

SERFF Tracking Number: FRCS-127808925 State: Arkansas
Filing Company: American Republic Insurance Company State Tracking Number: 50251
Company Tracking Number: 5637
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental Filing
Project Name/Number: Secur/79/79

Filing at a Glance

Company: American Republic Insurance Company

Product Name: Group Dental Filing

SERFF Tr Num: FRCS-127808925 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-
Closed State Tr Num: 50251

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: 5637

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor,
Donna Lambert

Author: Kevin Wiggs

Disposition Date: 05/01/2012

Date Submitted: 11/11/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Secur/79

Status of Filing in Domicile: Pending

Project Number: 79

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Submitted on or
about this same date (IA).

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Discretionary, Trust

Overall Rate Impact:

Filing Status Changed: 05/01/2012

State Status Changed: 05/01/2012

Deemer Date:

Created By: Kevin Wiggs

Submitted By: Kevin Wiggs

Corresponding Filing Tracking Number:

Filing Description:

We have been retained by American Republic Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$250 has been sent by EFT on this same date.

The Company offers their assurance that the information required by Section 23-79-138 will be provided.

The Company offers their assurance that the Guaranty Association notice required by Regulation 49 will be provided.

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The captioned forms provide group dental insurance that will be issued pursuant to a group master policy issued to the Voluntary Supplemental Benefits Trust, which is situated in Wyoming. This trustee group was found acceptable by the Wyoming Department in 2000.

Benefit descriptions are found in the exemplified schedule pages of the policy and rider(s). The enclosed Coverage Schedules pages are representative of those intended for use. Information on these pages is variable, but will never be less than the applicable minimum requirements of your state's laws.

The insurance will be marketed through properly licensed representatives.

All forms are written in readable language and will be in a format that is acceptable to the Department. Printing is subject to changes in ink, paper stock, page numbering, margins, positioning, and format. Printing standards will never be less than that required by law.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

State Narrative:

Company and Contact

Filing Contact Information

Kevin Wiggs, Compliance Specialist kevin.wiggs@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2736 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

American Republic Insurance Company	CoCode: 60836	State of Domicile: Iowa
PO Box 1	Group Code: 3527	Company Type:
Des Moines, IA 50306	Group Name:	State ID Number:
(515) 245-2000 ext. [Phone]	FEIN Number: 42-0113630	

Filing Fees

SERFF Tracking Number: FRCS-127808925 State: Arkansas
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Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No
Fee Explanation: AR fee of \$50 per form (5) = \$250
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Insurance Company	\$250.00	11/11/2011	53692736
American Republic Insurance Company	\$50.00	12/20/2011	54698721

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2012	05/01/2012
Approved	Donna Lambert	12/21/2011	12/21/2011
Closed-Incomplete	Donna Lambert	12/19/2011	12/19/2011

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	Rosalind Minor	11/16/2011	11/16/2011	Lynn Cravin	12/07/2011	12/20/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Enrollment Form	Marilyn Odell	04/30/2012	04/30/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open	Note To Reviewer	Jana Finlay	04/18/2012	04/18/2012

SERFF Tracking Number: *FRCS-127808925* *State:* *Arkansas*
Filing Company: *American Republic Insurance Company* *State Tracking Number:* *50251*
Company Tracking Number: *5637*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental Filing*
Project Name/Number: *Secur/79/79*

Disposition

Disposition Date: 05/01/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-127808925 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Voluntary Supplemental Benefits Trust document	Approved	Yes
Form	Group Certificate	Approved	Yes
Form	Certificate Schedules	Approved	Yes
Form	Orthodontia Benefit Rider	Approved	Yes
Form	Endorsement	Approved	Yes
Form (revised)	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form	Vision Benefit Rider	Approved	Yes

SERFF Tracking Number: FRCS-127808925 *State:* Arkansas
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TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Group Dental Filing
Project Name/Number: Secur/79/79

Disposition

Disposition Date: 12/21/2011

Implementation Date: 01/23/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Product Name: Group Dental Filing
Project Name/Number: Secur/79/79

Disposition

Disposition Date: 12/19/2011

Implementation Date: 12/19/2011

Status: Closed-Incomplete

Comment:

Rate data does NOT apply to filing.

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Form (revised)	Enrollment Form	Approved-Closed	Yes
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Project Name/Number: Secur/79/79

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/16/2011

Submitted Date 11/16/2011

Respond By Date

Dear Kevin Wiggs,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Certificate, AR-Cert3200 (Form)

Comment:

it is stated that the Policyholder is the Voluntary Supplementary Benefits Trust which was found acceptable by the Wyoming Department in 2000.

Is this a Multiple Employer Trust? If so, the trust must register with our License Division. The forms and instructions may be found at our License Division website at: <http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TRUST, MET, MEWA.

If it is not a multiple employer trust, please provide us a copy of the trust agreement.

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,

Rosalind Minor

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Project Name/Number: Secur/79/79

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/07/2011
Submitted Date 12/20/2011

Dear Rosalind Minor,

Comments:

In response to your objection letter dated 11-16-11, on behalf of the Company, we offer the following for your consideration.

Response 1

Comments: In accordance with your request, we have attached (in Supporting Documentation) a copy of the Trust document relating to the Voluntary Supplemental Benefits Trust, which is situated in the state of Wyoming. This trust is not a Multiple Employer Trust.

As noted in the filing description, the trust was found acceptable in Wyoming in 2000. It is also our understanding that the trust was found acceptable in Arkansas in 2000 as well.

Related Objection 1

Applies To:

- Group Certificate, AR-Cert3200 (Form)

Comment:

it is stated that the Policyholder is the Voluntary Supplementary Benefits Trust which was found acceptable by the Wyoming Department in 2000.

Is this a Multiple Employer Trust? If so, the trust must register with our License Division. The forms and instructions may be found at our License Division website at:

<http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TRUST, MET, MEWA.

If it is not a multiple employer trust, please provide us a copy of the trust agreement.

Changed Items:

Supporting Document Schedule Item Changes

SERFF Tracking Number: FRCS-127808925 State: Arkansas
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Satisfied -Name: Voluntary Supplemental Benefits Trust document
 Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Vision Benefit Rider	AR3211		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		63.900	Vision Rider AR3211.pdf

No Rate/Rule Schedule items changed.

In addition to the requested information, we have added a new form to this filing. Form AR3211, a Vision Benefit Rider, has been added to the Form Schedule. Since your filing fees are based on the number of forms in the filing, we have also added \$50 to the fee schedule on this same date.

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Sincerely,
 Kevin Wiggs

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 Project Name/Number: Secur/79/79

Amendment Letter

Submitted Date: 04/30/2012

Comments:

Thank you for re-opening this filing for us. Subsequent to the approval of this filing, the Company made changes to the enrollment form AR3306. The Company would like to replace the previously approved enrollment form with the revised version. The Company verifies that the approved enrollment form that is being replaced has not been and will not be issued or used.

If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR3306	Application/Enrollment Form	EEnrollment Form	Initial				0.000	Enrollment form -01-112-0970-0412-US with brackets.pdf

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Product Name: Group Dental Filing
Project Name/Number: Secur/79/79

Note To Reviewer

Created By:

Jana Finlay on 04/18/2012 04:35 PM

Last Edited By:

Jana Finlay

Submitted On:

04/18/2012 04:47 PM

Subject:

Request to re-open

Comments:

Subsequent to the approval of this filing, the Company made changes to the enrollment form AR3306. We are requesting that you reopen the SERFF filing so we may replace the enrollment form with the revised version. The Company verifies that the approved enrollment form that will be replaced has not been and will not be issued or used.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

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Form Schedule

Lead Form Number: AR-Cert3200

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/21/2011	AR-Cert3200	Certificate	Group Certificate	Initial		56.500	Cert-AR-Cert3200_bk mrkd.pdf
Approved 12/21/2011	AR3200	Certificate	Certificate Schedules	Initial		50.000	Sched R&C AR3200.pdf Sched_Age65 & Over AR3200.pdf
Approved 12/21/2011	AR3199	Certificate	Orthodontia Benefit	Initial		66.300	Ortho Rider- AR3199 (group).pdf
Approved 12/21/2011	AR3230(A R)	Certificate	Endorsement	Initial		62.900	(AR) End_AR3230 - 11-3-11.pdf
Approved- Closed 05/01/2012	AR3306	Application/	Enrollment Form	Initial		0.000	Enrollment form -01-112- 0970-0412- US with brackets.pdf
Approved 12/21/2011	AR3211	Certificate	Vision Benefit Rider	Initial		63.900	Vision Rider AR3211.pdf

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nt or Rider

American Republic Insurance Company (herein called We, Our or Us) certifies that the Insureds listed on the Certificate sticker below are covered under the Policy issued to the Policyholder. The Certificateholder is called You, Your and Yours in this Certificate.

Policyholder: [Voluntary Supplementary Benefits Trust]	Policy #: [12345]
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YOUR GROUP INSURANCE CERTIFICATE

GENERAL INFORMATION

About Your Insurance

This Certificate explains the plan of insurance underwritten by American Republic Insurance Company. Read it closely to become familiar with Your coverage.

In the Policy and this Certificate the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Important Notice - Benefits are payable only for expenses incurred while Your insurance is in force.

No agent has the right to change the Policy or to waive any part of it.

The Policy, under which this Certificate is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Signed for American Republic Insurance Company



Michael E Abbott
President

TABLE OF CONTENTS

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DEFINITIONS

ADA CODE - means the American Dental Association Code assigned to a particular dental procedure.

COURSE OF TREATMENT- means all treatment and procedures performed in the oral cavity under a plan of treatment during all sessions that are the result of the same initial diagnosis. It also includes any complications during such treatment.

DENTAL HYGIENIST - means a person who works under the supervision of a Dentist/Physician and who is currently licensed to practice dental hygiene.

DENTIST/PHYSICIAN- means a person who is licensed to practice and who is operating within the scope of his license. It does not mean a member of an Insured's immediate family.

DEPENDENT - means any of the following persons:

1. Your spouse;

2. Each unmarried child, from birth to age 19, for whom You can claim an exemption on Your federal income tax.
3. Each unmarried child at least 19 years of age:
 - a. who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
 - b. who was incapacitated and insured under the Policy on his 19th birthday and continues to be incapacitated beyond his 19th birthday.

Any exception to the definition of Dependent for a full-time student may be found in the Coverage Schedule.

ELIGIBLE EXPENSES - means covered dental services and procedures described in this Certificate.

INSURED - means You and Your Dependents covered under the Policy and for whom a premium is paid.

POLICY - means the Policy issued to the Policyholder.

CONDITIONS FOR INSURANCE

YOUR INSURANCE STARTS- You and Your Dependents are covered on the later of:

1. the date We accept Your enrollment and determine an effective date; or
2. the date You first acquire a Dependent, if the date is after Your coverage begins.

NEWBORN INFANT COVERAGE - A Dependent child is covered from the moment of birth. If any additional premium is required, a notice of birth together with the premium must be submitted to Us. This must be done within 31 days after the date of birth to continue coverage beyond the first 31-day period.

ADOPTED CHILDREN COVERAGE - A Dependent child placed with You for adoption is covered from the date of such placement. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

If any premium is required, a notice of placement for adoption together with the premium must be submitted to us. This must be done within 31 days after the date of such placement to continue coverage beyond the 31-day period.

YOUR INSURANCE ENDS - Insurance for You and Your Dependents will end on the earliest of:

1. the last day You cease to be eligible;
2. the last day Your Dependent ceases to be a Dependent, as defined;
3. last day of the month for which a premium has been paid, subject to the Grace Period; or
4. date the Policy ends.

If Your coverage ends it will not prejudice any existing claim.

DENTAL INSURANCE

ELIGIBLE EXPENSES: We will pay for Eligible Expenses You incur for Yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule.

To be an Eligible Expense, the dental service or procedure must be performed by a:

1. Dentist;
2. Physician; or
3. Dental Hygienist.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates:

1. For dentures - the date the final impression is taken.
2. For fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For all other services - the date the service is performed.

PRETREATMENT REVIEW: If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will require prior review.

We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate less expensive Course of Treatment if it will produce professionally -satisfactory results

If You do not request a pretreatment review We will pay for the least expensive method of treatment regardless of the method actually used.

ALTERNATE BENEFIT: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and

2) the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

MAXIMUM CALENDAR YEAR LIMIT: The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

DEDUCTIBLE: The lifetime and calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

COORDINATION OF BENEFITS

If any person is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans. This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and
2. the benefits that would be payable under all other plans without provisions for coordination in those plans would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits is applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other plans will not exceed the total of those Eligible Expenses. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

Rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person other than as a dependent will be determined before the benefits of a plan covering the person as a dependent.
2. Except as stated in (3) below, when this Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the parent whose birthday falls later in that year; but
 - b. if both parents have the same birthday, the benefits of the plan covering the parent longer are determined before benefits covering the other parent for the shorter period of time. However, if the other plan does not have this rule and instead uses a different method, and as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:
 - a. first, the plan of the parent with custody of the child;
 - b. then, the plan of the spouse of the parent with custody of the child; and
 - c. finally, the plan of the parent not having custody of the child.

However, if the terms of a court decree state that one of the parents is responsible for the health care expenses of a child, and the entity obligated to pay or provide the benefits of the has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any Claim Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as the 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 4. is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a plan covering the person the shorter period of time.

If We are responsible for secondary coverage for Eligible Expenses, We will not deny coverage or payment of the amount We owe as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This will not require Us to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Plan or any similar provisions of other plans, We may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which We consider necessary.

Any person claiming benefit under this Plan will furnish Us with any information necessary.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other plans, We will have the right, at Our sole discretion, to pay any organizations making these payments any amount We determine to be due.

Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these

payments, We will be fully discharged from liability under this Plan.

Whenever payments have been made by Us, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, We will have the right to recover the excess from one or more of the following: (1) other insurance companies; (2) other organizations; or (3) persons to or for whom payments were made. All benefits provided under the Policy are subject to coordination.

DEFINITIONS. The following definitions apply only to this Coordination of Benefits section:

1. The term "plan" means coverage providing hospital, medical or dental benefits or services by:
 - a. group or blanket insurance coverage except school accident coverage;
 - b. group Blue Cross and Blue Shield, group practice or other pre-payment coverage on a group basis; or
 - c. labor-management trustee plans, union

welfare plans, employer organization plans or employee benefit plans.

"plan" will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

2. The term "Eligible Expense" means any necessary, reasonable and customary item of expense all or part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both a Eligible Expense and a benefit paid.
3. The term "Claim Period" means a calendar year or portion of a calendar year for a claim on a person covered under this Plan.

GENERAL PROVISIONS

OUR RIGHT TO CONTEST: After coverage for the insured person has been in force for two years during the insured person's lifetime, we do not have the right to contest the insured person's coverage except for fraud or non-payment of premium.

REINSTATEMENT: If Your coverage lapses, it may be reinstated with a request for reinstatement in writing. We will only cover losses that begin more than 10 days from Our acceptance of Your reinstatement and required premium.

NOTICE OF CLAIM: Written notice of claim must be given to Us within 30 days after the beginning of the loss, or as soon as reasonably possible. Notice given to Us at Our Administrative Service Office or to Our authorized administrator with information sufficient to identify the insured person will be notice to Us.

PAYMENT OF CLAIMS: If the Policy provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care, and such parent does not have custody of the dependent, We may, upon request of the custodial parent, make the payments directly to the provider of care. Any payments so made will release Us from all further liability to the Insured to the extent of the payments made. Benefits for other losses are paid to the Insured. However, We have the right to pay all or part of the benefits due to the provider of care. This is true whether or not the Insured is alive. If the Insured has died and We do not pay accrued benefits to the provider of care, benefits will be paid to the Insured's estate.

CLAIMS FORM: When We receive written notice of claim, We will send forms for filing proof of loss. If such forms are not sent within 15 days after giving notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of loss.

PROOF OF LOSS: Written proof of loss must be furnished to Us within 90 days after the date of loss. If it is not possible to give notice within the time required We will not deny the claim for such reason, if proof is given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIM: We will pay immediately, or within 30 days following receipt of due written proof of loss, all benefits due under the Policy.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to examine the person whose injury or sickness is the basis of claim as often as We may reasonably require during the pendency of a claim.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Policy. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

RIGHT OF REFUND

(This provision will apply except where prohibited by law.)

WHEN THIS PROVISION APPLIES: An insured person may incur charges due to injuries for which benefits are paid by the Policy. The injuries may be caused by the act or omission of another person. If so, the insured person may have a claim against that other person for payment of dental charges. If recovery under the claim is made, the insured person must repay Us the recovery made from: (a) the other person; or (b) the other person's insurer.

AMOUNT SUBJECT TO REFUND: Only the amount recovered for charges incurred will be subject to refund. One-third of the net recovery will be deemed to be for such charges. However, in no case will the amount of refund exceed the amount of Policy benefits paid for the injury.

DEFINED TERMS: "Recovery" means monies paid to the insured person through judgment, settlement or otherwise to compensate for all losses caused by the injuries. "Net Recovery" means the insured person's recovery less attorney's fees and court costs incurred in making the recovery. "Refund" means repayment to us for benefits paid.

RECOVERY FROM ANOTHER INSURER OF THE INSURED: This right of refund also applies when an insured person recovers under an uninsured or underinsured motorist plan.

**COVERAGE SCHEDULE
 DENTAL INSURANCE PLAN**

WE WILL PAY THE REASONABLE AND CUSTOMARY CHARGE FOR DENTAL PROCEDURES AND SERVICES AFTER ANY REQUIRED DEDUCTIBLE AMOUNT, AS SHOWN BELOW.

[Class A. Preventive Services Include:

1. two routine examinations of mouth and teeth per calendar year;
2. two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
3. one topical fluoride per calendar year, to age 16;
4. space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment.

Deductible, each calendar year	\$50*
We pay, after Deductible	100%

Class B. Basic Services, Include:

1. simple extraction of teeth;
2. one diagnostic x-ray, full or panoramic in any 3-year period;
3. bitewing x-rays, 2 per calendar year; and
4. pin retention of fillings;
5. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
6. antibiotic injections administered by Dentist; or

Deductible, each calendar year	\$50*
We pay, after Deductible	80%
Waiting Period - 6 Months.	

Class C. Major Services Include:

1. oral surgery , including postoperative care for:
 - a. removal of teeth, including impacted teeth;
 - b. extraction of tooth root,
 - c. alveolectomy, alveoplasty, and frenectomy;
 - d. excision of periocoronary gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
 - e. reimplantation or transplantation of a natural tooth; and
 - f. excision of a tumor or cyst and incision and drainage of an abscess or cyst.
2. endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
 - a. root canal therapy (not covered, if pulp chamber was opened before covered);
 - b. pulpotomy;
 - c. apicoectomy; and
 - d. retrograde fillings.
3. periodontic services, limited to:
 - a. two prophylaxis following surgery per calendar year;
 - b. root scaling and planing, once per quadrant of mouth in any 6 month period;
 - c. occlusal adjustment, performed with covered surgery;
 - d. gingivectomy, gingival curettage, and mucogingival;
 - e. osseous surgery including flap entry and closure;
 - f. pedicle or free soft tissue grafts; and
 - g. one appliance (night guards) in 5-year period.

COVERAGE SCHEDULE DENTAL INSURANCE PLAN

Class C. Major Services Include:

4. one study model in 3-year period;
5. crown build-up for non-vital teeth;
6. recementing inlays, onlays and crowns;
7. recementing bridges;
8. one repair of dentures or bridges in any 2-year period, limited to 20% of cost of replacement;
9. general anesthesia and analgesic, including intravenous sedation, for oral surgery;
10. restoration services, limited to:
 - a. gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
 - b. replacement of existing inlay, onlay, or crown, after 5 years of the restoration initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered.
 - c. stainless steel crowns.
 - d. post and core.
11. prosthetic services, limited to:
 - a. initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after covered under the Policy for 36 months.
 - b. replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of placed or last replaced.
 - c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation will not apply after covered under the Policy for 36 months.
 - d. relining or rebasting of existing removable dentures, only after one year from date the denture was placed and only once in any 2-year period

Deductible, each calendar year	\$50*
We pay, after Deductible	50%
Waiting Period - 18 Months.	

Maximum Benefit Amount:	
Combined per calendar year for Classes A, B and C	\$1,500
*Class A, B and C Deductible is combined \$50 each calendar year.	
If Course of Treatment is to exceed \$300, prior review is required.	

COVERAGE SCHEDULE DENTAL INSURANCE PLAN

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures.
2. for charges in excess of those considered reasonable and customary.
3. for cosmetic procedures.
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
5. for implants; and for:
 - a. replacement of lost or stolen appliances;
 - b. replacement of retainers;
 - c. athletic mouthguards;
 - d. precision or semi-precision attachments;
 - e. denture duplication; or
 - f. sealants.
6. for oral hygiene instructions; and for:
 - a. plaque control;
 - b. completion of a claim form;
 - c. acid etch;
 - d. broken appointments;
 - e. prescription or take-home fluoride; or
 - f. diagnostic photographs.
7. for services not completed by the end of the month in which coverage ends, unless continuation of coverage has been requested and accepted by Us.
8. for procedures that are begun, but not completed.
9. for services and treatment provided without charge or for which there would be no charge in the absence of insurance.
10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
11. for a condition covered under any Worker's Compensation Act or similar law.
12. that are applied toward satisfaction of a Deductible, if any.
13. that are generally considered by the dental profession as experimental or investigational.
14. for the treatment of cleft palate and anodontia.
15. for services or supplies payable under any medical expense plan.
16. for orthodontia, unless included by rider.
17. prior to the date the Insured is covered under the Policy.
18. for the diagnosis or treatment of TMJ.
19. for hospital services.
20. following Your 65th birthday, unless We waive this limitation on the Coverage Schedule;
21. for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23.
22. during any waiting period We require, when You voluntarily end Your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date Your coverage first ended.]

[REASONABLE AND CUSTOMARY - means the usual, customary and regular charges for the area where expenses are incurred.]

DENTAL INSURANCE PLAN

WE WILL PAY FOR THE PROCEDURES AND SERVICES LISTED IN THE SCHEDULE OF ELIGIBLE EXPENSES, NOT TO EXCEED THE LESSER OF THE ACTUAL CHARGE OR THE SCHEDULED BENEFIT FOR THE PROCEDURE OR SERVICE.

[Maximum Limit:
 Each Calendar Year \$ 1,000.00

Deductible Amount
 Each Insured, each calendar year \$ 75.00
 Each Family, each calendar year \$ 225.00
 The Deductible Amount is not required for Class A Eligible Expenses.

Coinsurance Amount, We will pay the following percentage after the Deductible
 Eligible Expenses in Class A 80%
 Eligible Expenses in Class B 80%
 Eligible Expenses in Class C 50%

Waiting Period For:
 Eligible Expenses in Class A NONE
 Eligible Expenses in Class B 6 Months
 Eligible Expenses in Class C 18 Months]

SCHEDULED BENEFIT - means the specific benefit for each particular procedure shown in the Schedule of Eligible Expenses.

[SCHEDULED PROCEDURE CODES

Class	From:	To:
Class A. – Preventive	Code – 1	Code - 99
Class A. – Preventive	Code - 400	Code - 1999
Class B – Basic	Code – 200	Code - 399
Class B – Basic	Code – 2000	Code - 2499
Class B – Basic	Code – 7110	Code – 7120
Class B – Basic	Code - 9000	Code - 9999
Class C – Major	Code – 7130	Code - 7999
Class C – Major	Code – 2500	Code - 6999

]

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred:

1. for overdentures and associated procedures.
2. for charges in excess of those considered reasonable and customary.
3. for cosmetic procedures.
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
5. for implants; and for:
 - a. replacement of lost or stolen appliances;
 - b. replacement of retainers;
 - c. athletic mouthguards;
 - d. precision or semi-precision attachments;
 - e. denture duplication; or
 - f. sealants.
6. for oral hygiene instructions; and for:
 - a. plaque control;
 - b. completion of a claim form;

- c. acid etch;
 - d. broken appointments;
 - e. prescription or take-home fluoride; or
 - f. diagnostic photographs.
7. for services not completed by the end of the month in which coverage ends, unless continuation of coverage has been requested and accepted by Us.
 8. for procedures that are begun, but not completed.
 9. for services and treatment provided without charge or for which there would be no charge in the absence of insurance.
 10. for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
 11. for a condition covered under any Worker's Compensation Act or similar law.
 12. that are applied toward satisfaction of a Deductible, if any.
 13. that are generally considered by the dental profession as experimental or investigational.
 14. for the treatment of cleft palate and anodontia.
 15. for services or supplies payable under any medical expense plan.
 16. for orthodontia, unless included by rider.
 17. prior to the date the Insured is covered under the Policy.
 18. for the diagnosis or treatment of TMJ.
 19. for hospital services.
 20. for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23.
 21. during any waiting period We require, when You voluntarily end Your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date Your coverage first ended.]

SCHEDULE OF ELIGIBLE EXPENSES

<u>[Code</u>	<u>Benefit</u>	<u>Code</u>	<u>Benefit</u>
120	PERIODIC ORAL EVALUATION	19	
140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	29	
150	COMPREHENSIVE ORAL EVALUATION	31	
150	DETAILED EXTEN ORAL EVALUATION-PROBLEM FOCUSED, BY REPORT	43	
210	INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS	54	
220	INTRAORAL-PREIAPICAL-FIRST FILM	11	
230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	8	
240	INTRAORAL-OCCLUSAL FILM	15	
250	EXTRAORAL-FIRST FILM	21	
260	EXTRAORAL – EACH ADDITIONAL FILM	20	
270	BITEWINGS-SINGLE FILM	12	
272	BITEWINGS-TWO FILMS	19	
274	BITEWINGS-FOUR FILMS	24	
290	POST/ANT OR LAT SKULL AND FACE BONE SURVEY FILM	72	
310	SIALOGRAPHY	183	
320	TMJ ARTHROGRAM INCLUDING INJECTION	313	
321	OTHER TMJ FILMS, BY REPORT	0	
322	TOMOGRAPHIC SURVEY	251	
330	PANORAMIC FILM	49	
340	CEPHALOMETRIC FILM	53	
415	BACTERIOLOGIC STUDIES FOR DETERM. PATH. AGENTS	17	
425	CARIES SUSCEPTIBILITY TESTS	11	
460	PULP VITALITY TESTS	20	
470	DIAGNOSTIC CASTS	42	
471	DIAGNOSTIC PHOTOGRAPHS	24	
501	HISTOPATHOLOGIC EXAMINATIONS	54	
502	OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT	0	
999	UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT	0	
1110	PROPHYLAXIS-ADULT	41	
1120	PROHPYLAXIS-CHILD	27	
1201	TOPICAL APPLICATION OF FLUORIDE INCLD/PXS CHILD	41	
1203	TOPICAL APPLIC FLUORIDE PXS NOT INCL-CHILD	18	
1204	TOPICAL APPLIC FLUORIDE PXS NOT INCL-ADULT	17	
1205	TOPICAL APPLIC OF FLUORIDE INCLD/PXS ADULT	48	
1310	NUTRITIONAL COUNSELING-CONTROL DENTAL DISEASE	20	
1320	TOBACCO COUNSELING-CONTROL & PREVENTION OF ORAL DISEASE	18	
1330	ORAL HYGIENE INSTRUCTIONS	26	
1351	SEALANT-PER TOOTH	21	
1510	SPACE MAINTAINER-FIXED-UNILATERAL	128	
1515	SPACE MAINTAINER-FIXED-BILATERAL	180	
1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	159	
1525	SPACE MAINTAINER-REMOVABLE BILATERAL	218	
1550	RECEMENTATION OF SPACE MAINTAINER	28	
2110	AMALGAM-ONE SURFACE, PRIMARY	40	
2120	AMALGAM-TWO SURFACE, PRIMARY	51	
2130	AMALGAM-THREE SURFACE, PRIMARY	61	
2131	AMALGAM-FOUR OR MORE SURFACE, PRIMARY	73	
2140	AMALGAM-ONE SURFACE, PERMANENT	44	
2150	AMALGAM-TWO SURFACE, PERMANENT	59	
2160	AMALGAM-THREE SURFACE, PERMANENT	74	
2161	AMALGAM-FOUR OR MORE SURFACE, PERMANENT	84	
2210	SILICATE CEMENT-PER RESTORATION	40	
2330	RESIN-ONE SURFACE, ANTERIOR	57	
2331	RESIN-TWO SURFACE, ANTERIOR	78	
2332	RESIN-THREE SURFACE, ANTERIOR	91	
2335	RESIN-FOUR OR SURFACE OR INVL INCISAL ANGLE (ANTERIOR)	108	
2336	COMPOSITE RESIN CROWN-ANTERIOR PRIMARY	117	
2380	RESIN-ONE SURFACE, POSTERIOR-PERMANENT	67	
2381	RESIN-TWO SURFACE, POSTERIOR-PRIMARY	78	
2382	RESIN-THREE OR MORE SURFACE, POSTERIOR-PRIMARY	95	
2385	RESIN-ONE SURFACE, POSTERIOR PERMANENT	66	
2386	RESIN-TWO SURFACE, POSTERIOR-PERMANENT	91	
2387	RESIN-THREE OR MORE SURFACE, POSTERIOR-PERMANENT	113	
2410	GOLD FOIL-ONE SURFACE	130	
2420	GOLD FOIL-TWO SURFACE	217	
2430	GOLD FOIL-THREE SURFACE	375	
2510	INLAY-METALLIC-ONE SURFACE	344	
2520	INLAY-METALLIC-TWO SURFACE	390	
2530	INLAY-METALLIC-THREE OR MORE SURFACES	449	
2543	ONLAY-METALLIC-THREE-SURFACES	461	
2544	ONLAY-METALLIC-FOUR OR MORE SURFACE	479	
2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	404	
2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACE	427	
2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACE	455	
2641	ONLAY PORCELAIN/CERAMIC-TWO SURFACE	442	
2643	ONLAY PORCELAIN/CERAMIC-THREE SURFACE	477	
2644	ONLAY POCESLAIN/CERAMIC-FOUR OR MORE SURFACE	505	
2650	INLAY-COMPOSITE/RESIN-ONE SURF (LAB PROCESSED)	332	
2651	INLAY-COMPOSITE/RESIN-TWO SURFACE (LAB PROCESSED)	396	
2652	INLAY-COMPOSITE/RESIN-THREE OR MORE SURFACE (LAB PROCESSED)	416	
2662	ONLAY-COMPOSITE/RESIN-TWO SURFACE (LAB PROCESSED)	361	
2663	ONLAY-COMPOSITE/RESIN-THREE SURFACE (LAB PROCESS)	425	
2664	ONLAY-COMPOSITE/RESIN-FOUR OR MORE SURFACE (LAB PROCESSED)	455	
2710	CROWN-RESIN-LABORATORY	205	
2720	CROWN-RESIN WITH HIGH NOBLE METAL	505	
2721	CROWN-RESIN WITH MOSTLY BASE METAL	474	
2722	CROWN-RESIN WITH NOBLE METAL	484	

<u>Code</u>	<u>Benefit</u>	<u>Code</u>	<u>Benefit</u>
2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	519	
2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	501	
2751	CROWN- PORCELAIN FUSED TO MOSTLY BASE METAL	477	
2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	488	
2790	CROWN-FULL CAST HIGH NOBLE METAL	494	
2791	CROWN-FULL CAST MOSTLY BASE METAL	468	
2792	CROWN-FULL CAST NOBLE METAL	477	
2810	CROWN-3/4 CAST METALLIC	482	
2910	RECEMENT INLAY	36	
2920	RECEMENT CROWN	38	
2930	PREFABRICATED STAINLESS CROWN-PRIMARY	103	
2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT	116	
2932	PREFABRICATED RESIN CROWN	127	
2933	PREFABRICATED. STAINLESS STEEL CROWN W/RESIN WINDOW	142	
2940	SEDATIVE FILLING	39	
2950	CORE BUILD-UP, INCLUDING ANY PINS	98	
2951	PIN RETENTION/TOOTH, IN ADDITION TO RESTORATION	21	
2952	CAST POST AND CORE IN ADDITION TO CROWN	150	
2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	124	
2955	POST REMOVAL (NOT IN CONJUNCTION W/ENDODONTIC THERAPY)	93	
2960	LABIAL VENEER (LAMINATE)-CHAIRSIDE	304	
2961	LABIAL VENEER (RESIN LAMINATE)-LABORATORY	340	
2962	LABIAL VENEER (PORCELAIN LAMINATE)-LABORATORY	369	
2970	TEMPORARY CROWN (FRACTURED TOOTH)	88	
2980	CROWN REPAIR, BY REPORT	0	
2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	0	
3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)	29	
3120	PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)	23	
3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL REST)	70	
3230	PULPAL THER (RESTORABLE FILL)-ANTERIOR PRIMARY TOOTH	74	
3240	PULPAL THER (RESTORABLE FILL)-POST PRIM ARY TOOTH	79	
3310	ROOT CANAL-ANTERIOR (EXCLUDING FINAL RESTORATION)	295	
3320	ROOT CANAL-BICUSPIC (EXCLUDING FINAL RESTORATION)	360	
3330	ROOT CANAL-MOLAR (EXCLUDING FINAL RESTORATION)	477	
3346	RETREATMENT PREVIOUS ROOT CANAL THERAPY-ANTERIOR	397	
3347	RETREATMENT PREVIOUS ROOT CANAL THERAPY-BICUSPID	468	
3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY-MOLAR	562	
3351	APEXIFICATION/RECALCIFICATION.-INITIAL VISIT (AP.CLOS./CAL. REP.ETC)	167	
3352	APEXIFICATION/RECALCIFICATION.-INTERIM MEDICATION REPLACEMENT	73	
3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT	247	
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	337	
3421	APICOECTOMY/PERIRADICULAR SURG.-BICUSP (FIRST ROOT)	368	
3425	APICOECTOMY/PERIRADICULAR SURG.-MOLAR (FIRST ROOT)	442	
3426	APICOECTOMY/PERIRADICULAR SURG - (EACH ADDITIONAL ROOT)		
3430	RETROGRADE FILLING-PER ROOT	116	
3450	ROOT AMPUTATION-PER ROOT	207	
3460	ENDODONTIC ENDOSSEOUS IMPLANT	961	
3470	INTENTIONAL REPLANTATION (INCL.NECESARY SPLINTING)	413	
3910	SURGICAL PROCEDURE FOR ISOLATION TOOTH WITH ROOT DAM	54	
3920	HEMISECTION (INC ROOT REMOVAL) NOT INC ENDODONTIC	162	
3950	CANAL PREP AND FITTING OR PREFORMED DOWEL/POST	74	
3960	BLEACHING OF DISCOLORED TOOTH	148	
3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	0	
4210	GINGIVECTOMY OR GINGIVOPLASTY-PER QUADRANT	290	
4211	GINGIVECTOMY OR GINGIVOPLASTY-PER TOOTH	83	
4220	GINGIVAL CURETTAGE, SURGICAL - PER QUAD, BY REPORT	103	
4240	GINGIVAL FLAP PROCEDURE INC ROOT PLANING/QUAD	342	
4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	390	
4250	MUCOGINGIVAL SURGERY-PER QUADRANT	394	
4260	OSSEOUS SURGERY INCLUDING FLAP ENTRY/CLOSURE/QUAD	552	
4263	BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT	417	
4264	BONE REPLACEMENT GRAFT-EACH ADDITIONAL SITE IN QUADRANT	316	
4266	GUIDED TISSUE REGEN-RESORB BARRIER/SITE/TOOTH	445	
4267	GUIDED TISSUE REGEN-NON RESORB PER SITE, TOOTH	471	
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	408	
4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCL DONOR SITE SURGERY)	419	
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT (INCL DONOR)	448	
4274	DISTAL/PROXIMAL WEDGE PROCEDURE (NOT W/PROCEDURE SAME AREA)	126	
4320	PROVISIONAL SPLINTING-INTRACORONAL	205	
4321	PROVISIONAL SPLINTING-EXTRACORONAL	180	
4341	PERIO SCALING AND ROOT PLANING-PER QUADRANT	103	
4355	FULL MOUTH DEBRIDE-ENABLE PERIODONTAL EVALUATION & DX	74	
4381	LOCAL DELIV-CHEMO TO DISEASED CREVICULAR TISSUE BR	0	
4910	PERIO MAINTENANCE PROCEDURE FOLLOWING ACTIVE THERAPY	65	
4920	UNSCHEDULED DRESSING CHANGE (NOT BY TREATING DENTIST)	57	
4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	0	

<u>Code</u>	<u>Benefit</u>	<u>Code</u>	<u>Benefit</u>	
5110	COMPLETE DENTURE-MAXILLARY	690	5916 OCULAR PROSTHESIS	1330
5120	COMPLETE DENTURE-MANDIBULAR	690	5919 FACIAL PROSTHESIS	0
5130	IMMEDIATE DENTURE-MAXILLARY	752	5922 NASAS SEPTAL PROSTHESIS	0
5140	IMMEDIATE DENTURE-MANDIBULAR	752	5923 OCULAR PROSTHESIS, INTERIM	0
5211	MAXILLARY PART DENTURE- RESIN BASE (CLASP/RESTS)	582	5924 CRANIAL PROSTHESIS	0
5212	MANDIBULAR PART DENTURE- RESIN BASE (CLASP/RESTS)	677	5925 FACIAL AUGMENTATION IMPLANT PROSTHESIS	0
5213	MAXILLARY PART DENTURE- METAL FRAME W/RESIN BASE	762	5926 NASAL PROSTHESIS, REPLACEMENT	0
5214	MANDIBULAR PART DENTURE- METAL FRAME W/RESIN BASE	762	5927 AURICULAR PROSTHESIS, REPLACEMENT	0
5281	REMOV UNILAT PART DENTURE- 1 PIECE METAL (W/TEETH)	445	5928 ORBITAL PROSTHESIS, REPLACEMENT	0
5410	ADJUST FULL DENTURE-MAXILLARY	38	5929 FACIAL PROSTHESIS, REPLACEMENT	0
5411	ADJUST FULL DENTURE-MANDIBULAR	38	5931 OBTURATOR PROSTHESIS, SURGICAL	1657
5421	ADJUST PARTIAL DENTURE-MAXILLARY	38	5932 OBTURATOR PROSTHESIS, DEFINITIVE	3147
5422	ADJUST PARTIAL DENTURE-MANDIBULAR	38	5933 OBTURATOR PROSTHESIS, MODIFICATION	0
5510	REPAIR BROKEN FULL DENTURE BASE	76	5934 MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	2897
5520	REPLACE MISSING/BROKEN TEETH- FULL DENTURE - PER TOOTH	63	5935 MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	2515
5610	REPAIR RESIN DENTURE BASE	82	5936 OBTURATOR PROSTHESIS, INTERIM	2682
5620	REPAIR CAST FRAMEWORK, FOR PARTIAL	88	5937 TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	416
5630	REPAIR OR REPLACE BROKEN CLASP, FOR PARTIAL	107	5951 FEEDING AID	540
5640	REPLACE BROKEN TEETH-PER TOOTH, FOR PARTIAL	69	5952 SPEECH AID PROSTHESIS, PEDIATRIC	1413
5650	ADD TOOTH TO EXISTING PARTIAL	94	5953 SPEECH AID PROSTHESIS, ADULT	2865
5660	ADD CLASP TO EXISTING PARTIAL	113	5954 PALATAL AUGMENTATION PROSTHESIS	2549
5710	REBASE COMPLETE MAXILLARY DENTURE	280	5955 PALATAL LIFT PROSTHESIS, DEFINITIVE	2440
5711	REBASE COMPLETE MANDIBULAR DENTURE	268	5958 PALATAL LIFT PROSTHESIS, INTERIM	0
5720	REBASE MAXILLARY PARTIAL	264	5959 PALATAL LIFT PROSTHESIS, MODIFICATION	0
5721	REBASE MANDIBULAR PARTIAL	264	5960 SPEECH AND PROSTHESIS, MODIFICATION	0
5730	RELIN FULL MAXILLARY DENTURE (CHAIRSIDE)	158	5982 SURGICAL STENT	343
5731	RELIN FULL MANDIBULAR DENTURE (CHAIRSIDE)	158	5983 RADIATION CARRIER	831
5740	RELIN MAXILLARY PARTIAL (CHAIRSIDE)	145	5984 RADIATION SHIELD	831
5741	RELIN MANDIBULAR PARTIAL (CHAIRSIDE)	145	5985 RADIATION CONE LOCATOR	831
5750	RELIN FULL MAXILLARY DENTURE (LABORATORY)	211	5986 FLUORIDE GEL CARRIER	71
5751	RELIN FULL MANDIBULAR DENTURE (LABORATORY)	211	5987 COMMISSURE SPLINT	1009
5760	RELIN MAXILLARY PARTIAL (LABORATORY)	208	5988 SURGICAL SPLINT	1133
5761	RELIN MANDIBULAR PARTIAL (LABORATORY)	208	5999 UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	0
5810	INTERIM FULL DENTURE (MAXILLARY)	334	6010 SURGICAL PLACEMENT-IMPLANT BODY - ENDOSTAL IMPLANT	1153
5811	INTERIM FULL DENTURE (MANDIBULAR)	331	6020 ABUTMENT PLACE OR SUBSTITUTION - ENDOSTEAL IMPLANT	120
5820	INTERIM PARTIAL (MAXILLARY)	258	6040 SURGICAL PLACEMENT - EPOSTEAL IMPLANT	5303
5821	INTERIM PARTIAL (MANDIBULAR)	274	6050 SURGICAL PLACEMENT - TRANSOSTEAL IMPLANT	3291
5850	TISSUE CONDITIONING, MAXILLARY	63	6055 DENTAL IMPLANT SUPPORTED CONNECTING BAR	293
5851	TISSUE CONDITIONING, MANDIBULAR	66	6080 IMPLANT MAINTENANCE INCLLUDING REMOVAL/CLEAN/REINSERT	60
5860	OVERDENTURE-FULL, BY REPORT	0	6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	0
5861	OVERDENTURE-PARTIAL, BY REPORT	0	6095 REPAIR IMPLANT ABUTMENT, BY REPORT	0
5862	PRECISION ATTACHMENT, BY REPORT	0	6100 IMPLANT REMOVAL, BY REPORT	0
5899	UNSPECIFIED REMOVABLE PROSTHESIS PROCEDURES, BY REPORT.	0	6199 UNSPECIFIED IMPLANT PROCEDURE, BY REPORT	0
5911	FACIAL MOULAGE (SECTIONAL)	175	6210 PONTIC-CAST HIGH NOBLE METAL	459
5912	FACIAL MOULAGE (COMPLETE)	175	6211 PONTIC-CAST MOSTLY BASE METAL	430
5913	NASAL PROSTHESIS	3137	6212 PONTIC-CAST NOBLE METAL	447
5914	AURICULAR PROSTHESIS	3139	6240 PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	453
5915	ORBITAL PROSTHESIS	4162	6241 PONTIC-PORCELAIN FUSED TO MOSTLY BASE METAL	436
			6242 PONTIC-PORCELAIN FUSED TO NOBLE METAL	444
			6250 PONTIC-RESIN WITH HIGH NOBLE METAL	447

<u>Code</u>	<u>Benefit</u>	<u>Code</u>	<u>Benefit</u>
6251	PONTIC-RESIN WITH MOSTLY BASE METAL	413	
6252	PONTIC-RESIN WITH NOBLE METAL	426	
6520	RETAINER-INLAY-METALLIC-TWO SURFACE	395	
6530	RETAINER-INLAY-METALLIC-THREE OR MORE SURFACE	453	
6543	RETAINER-ONLAY-METALLIC-THREE SURFACE	465	
6544	RETAINER-ONLAY-METALLIC-FOUR OR MORE SURFACE	485	
6545	RETAINER-CAST METAL-RESIN BONDED FIXED PROSTHESIS	190	
6720	CROWN-BRIDGE RETAINER-RESIN W/HIGH NOBLE METAL	505	
6721	CROWN-BRIDGE RETAINER-RESIN MOSTLY BASE METAL	479	
6722	CROWN-RETAINER-RESIN WITH NOBLE METAL	488	
6750	CROWN-RETAINER-PORCELAIN FUSED TO HIGH NOBLE METAL	517	
6751	CROWN-RETAINER-PORCELAIN FUSED TO MOSTLY BASE METAL	482	
6752	CROWN-RETAINER-PORCELAIN FUSED TO NOBLE METAL	494	
6780	CROWN-RETAINER 3/4 CAST HIGH NOBLE METAL	488	
6790	CROWN-RETAINER-FULL CAST HIGH NOBLE METAL	499	
6791	CROWN-RETAINER-FULL CAST MOSTLY. BASE METAL	473	
6792	CROWN-RETAINER-FULL CAST NOBLE METAL	491	
6920	CONNECTOR BAR	87	
6930	RECEMENT FIXED PARTIAL	61	
6940	STRESS BREAKER	137	
6950	PRECISION ATTACHMENT	268	
6970	CAST POST AND CORE/ADDITION TO BRIDGE RETAINER	167	
6971	CAST POST AS PART OF BRIDGE RETAINER	147	
6972	PREFABRICATED POST AND CORE IN ADDITION TO BRIDGE RETAINER	136	
6973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS	110	
6975	COPING METAL	300	
6980	FIXED PARTIAL REPAIR, BY REPORT	0	
6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT.	0	
7110	EXTRACTION-SINGLE TOOTH	59	
7120	EXTRACTION-EACH ADDITIONAL TOOTH	51	
7130	ROOT REMOVAL-EXPOSED ROOT	71	
7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF FLAP/BONE REMOVAL AND/OR SECTION OF TOOTH	95	
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	119	
7230	REMOVAL OF IMPACTED TOOTH-PARTIAL BONY	157	
7240	REMOVAL OF IMPACTED TOOTH-COMPLETE BONY	185	
7241	REMOVAL OF IMPACTED.TOOTH-COMP BONY/UNUSUAL COMPLICATIONS	230	
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	99	
7260	ORAL ANTRAL FISTULA CLOSURE	812	
7270	REIMPLANT OR STAB ACCID EVUL TOOTH AND/OR ALVEOL	201	
7272	TOOTH TRANSPLANTATION (INCL ONE SITE TO ANOTHER)	286	
7280	SURG EXP-IMP/UNERUP TOOTH FOR ORTHO INCL ATTACH	220	
7281	SURG EXP-IMP/UNERUP TOOTH TO AID ERUPTION	186	
7285	BIOPSY OF ORAL TISSUE-HARD	333	
7286	BIOPSY OF ORAL TISSUE-SOFT	160	
7290	SURGICAL REPOSITIONING OF TEETH	182	
7291	TRANSSEPTAL FIBEROTOMY, BY REPORT	0	
7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS-PER QUAD	109	
7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS-PER QUAD	403	
7340	VESTIBULOPLASTY-RIDGE EXTENSION (SEC. EPITH)	872	
7350	VESTIBULOPLASTY-(INCLUDING GRAFTS, HYPERTISSUE)	2724	
7410	RADICAL EXC-REAC INFLAMM LESION DIAMETER <1.25CM	605	
7420	RADICAL EXCISION-REAC INFLAMM DIAMETER >1.25 CM	545	
7430	EXCISION OF BENIGN TUMOR LESION < 1.25 CM	347	
7431	EXCISION OF BENIGN TUMOR LESION > 1.25 CM	501	
7440	EXCISION OF MALIGNANT TUMOR/LESION DIAMETER <1.25 CM	522	
7441	EXCISION OF MALIGNANT TUMER/LESION DIAMETER >1.25 CM	797	
7450	REMOVAL OF ODONTOGENIC CYST/TUMOR /LESION <1.25 CM	291	
7451	REMOVAL OF ODONTOGENIC CYST/TUMOR /LESION >1.25 CM	477	
7460	REMOVAL OF NONODONTOGENIC CYST/TUMOR /LESION <1.25 CM	300	
7461	REMOVAL OF NONODONTOGENIC CYST/ TUMOR/LESION >1.25 CM	486	
7465	DESTRUCTION OF LESION BY PHYSICAL OR CHEMICAL METHODS, BY.REPORT	166	
7470	REMOVAL OF EXOSTOSIS-MAXILLA OR MANDIBLE	419	
7480	PARTIAL OSTECTOMY (GUTTING OR SAUCERIZATION)	405	
7490	RADICAL RESECTION OF MANIDBLE WITH BONE GRAFT	4918	
7510	I & D ABCESS INTRAORAL-SOFT TISSUE	104	
7520	I&D ABCESS-EXTRAORAL-SOFT TISSUE	396	
7530	REMOVE FOREIGN BODY, SKIN, OR SUBQ AREOLAR TISSUE	144	
7540	REM REACTION-PROD FOREIGN BODIES-MUSCULOSKELETAL	198	
7550	SEQUESTRECTOMY FOR OSTEOMYLELITIS	123	
7560	MAXILLARY SINUSOTOMY FOR REMOVAL TOOTH FRAG OR F.B.	838	
7610	MAXILLA FX-OPEN REDUCTION (TEETH IMMOBIL), SIMPLE	1244	
7620	MAXILLA FX-CLOSED REDUCTION (TEETH IMMOBIL), SIMPLE	935	
7630	MANDIBLE FX-OPEN REDUCT (TEETH IMMOBIL), SIMPLE	1601	
7640	MANDIBLE FX-CLOSED REDUCTION (TEETH IMMOBIL), SIMPLE	1024	
7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION, SIMPLE	991	

<u>Code</u>	<u>Benefit</u>	<u>Code</u>	<u>Benefit</u>
7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION, SIMPLE	7946	LEFORT I MAXILLA-TOTAL
7670	ALVEOLUS-STABIL TEETH, OPEN REDUCTION SPLINT, SIMPLE	7947	LEFORT I MAXILLA-SEGMENTED
7680	FAC BONES-COMPL REDUCTION W/FIX/MULT SURGICAL APPR, SIM	7948	LEFORT II OR III (OSTEO-FACIAL BONES W/O GRAFT)
7710	MAXILLA FRACTURE-OPEN REDUCTION, COMPOUND	7949	LEFORT II OR LEFORT III WITH BONE GRAFT
7720	MAXLLA FRACTURE-CLOSED REDUCTION, COMPOUND	7950	OSSEOUS OR OTHER GRAFT-MANDIB/FACIAL-AUTO/NON, BR
7730	MANDIBLE FRACTURE-OPEN REDUCTION, COMPOUND	7955	REPAIR-MAXILLOFACIAL SOFT & HARD TISSUE DEFECT
7740	MANDIBLE FRACTURE-CLOSED REDUCTION, COMPOUND	7960	FRENULECTOMY (FRENECTOMY /FRENOTOMY) SEPARATE PROCEDURE
7750	MALAR AND/OR ZYGOMATIC ARCH OPEN REDUCTION, COMPOUND	7970	EXCISION OF HYPERPLASTIC TISSUE/PER ARCH
7760	MALAR AND/OR ZYGOMATIC ARCH CLOSED REDUCT, COMPOUND	7971	EXCISION OF PERICORONAL GINGIVA
7770	ALVEOLUS-STABIL TEETH, OPEN REDUCT SPLINT, COMPOUND	7980	SIALOLITHOTOMY
7780	FAC BONES-COMLETE REDUCTION W/FIX/MULT SURGICAL APPR, COMPOUND	7981	EXCISION-SALIVARY GLAND, BY REPORT
7810	OPEN REDUCTION OF DISLOCATION TMJ	7982	SIALODOCHOPLASTY
7820	CLOSED REDUCTION OF DISLOCATION TMJ	7983	CLOSURE OF SALIVARY FISTULA
7830	MANIPULAITON UNDER ANESTHESIA TMJ	7990	EMERGENCY TRACHEOTOMY
7840	CONDYLECTOMY	7991	CORONOIDECTOMY
7850	SURGICAL DISCECTOMY; WITH/WITHOUT IMPLANT	7995	SYNTHETIC GRAFT-MANDIBLE/FACIAL BONES, BY REPORT
7852	DISC REPAIR	7996	IMPLANT-MANDIVLE AUGMENTATION (EXCL ALVEOLAR) BR
7854	SYNOVECTOMY	7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT
7856	MYOTOMY	9110	PALLIATIVE (ER) TX-DENTAL PAIN-MINOR PROCEDURE
7858	JOINT RECONSTRUCITON	9210	LOCAL ANESTHESIA NOT IN CONJUNCTION W/OPERATIVE
7860	ARTHROTOMY	9211	REGIONAL BLOCK ANESTHESIA
7865	ARTHROPLASTY	9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA
7870	ARTHROCENTESIS	9215	LOCAL ANESTHESIA
7872	ARTHROSCOPY-DIAGNOSIS, WITH OR WITHOUT BIOPSY	9220	GENERAL ANESTHESIA-FIRST 30 MINUTES
7873	ARTHROSCOPY-SURGICAL - LAVAGE AND LYSIS OF ADHES.	9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES
7874	ARTHROSCOPY-SURGICAL - DISC REPOSIT, AND STABIL.	9230	ANALGESIA
7875	ARTHROSCOPY-SURGICAL - SYNOVECTOMY	9240	INTRAVENOUS SEDATION
7876	ARTHROSCOPY-SURGICAL - DISCECTOMY	9310	PROFESSIONAL CONSULTING (DIAGNOSTIC SERVICES BY OTHER DENTIST/PHYSICIAN)
7877	ARTHROSCOPY-SURGICAL - DEBRIDEMENT	9410	PROFESSIONAL VISIT-HOUSE CALL
7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	9420	PROFESSIONAL VISIT-HOSPITAL CALL
7899	UNSPECIFIED TMD THERAPY, BY REPORT	9430	OFFICE VISIT FOR OBSER (REG HOURS) NO OHER SERVS
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	9440	OFFICE VISIT-AFTER REGULAR HOURS
7911	COMPLICATED SUTURE UP TO 5 CM, METICULOUS CLOSURE	9610	THERAPEUTIC DRUG INJECTION, BY REPORT
7912	COMPLICATED SUTURE > 5 CM, METICULOUS CLOSURE	9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT
7920	SKIN GRAFT (IDENT DEFECT, LOCATION & TYPE)	9910	APPLICATION-DESENSITIZING MEDICAMENT
7940	OSTEOPLASTY-FOR ORTHGNATHIC DEFORMITIES	9920	BEHAVIOR MANAGEMENT, BY REPORT
7941	OSTEOTOMY-RAMUS, CLOSED	9930	TX OF COMPLICATIONS/POST SURGICAL/ UNUSUAL CIRC BR
7942	OSTEOTOMY-RAMUS, OPEN	9940	OCCLUSAL GUARD, BY REPORT
7943	OSTEOTOMY-RAMUS, OPEN WITH BONE GRAFT	9941	FABRICATION OF ATHLETIC MOUTHGUARD
7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL/SEXTANT OR QUAD	9950	OCCLUSION ANALYSIS-MOUNTED CASE
7945	OSTEOTOMY-BODY OF MANDIBLE	9951	OCCLUSION ADJUSTMENT-LIMITED
		9952	OCCLUSION ADJUSTMENT-COMLETE
		9970	ENAMEL MICROABRASION
		9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT

Certificateholder: [John Doe]
Certificate No.: [12345]
Effective Date for Rider: [September 1, 2011]

This Rider is issued as part of the Policy and any Certificate to which it is attached. It is subject to all the terms and provisions of the Policy, except as stated below.

ORTHODONTIA BENEFIT RIDER

Insuring Clause: We will pay Eligible Expenses incurred by an Insured as shown in the schedule below.

Eligible Expenses: Eligible Expenses means the Reasonable and Customary charge for the following dental services:

- D. Orthodontia Services Include (Must begin before the 19th birthday.):
1. surgical therapy
 2. appliance therapy
 3. functional/myofunctional therapy

COVERAGE SCHEDULE

[Deductible, each calendar year	[None]
We pay, after Deductible	[50%]
Maximum Limit	[\$1,000]
Waiting Period –[24 Months.]	

This Rider takes effect and ends with the Policy and any Certificate to which it is attached. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy except as herein stated.

Signed for American Republic Insurance Company

Michael E Abbott

President

ENDORSEMENT FOR RESIDENTS OF ARKANSAS

This endorsement is issued as a part of the Policy and of any Certificates to which it is attached. Notwithstanding anything to the contrary in the Policy, the following changes and/or additions apply with respect to an Insured who resides in the state of Arkansas:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-xxx-xxxx]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

The following are added or changed:

1. For a newborn child, You must notify Us and pay any required premium within the first 90 days after such birth for coverage to continue beyond the first 90 days after birth.
2. Any minor child under Your charge, care and control when a petition for adoption has been filed, will be covered from the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth if applied for within 60 days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption.

This endorsement takes effect and expires with the Policy and any Certificate to which it is attached. Nothing contained in this endorsement will be held to change, waive or extend any provisions of the Policy except as stated.

Signed for on behalf of American Republic Insurance Company.

Michael E Abbott

President



Your Name (First, Middle Initial, Last)		Birth Date	Sex
<input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Address	City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Phone	Work Phone	Marital Status
()	()	<input type="checkbox"/> Married <input type="checkbox"/> Single

Please list your spouse and all your eligible dependents up to age 26, if also applying for insurance.

Spouse's Name (First, Middle Initial, Last)		Birth Date	Sex
<input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Dependent's Name (First, Middle Initial, Last)		Birth Date	Sex
1. <input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
2. <input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
3. <input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
4. <input type="text"/>	<input type="text"/>	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Please Note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

By my signature below, I hereby apply for coverage with American Republic Insurance Company. I also certify that I have read the applicable fraud notice.

Signature	Date
X	

FOR AGENT USE ONLY

I, the agent for the above signed, state that I have truly and accurately recorded on this application the information supplied by the Insured as certified by my signature below.

Agent Name	Agent #
<input type="text"/>	<input type="text"/>

Address	City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Email	Phone
<input type="text"/>	()

Agent Signature	Date
X	

Certificateholder:
Certificate No.:
Effective Date for Rider:

This Rider is issued as part of the Policy and any Certificate to which it is attached. It is subject to all the terms and provisions of the Policy, except as stated below. In consideration of the payment of any additional premium, We will provide the coverage described in this Rider.

VISION BENEFIT RIDER

ELIGIBLE EXPENSES: We will pay for Eligible Expenses incurred by or on behalf of an Insured. Expense must be incurred while this Rider and the Policy are in force and the Insured is covered. Payment is subject to the applicable Deductible, Waiting Period, and Maximum Benefit Amount for this Rider as shown in the Coverage Schedule.

Class A. Eligible Expenses consist of charges for a complete visual analysis including case history, refraction, etc., and are payable only when an eye refraction is performed, limited to one time in any 12-month period.

Class B. Eligible Expenses consist of charges for lenses and frame, limited to one set in any 24-month period.

Class C. Eligible Expenses consist of charges for contact lenses and are provided in lieu of all other eyewear benefits, if the visual acuity of the patient is 20/70 or worse in the patient's better eye, limited to 1 pair in any 24-month period.

EXCEPTIONS AND LIMITATIONS: The cost of lens in excess of a standard lens will not be covered. A standard lens is any lens fitting a frame with an eye size less than 61mm. Charges for replacement lenses will not be covered unless there is a change in prescription.

The cost of a frame in excess of a standard frame will not be covered. A standard frame is any frame with a retail value of \$75.00 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

In addition to the above, the following expenses are not covered:

1. any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
2. special procedures, such as orthoptics, vision training and subnormal vision aids;
3. plano or prescription sunglasses or other special purpose vision aids;
4. medical or surgical treatment of the eyes, including hospital expenses;
5. replacement of lost or broken lenses and/or frames;
6. duplicate glasses or lenses or frames; and
7. services or material not listed as an Eligible Expense.

This Rider takes effect and ends with the Policy. This Rider takes effect for You on the Rider Effective Date above, and it ends with any Certificate to which it is attached. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy except as herein stated.

Signed on behalf of American Republic Insurance Company.



President

SERFF Tracking Number: FRCS-127808925 State: Arkansas
 Filing Company: American Republic Insurance Company State Tracking Number: 50251
 Company Tracking Number: 5637
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental Filing
 Project Name/Number: Secur/79/79

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments: AR RDB.pdf AR CoC.pdf Authorization Letter Dental Insurance 8-29-11.pdf</p>	Approved	12/21/2011
<p>Satisfied - Item: Application</p> <p>Comments: Provided under the Form Schedule tab, AR3306.</p>	Approved	12/21/2011
<p>Satisfied - Item: Voluntary Supplemental Benefits Trust document</p> <p>Comments:</p> <p>Attachment: Trust Agreement.pdf</p>	Approved	12/21/2011

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: American Republic Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
AR-Cert3200	56.5
AR3200	*
AR3199	66.3
AR3230(AR)	62.9
AR3306	*

* Achieves a score of 50+ when combined with the policy.



Elizabeth Powell
Senior Vice President

November 10, 2011
Date

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: American Republic Insurance Company

Form Title(s): Group Certificate
Certificate Schedules
Orthodontia Benefit Rider
Endorsement

Form Number(s): AR-Cert3200
AR3200
AR3199
AR3230(AR)

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Elizabeth Powell
Senior Vice President

November 10, 2011
Date



American Republic Insurance Company

601 6th Avenue, Des Moines, Iowa 50334

August 29, 2011

RE: American Republic Insurance Company
Authorization to File Rates, Rules and Forms

Dear Sir or Madam:

This letter authorizes First Consulting to make rate, rule, and form filings and to file related riders and amendments on behalf of American Republic Insurance Company ("American Republic") as applicable only for American Republic's dental insurance program. This authorization is limited to the American Republic dental product, and does not apply to any other products of American Republic. In addition, First Consulting is authorized to respond, in a timely and compliant manner, to all correspondence and inquiries from the state departments or bureaus of insurance related to those filings. First Consulting understands that Security Life Insurance Company ("Security Life") is responsible for all compliance activities related to the American Republic dental products, pursuant to a Letter of Understanding between American Republic and Security Life, dated July 14, 2011. Accordingly, First Consulting may consult with Security Life on applicable compliance matters. First Consulting shall comply with all state and federal regulations and statutes, and shall provide to Security Life and/or American Republic copies of all filings and correspondence applicable to the American Republic dental products.

This authorization continues in full force and effect until revoked or otherwise amended by an authorized representative of American Republic Insurance Company.

Sincerely,

Elizabeth A. Powell
Senior Vice President, Health Markets
American Republic Insurance Company

TRUST AGREEMENT

THIS AGREEMENT is made and entered into this 1st day of July 2000 by and between World Insurance Company, hereinafter referred to as the "Settlor" and the SentryCorp, Ltd., hereinafter referred to as the "Trustee".

WITNESSETH

WHEREAS, many individuals are inadequately insured or not insured against loss resulting from death or disability because of the lack of availability of appropriate insurance protection; and

WHEREAS, the availability of coverage on a group insurance basis:

- i) is not contrary to the interest of the public;
- ii) will generally result in economies of acquisition or administration; and
- iii) will provide benefits reasonable in relation to the group premium charged; and

WHEREAS, the Settlor wishes to establish by this Agreement a method to make group insurance available on a favorable basis; and

WHEREAS, the Settlor will continue the Trust for such purposes; and

WHEREAS, SentryCorp, Ltd. has consented to act as Trustee in accordance with the provisions of this Agreement;

NOW, THEREFORE, the parties agree as follows:

ARTICLE I GENERAL PROVISIONS

A. Name of Trust - The Trust is known as the Voluntary Supplementary Benefits Trust.

B. Definitions - The following words as used in this Agreement will have the meaning indicated, unless otherwise required by context:

Administrator - means the organization appointed by the Settlor or Insurer to act on its behalf.

Insurer - means any insurance company underwriting a policy or policies of group insurance to be issued to the Trust.

Participant - means a person to whom a group certificate has been issued by nature of a relationship with a Sponsor.

Policy - The policy or policies of group insurance held by the Trustee in accordance with the purposes of this Agreement.

Sponsor - means a person, partnership, corporation, sole proprietorship or other entity that elects to endorse the availability of the group insurance issued to the Trust, for the benefit of Participants.

ARTICLE II TRUSTEES

A. Trustee's Appointment - the Settlor appoints SentryCorp, Ltd. as Trustee.

B. Acceptance of Trust - the Trustee, through its authorized officer will act as custodian of the Trust and Trust documents according to the terms and conditions of this Agreement, including, but not limited to, the following:

Trustee will be entitled to reasonable compensation for its services and will be reimbursed for any expenses incurred in the performance of its duties under this Agreement. Trustee will be compensated and reimbursed by the Settlor pursuant to agreement reached between them.

No Trustee acting hereunder shall be liable for any action taken or omitted by it in good faith, nor for the acts of the Settlor or any agent, employee or attorney selected by the Trustee with reasonable care; nor shall any Trustee be individually or personally liable for any of the obligations of the Trustee acting as such under this Agreement.

ARTICLE II TRUSTEES(cont.)

C. Resignation and Removal - Trustee may resign at any time upon delivering to the Settlor or the Administrator, if any, written notice of resignation, to take effect not less than 30 days after delivery, unless such notice is waived. The Settlor may remove the Trustee by delivering notice of removal to take effect on a date specified. However, no removal of a Trustee will become effective until a successor Trustee has been appointed.

D. Appointment of Successor Trustee - Upon the resignation or removal of the Trustee, the Settlor will appoint a successor Trustee. Any successor Trustee so appointed will qualify by executing, acknowledging and delivering to Settlor an acceptance of such appointment.

1. Any successor Trustee shall be vested, upon subscribing to this Agreement, without further act, with all the estate, rights, powers, discretion and duties of its predecessor Trustee, with like effect as if originally named as the Trustee. Upon resignation or termination of a Trustee, or any successor Trustee the Settlor may appoint a successor Trustee.

2. No Trustee shall be liable or responsible for any acts or default of any predecessor Trustee, or for any loss or expense resulting from or occasioned by anything done or neglected to be done in the administration of the Trust prior to its becoming the Trustee, nor shall any successor Trustee be required to inquire into or take any notice of the prior administration of the Trust.

ARTICLE III DUTIES OF TRUSTEE

A. Application for Insurance - Trustee will execute an application to procure, as the Trustee for the policyholder, group insurance under one or more policies. Trustee will hold said policy under the provisions of this Agreement.

B. Records Inspection and Audit - Trustee will maintain complete records of all transactions associated with the Trust. All such records will at all reasonable times be open to inspection by the Settlor, or its authorized representative and by the Insurer, or its authorized representative.

C. Duties - Trustee will use ordinary care and reasonable diligence in the performance of its duties; it will not be liable for any action taken or omitted upon the instructions of Settlor; or in the absence of such instruction, for the omission of any action as to which Settlor is required to instruct it; or for any mistake or judgment or other action made, taken, or omitted in good faith; or for any loss, unless resulting from its own misconduct or neglect; and it will not be required to give any bond or other security for the faithful performance of its duties.

1. If any tax or assessment is levied upon the Trust or any portion thereof, or upon the Trustee by reason of the existence of the Trust, the Trustee will notify the Settlor in writing.

2. Trustee will not be required to determine whether payment by any person or by any Insurer is in accordance with the requirements of this Agreement or any group insurance policy held by the Trustee.

3. Trustee will not be liable for the payment of any insurance premium. The Trustee will not assume any fiduciary duties or responsibilities with regard to the Trust or any group insurance policy issued to the policyholder. The Trustee will safely hold the property of the Trust deposited with it and no implied duties shall be read into this Agreement to be used against the Trustee.

ARTICLE IV POWERS AND DUTIES OF SETTLOR

The Settlor may appoint an Administrator for the administration of the group insurance issued to the Trust. The Administrator's responsibilities may include, but are not limited to, the following:

1. Collection of insurance premiums;
2. Maintenance of records;
3. Promotion of insurance plans;
4. Payment of compensation to Trustee;

5. Providing direction to the Trustee;
6. Removing Trustee and appointing Trustee.

ARTICLE V LIMITATION OF LIABILITY

No Trustee will have duty or liability to any Sponsor or Participant other than to perform in good faith its duties in the manner and within the limits herein provided.

In no event will the Trustee be guarantor of the solvency of any Insurer or be liable for the failure, refusal, or inability of any Insurer to make payments required of it. The benefits payable under any group policy or group policies issued to the Trust will be accordance to the terms of such policy..

ARTICLE VI SPONSOR

1. If required the Sponsor may execute an agreement electing to be a Sponsor.
2. Participation by a Sponsor may be declined if such Sponsor does not meet the Insurer's rules, standards, and underwriting practices.
3. Each Sponsor will furnish the Settlor such information as may be required for the proper administration of this Agreement and any policy issued to the policyholder

ARTICLE VII PARTICIPANT

1. A person whose enrollment for group insurance is accepted and to whom a group certificate is issued becomes a Participant. The Insurer may decline to issue a certificate to any person in accordance with its rules, standards and underwriting practices.

2. Each Participant will contribute or have contributed on his behalf the amount of premiums properly due, if any, in accordance with the terms of the policy, together with the proportionate share of administrative charges hereunder, if any.

3. Participation will cease with respect to any policy in accordance with the terms and provisions pertaining to termination or a Participant's interest therein.

4. All benefits payable under the policy will be paid by the Insurer in accordance with the terms of any such policy and will not be payable to or through the Trustee or constitute a part of the Trust property.

ARTICLE VIII MISCELLANEOUS

A. Amendments - The provisions of this Agreement may be amended in writing by an authorized officer for the Trustee and the Settlor.

B. Termination - This Agreement will end 100 days after the termination date of the last policy held by Trustee.

C. Notice - Any notice or instruction given pursuant to the terms of this Agreement must be in writing delivered by hand or sent by registered mail.

D. Rights in the Trust - No person will have any individual or collective right, title or interest in the Trust. No person will have any right or claim to benefits under this Agreement except as specified in a policy of group insurance issued pursuant to this Agreement. Any dispute of coverage will be resolved by the Insurer according to the terms and provisions of the policy.

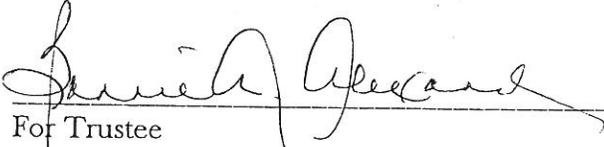
E. Indemnification - The Trustee will be held harmless for and against any and all claims, judgments, losses, costs, and expenses, including court costs and attorney's fees, that arise out of or result from the operation and administration of the Trust.

F. Reimbursement for Attorney Fees - The Trustee will be reimbursed for any necessary fees for legal services related to the operation and administration of the Trust.

ARTICLE IX Situs and Construction of Trust

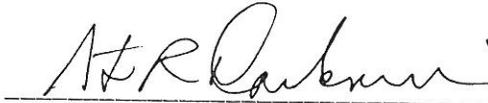
The situs of the Trust shall be the State of Wyoming and all questions pertaining to the Trust and/or Trust property shall be determined in accordance with the laws of the State of Wyoming.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date shown.



For Trustee
SentryCorp, Ltd.

10/10/00
Date



For Settlor
World Insurance Company

1/11/01
Date

SPONSORS ADDENDUM
FOR
VOLUNTARY SUPPLEMENTARY BENEFITS TRUST

This ADDENDUM is made part of the Agreement dated July 1, 2000. As applicable, group insurance policies will be issued to the Voluntary Supplementary Benefits Trust (referred to as VSBT) for each of the Sponsor groups described in this ADDENDUM.

Each Sponsor group will be for the following appropriate group type:

Group Type 1. - ASSOCIATION, FRATERNAL ORGANIZATION AND ORGANIZED CLUB GROUPS

The Sponsor must be an association, fraternal organization or club.

Group Type 2. - CREDIT CARDHOLDER GROUPS

The Sponsor must be a corporation, partnership, sole proprietor, or authorized representative acting for credit card groups.

Group Type 3. - FINANCIAL SERVICES GROUPS

The Sponsor must be a bank, savings and loan institution, or other financial services organization providing similar services, whether federal or state.

Group Type 4. - COOPERATIVE GROUPS

The Sponsor must be a farm cooperative, travel cooperative, consumer, rural electric cooperative or utilities cooperative. This group type includes Sponsors who are public utility companies for the benefit of customers.

Group Type 5. - PUBLISHERS, BOOK CLUBS AND MEMBERSHIP DISCOUNT CLUBS

The Sponsor must be a publisher, book club or membership discount club.

Group Type 6. -MAIL ORDER GROUPS

The Sponsor must be a mail order organization.

Group Type 7. - PROFESSIONAL GROUPS

The Sponsor must be a professional person licensed to practice or conduct the skill or business within the scope of that license.

Group Type 8. - TRAVEL GROUPS

The Sponsor must be a travel agency, tour operator, cruise line or airline.

Group Type 9. - CUSTOMER/LESSEE GROUPS

The Sponsor must be a customer or lessee of a commercial or business organization.

Group Type 10. - INSURANCE AGENCY CUSTOMER GROUPS

The Sponsor must be an insurance agency.

Group Type 11. - STUDENT/STUDENT GROUPS

The Sponsor must be an educational institution (elementary, junior and senior high school, vocational school, college or university).

For the purpose of this ADDENDUM the term "Insured" refers to member, credit cardholder, customer, student or such other term used to describe a person eligible to be an Insured. When the policy provides for dependent coverage the Insured may include eligible dependents according to the terms and condition of the policy.

SERFF Tracking Number: *FRCS-127808925* *State:* *Arkansas*
Filing Company: *American Republic Insurance Company* *State Tracking Number:* *50251*
Company Tracking Number: *5637*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental Filing*
Project Name/Number: *Secur/79/79*

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/11/2011	Form	Enrollment Form	04/30/2012	ENROLLMENT FORM.pdf (Superseded)

AMERICAN REPUBLIC INSURANCE COMPANY

DENTAL PLAN ENROLLMENT FORM

Applicant Name (First, Middle, Last)		Birthdate / / Mo. Day Yr	Sex M <input type="checkbox"/> F <input type="checkbox"/>	For Company Use Only
Address		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Effective Date
City	State Code	ZIP	Annual Coverage Maximum \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/>	
Work Phone ()	Home Phone ()	Social Security Number - -		
I apply for coverage on		<input type="checkbox"/> Myself <input type="checkbox"/> Myself and spouse		
Spouse, if also applying for Insurance (Last Name, First, Middle Initial)		Sex M F	Birthdate Mo. Day Yr. / /	

By my signature below, I hereby apply for coverage under American Republic Insurance Company Master Policy AR-MP3200

Applicant's Signature

Date

AR3201

IMPORTANT FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AR3306