ST
 NASHVILLE, TN 37206**



(2B.) STATE OR COUNTRY OF INCORPORATION
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
 627 WOODLAND STREET, NASHVILLE, TN 37206

B. CHANGE OF PRINCIPAL ADDRESS:
 STREET CITY STATE ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS.
 (ATTACH ADDITIONAL SHEET IF NECESSARY.)

Title	Name	Business Address	City, State, Zip Code + 4
President	PHIL MORSON	627 WOODLAND ST.	NASHVILLE, TN 37206
Secretary	JACKIE COLEMAN	627 WOODLAND ST.	NASHVILLE, TN 37206

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE.) (ATTACH ADDITIONAL SHEET IF NECESSARY.)
 SAME AS ABOVE, NONE, OR LISTED BELOW:

Name	Business Address	City, State, Zip Code + 4

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
 ROBERT A. O'CONNELL

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
 631 SECOND AVE N, PO BOX 24727, NASHVILLE, TN 37202-4724

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

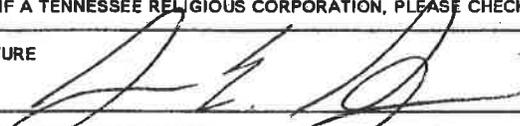
(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): 627 WOODLAND ST.
 (City) NASHVILLE (State) TN (Zip Code + 4) TN (County) DAVIDSON

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED:
 IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX: PUBLIC MUTUAL

MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK RELIGIOUS

(8) SIGNATURE 

(9) DATE 9/21/09

(10) TYPE/PRINT NAME OF SIGNER JON E. SNODIN

(11) TITLE OF SIGNER ACCOUNTANT II

**** THIS REPORT MUST BE DATED AND SIGNED ****



6609.1189

SECRETARY OF STATE
 2009 OCT -6 AM 8:26
 STATE OF TENNESSEE

TSEA BOARD OF DIRECTORS 2009-20010

PRESIDENT

Philip Morson
322 Harris Street
Bolivar, TN 38008-1815
WK: (731) 228-2303
HM: (731) 658-4900
pmorson66@hotmail.com (home)
philip.morson@tn.gov (work)

EAST VICE-PRESIDENT

James Ruth
815 Wildview Way
Knoxville, TN 37920
WK: (865) 397-0174 X135
HM: (865) 557-6291
jsruth1967@comcast.net (home)
james.ruth@tn.gov (work)

MIDDLE VICE-PRESIDENT

Gary A. Anderson, Sr.
1896 Savannah Highway
Waynesboro, TN 38485
HM: (931) 722-9238
Retired
garysr@netease.net (home)

WEST VICE PRESIDENT

Almous Austin
1039 Austin Road
Newbern, TN 38059-4607
WK: (731) 253-7070
HM: (731) 627-2431
FAX: (731) 627-9939
lolitaaustin@juno.com (home)

SECRETARY

Jackie Coleman
2602 Brittany Drive
Nashville, TN 37206
HM: (615) 226-0444
CELL: (615) 957-1303
Retired
jcvr@bellsouth.net (home)

TREASURER

Donnie Cole
920 Rock Creek Road
Estill Springs, TN 37330-3414
WK: 931-461-7720
HM: 931-649-2825
donnie.r.cole@tn.gov (work)

DISTRICT 1 DIRECTOR

Betty J. Kirkpatrick
931 Becton Williams Road
Ripley, TN 38063
HM: 731-635-2011
CELL: 731-413-7310
Retired
betkir@att.net

DISTRICT 2 DIRECTOR

Tom Haynes
4890 Shifri Avenue
Memphis, TN 38117
Retired
HM: (901) 761-9795

DISTRICT 3 DIRECTOR

Ernest Tisdale
P.O. Box 521
Whiteville, TN 38075
WK: (731) 228-2295
HM: (731) 254-8453
ernest.tisdale@tn.gov (work)

DISTRICT 4 DIRECTOR

Terrie V. Goble
3249 Oakridge Road
Palmyra, TN 37142
WK: (931) 648-5572
HM: (931) 326-9383
Terrie.Goble@tn.gov (work)
terriegoble@bellsouth.net (home)

DISTRICT 5 DIRECTOR

Martha Wettemann
714 Darrow Drive
Pleasant View, TN 37146
WK: (615) 253-6884
HM: (615) 746-8916
Martha.Wettemann@tn.gov (work)
jpowers8916@charter.net (home)

DISTRICT 6 DIRECTOR

Arlene Martin-Norman
681 Brewer Avenue
Nashville, TN 37211
WK: (615) 253-0042
HM: (615) 833-5893
arlene.martin-norman@tn.gov (work)
amartin-narman19@att.net

DISTRICT 7 DIRECTOR

JoAnn Bobo
1100 Ray Burton
Lynchburg, TN 37352
WK: 931-680-6901 ext. 122
HM: 931-759-4317
jo.bobo@tn.gov (work)
grannybobojo@gmail.com (home)

DISTRICT 8 DIRECTOR

Elizabeth Swafford
2220 Railroad Street
Dayton, TN 37321
Retired
HM: (423) 570-8199
swafford2220@aol.com (home)

DISTRICT 9 DIRECTOR

Stephen Thomas
423 19th Street NE
Cleveland, TN 37311
WK: (423) 338-5332 x109
CELL: (423) 421-1882
sathomas423@yahoo.com (home)

DISTRICT 10 DIRECTOR

Ms. Betty Hardin
215 Widow Newman Lane
Knoxville, TN 37924-3418
WK: (865) 594-2458
HM: (865-932-0273
FAX: (865)
bhardil10@bellsouth.net (home)

DISTRICT 11 DIRECTOR

Bryan Merritt
#5 Kensington Court
Johnson City, TN 37601
WK: (423) 743-3166 ext 32
HM: (423) 928-4315
bryan.merritt@tn.gov (work)
bryandistrict11@yahoo.com (home)

DISTRICT 12 DIRECTOR

Donald Burnette
3140 Joppa Mountain Road
Powder Springs, TN 37848
WK: 865-397-0174 ex 314
HM: 865-497-2656
donald.burnette@tn.gov (work)
bigdonepib@frontiernet.net (home)

IMM. PAST PRESIDENT

VACANT

6609.1190