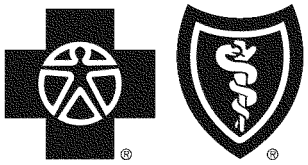

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

DENTALBLUE

VOLUNTARY DENTAL COVERAGE
GROUP BENEFIT CERTIFICATE

for

ARK STATE UNIV JONESBORO
GROUP NO.: 027140
PACKAGE NO.: 01

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS

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ARTICLE I. STATEMENT OF COVERAGE

A. This Benefit Certificate contains the insurance benefits provided by the Group Policy issued by Arkansas Blue Cross and Blue Shield (the Company) to your Employer and is subject to the terms of that policy. Payment for dental services under an Employer's Plan will be made in accordance with this Benefit Certificate; however, only services specifically listed in the Schedule of Benefits for each Employer are covered.

B. This coverage is most effective and advantageous when the services of Participating Dentists are used.

C. Participating Dentists are paid directly by the Company and have agreed to accept the Company's payment for Covered Services as payment in full except for your Deductible and Coinsurance, if applicable, until the Calendar Year Maximum has been reached. You are responsible for your Deductible, Coinsurance and any charges beyond the Benefit Certificate payment, even if the Calendar Year Maximum has not been reached, when you receive services from a Non–Participating Dentist. The determination of whether a Dentist is a Participating Dentist or Non–Participating Dentist is the responsibility of the Company. The Company can provide a list of Participating Dentists, or you may also access our web site at WWW.ARKANSASBLUECROSS.COM. You should always ask your chosen provider if he/she participates. We also recommend that you take this Benefit Certificate with you to your provider's office.

D. The decision about whether to use a Participating Dentist is the sole responsibility of the Covered Person. Participating Dentists are not employees or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any dentist with respect to any service. The evaluation of such factors and the decision about whether to use any dentist is the sole responsibility of the Covered Person.

E. The effective date of your coverage is indicated in the Schedule of Benefits.

F. Continuance of coverage under this Benefit Certificate shall be contingent upon receipt of premiums remitted in advance by your Employer on your behalf.

G. The Group Member (your Employer) is recognized as your agent for all dealings with respect to:

1. paying premiums to the Company;
2. submitting enrollment applications to the Company;
3. changes in coverage status (from individual to family or from family to individual); and
4. all communications and notices from the Company.

We will consider you to have received any notice mailed to you at the current address on our records.

H. The Company reserves the right to amend the benefits, conditions and premiums covered under the Benefit Certificate. If we do so, we will give thirty (30) days written notice to your Employer or his agent and the change will go into effect on the date indicated in the notice.

I. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this document. Any change or amendment must be in writing and signed by an Officer of the Company.

ARTICLE II. DEFINITIONS

A. Benefit Certificate means this document containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of the Company.

B. Calendar Year Maximum means the greatest amount the Company will pay in a calendar year for Covered Services. The maximum amount the Company will pay in a calendar year for ALL Covered Services is listed in the Schedule of Benefits.

C. Charge, when used in connection with dental services or supplies covered in this contract, will be the amount deemed by the Company to be reasonable. An amount equaling the lesser of the charge billed by the dentist or the Arkansas Blue Cross and Blue Shield allowance is the basic Charge. However, this Charge may vary, given the facts of the case and the opinion of the Company's Dental Advisor.

D. Child means an Employee's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Employee for adoption. "Child" also means a Child for whom the Employer must provide medical support under a qualified medical Child support order or for whom the Employee has been appointed the legal guardian.

E. Coinsurance means the obligation of the Company "our Coinsurance," to pay a Charge. The Company's Coinsurance and your Coinsurance are expressed as a percentage in the Schedule of Benefits.

F. Company means Arkansas Blue Cross and Blue Shield.

G. Cosmetic Treatment means a procedure which is not Dentally Necessary and which is undertaken primarily, in

the opinion of the Company, to improve or otherwise modify the Covered Person's appearance.

H. Covered Person is an Employee or Dependent who is insured under this Benefit Certificate.

I. Covered Services mean a service or supply specified in this Benefit Certificate or specifically approved by the Company for which the Company will reimburse Charges.

J. Date of Service is the date that treatment is completed.

K. Deductible means the amount shown in the Schedule of Benefits that must be paid by the Covered Person before the Company will assume liability.

L. Dental Advisor is a dentist, group of dentists, or another qualified person or persons utilized by the Company to review claims for treatment.

M. Dentally Necessary means a dental service or procedure required to establish or maintain a patient's dental health. The determination as to when a dental service is necessary shall be governed in accordance with guidelines established by the Company. In the event of a conflict of opinion between the treating dentist and the Company as to if a dental service or procedure is Dentally Necessary, the opinion of the Company shall be final.

N. Dependent means only the following persons who are not otherwise eligible as employees:

1. Spouse;
2. Child less than 26 years of age, provided the Child was covered by the Plan or by another Health benefit Plan on May 31, 2010 and has had had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan;
3. unmarried Child less than 26 years of age; who is:
   a. living with the Employee in a parent-child relationship; and
   b. is claimed as a dependent on the Employee's federal income tax return;
4. Child less than 26 years of age, provided the Child enrolls on or after the anniversary date of the Policy after September 23, 2010;
5. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided 1.) such Child is or was under the limiting age of dependency stated in Subsections 2. and 3. above at the time of application for coverage in the Plan or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

Note: Domestic partners are not eligible for coverage as Dependents under this Benefit Certificate.

O. Eligibility Period means the time beginning with the Employee's most recent date of continuous employment with the Employer and ending on the date he is eligible for insurance. The Employer establishes the Eligibility Period but for purposes of coverage or eligibility determinations under this Benefit Certificate, the Eligibility Period shall be such period as is reflected in the enrollment records of the Company.

P. Employer, Group, Member and Policyholder shall have a common meaning when used herein.

Q. Employee means the person employed by the Employer who has coverage for himself and his Dependents based upon his submission of an enrollment form.

R. Full-Time Employment means a full-time active Employee, and like terms means a job with the Employer:

1. on a permanent and active basis;
2. for compensation; and
3. for at least thirty (30) hours a week, forty-eight (48) weeks a year.

S. Group Policy or Group Insurance Contract means the insurance policy issued by the Company to the Employer.

T. Integral Service means a service or procedure that is considered part of another procedure. No additional allowances are given for Integral Services.

U. Maximum means the greatest amount the Company will pay in a calendar year for Covered Services or in a lifetime for orthodontic treatment. The Maximums are set forth in the Schedule of Benefits.

V. Missing Teeth mean teeth missing prior to the effective date of coverage. Services for Missing Teeth are not covered.

W. Non-Diseased Tooth is a tooth that is whole or properly restored, and is free of decay and/or periodontal conditions.

X. Non Participating Dentist means a dentist who does not have a contract with the Company to provide Covered Services.

Y. Open Enrollment Period means the period annually, that is designated by the Employer and set forth in the Group Application, when Employees who are eligible for coverage may enroll in the Plan. During the Open

Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered Dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy. If for any reason, Employer fails to designate an Open Enrollment Period, or the Group Application fails to indicate it, the Open Enrollment Period shall be the month prior to the anniversary of the effective date of the Group Policy.

Z. Participating Dentist means a dentist who has signed a contract with the Company to provide Covered Services. The Company will pay a Participating Dentist directly.

AA. Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's placement for adoption with such person terminates upon the termination of such legal obligation.

AB. Plan means the Employee health benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Insurance Contract between the Company and your Employer.

AC. Plan Administrator means your Employer.

AD. Plan Year means the Plan Year stated in the Employee Health Benefit Plan or Summary Plan Description. If not stated in these documents, or if these documents do not exist, the Plan Year is the twelve-month period ending on the day before the anniversary of the effective date of the policy.

AE. Policy Month means the month commencing on the first day of the calendar month and expiring on the last day of the calendar month or commencing on the fifteenth day of the month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by the Company.

AF. Spouse means a member of the opposite sex who is the husband or wife of an Employee as a result of a marriage that is legally recognized in the state of Arkansas.

AG. Stepchild means a natural or adopted Child of the Spouse of the Employee provided:

1. such Child lives with the Employee in a parent-Child relationship; and
2. the Employee has a legal right to claim and does claim such Child as a Dependent on his federal income tax form.

AH. The masculine gender when used herein shall include the feminine gender.

AI. Treatment Plan means a written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared by a dentist as a result of an examination of the Covered Person.

AJ. Waiting Period is the period after the effective date of coverage for which benefits are not payable for each Covered Person. If a Dependent is added by endorsement, the Waiting Period will begin from the effective date of the addition. In the event of a reinstatement, all Covered Persons will be subject to new Waiting Periods beginning with the effective date of reinstatement. Waiting Periods may or may not be applicable to a Covered Person's benefits. Check the Schedule of Benefits to determine if services have a Waiting Period.

AK. We, Our and Us means the Company, Arkansas Blue Cross and Blue Shield.

AL. You and Your means a Covered Person.

ARTICLE III. ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

A. **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Employees and Dependents by the Company.

1. **Employee Coverage.** To be eligible, an Employee must:
   a. work on a full-time basis for the Employer;
   b. complete the required Eligibility Period, if applicable;
   c. be in a class of Employees who are included in the Plan; and
   d. work at least thirty (30) hours per week and forty-eight (48) weeks per year.
2. **Dependent Coverage.** Eligible Dependents are the Employee's:
   a. Spouse;
   b. Child less than 26 years of age, provided the Child was covered by the Plan or by another Health benefit Plan on May 31, 2010 and has had had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan;
   c. unmarried Child less than 26 years of age; who is:
      i. living with the Employee in a parent-child relationship; and
      ii. is claimed as a dependent on the Employee's federal income tax return;

d. Child less than 26 years of age, provided the Child enrolls on or after the anniversary date of the Policy after September 23, 2010;

e. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided 1.) such Child is or was under the limiting age of dependency stated in Subsections b. and c. above at the time of application for coverage in the Plan or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

Note: Domestic partners are not eligible for coverage as Dependents under this Benefit Certificate.

3. **Additional Eligibility Requirements for Dependent Coverage.** In order for an employee's Dependent to be eligible for coverage:

   a. the Employee must be eligible for and have coverage; and

   b. the Dependent must not be in active military service;

4. **Proof of Mental Retardation or Physical Disability.** In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or disability must be furnished to the Company prior to the Child's attainment of the applicable limiting age referenced in sections A.2.b. and A.2.c. above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (i.e. are declaring the Child as a dependent on their federal income tax return.) Subsequent evaluation for continued retardation or physical disability and dependency may be required by the Company, but not more frequently than once per year. An Employee who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age, and the Child has been continuously covered under a health benefit plan as a Dependent of the Employee since before attaining the limiting age. The Company's determination of eligibility shall be conclusive.

5. **Military Duty.** If a Covered Person is called to active duty in the armed services of the United States of America, the Covered Person's (and any covered Dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA). A former Covered Person returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The Company may require a copy of the returning member's orders terminating the active duty or other proof of the active duty or termination date thereof.

B. **Effective Date of Coverage.** The following provisions outline the Company's policies relative to effective dates of coverage.

1. **Application and Effective Date.** In order for an Employee's coverage to take effect, the Employee must submit an application for coverage for the Employee and any Dependents. The effective date(s) of coverage shall be determined in accordance with this Subsection B.1 and indicated by the Company on the identification card, Benefit Certificate, Schedule of Benefits or letter issued to Covered Persons by the Company.

2. **Employees and Dependents on Group Policy Effective Date**. Coverage under this Benefit Certificate shall become effective on the Group Policy effective date for all Employees and Dependents for whom an enrollment application is completed and premium is paid during the enrollment period prior to the Group Policy effective date.

3. **Initial Enrollment of New Employees.** If the Company receives an Employee's enrollment application within thirty (30) days of the date the Employee is first eligible for coverage, the Employee's coverage will become effective on the first day of the month following the date the Employee is first eligible for coverage.

4. **Coverage in the Case of Late Enrollment.** If an Employee or an Employee's Dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible for coverage, the Employee or Dependent can not subsequently obtain coverage, except during an Open Enrollment Period.

5. **Open Enrollment Period.** Annually, during the period designated by the Employer and set forth in the Group Policy Application. Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered Dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy.

6. **Initial Enrollment Period for Existing Dependents.** If the Employee has eligible Dependents on the

date the Employee's coverage begins, the Employee's Dependents' coverage will begin on the Employee's effective date if:

a. Employee submits a an application for Dependents' coverage within 30 days of the Employee's effective date; and

b. The appropriate premium is timely paid.

7. **Initial Effective Date for Newly Acquired Dependents.** If an Employee acquires a new eligible Dependent after the date the Employee's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:

a. **Spouse**. When an Employee marries and wishes to have the Employee's Spouse covered, the Employee shall submit an application or change form within 30 days of the date of marriage. The effective date will be the first of the month following the date of marriage. If an Employee submits the application or change form after the 30-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollment. See Subsection B.4, above.

b. **Newborn Children**. Coverage for an Employee's newborn Child shall become effective as of the Child's date of birth if the employee gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Employee submits the application or change form after the applicable 90-day time period, coverage for the Employee's newborn Child will become effective in accordance with the provisions for Late Enrollment. See Subsection B.4, above.

c. **Qualified Medical Child Support Order.** If a court has ordered an Employee to provide coverage for a Child, coverage will be effective on the first day of the month following the date the Company receives notification of the court order. If the Employee fails to apply to obtain coverage for a Child, the Company shall enroll the Child on the first day of the month following the Company's receipt of a written application from a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due. In the event a court has ordered an Employee of the Employer who is not covered by the Plan to provide coverage for a Child, the Employee will be enrolled with the Child on the first day of the month following the Company's receipt of a written application from the Employer, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.

d. **Newly Adopted Children.** Subject to payment of all applicable premiums, coverage for a Child placed with an Employee for adoption or for whom the employee has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided an application for the Child's coverage is submitted to the Company within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the application for coverage is submitted to the Company within 60 days of the Child's birth. If the Employee submits the application or change form after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollment. See Subsection B.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

e. **Other Dependents**. An application for enrollment received by the Company within 30 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such Dependent on the first day of the month following the date that application for coverage is received by the Company. Such Dependent will not be a Late Enrollee. If the Employee submits the application or change form after the 30 day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollment. See Subsection B.4, above.

8. **Employee's Effective Date Controls**. In no event will a Dependent's coverage become effective prior to the Employee's effective date.

C. **Termination of Coverage.** The following provisions outline the Company's policies relative to termination of coverage for Employees and Dependents.

1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Covered Person shall terminate if any of the following events occur:

a. Coverage shall terminate at 12:00 midnight Central Time on the date of event when:

(i) An Employee or Dependent dies.

(ii) This Plan terminates.

(iii) The Employer to which the Group Policy is issued, terminates or ceases to sponsor the Plan.

b. Coverage shall terminate at 12:00 midnight Central Time on the last day of the Policy Month in which the event occurs when:

(i) The Covered Person ceases to be eligible as an Employee or Dependent for any reason.

(ii) The Covered Person is a Dependent Spouse who becomes legally separated from the Employee.

c. Any Covered Person's coverage shall terminate at 12:00 midnight Central Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before expiration of the Grace Period. See ARTICLE II. D of the Group Policy regarding when a premium is deemed "paid" or "payment" occurs.

NOTE: Although the Company, as a courtesy and to complete its documentation, may chose to provide a written notice of termination in the foregoing circumstances, no notice of termination shall be required as termination for any of the foregoing reasons shall be deemed to occur automatically upon occurrence of the described events.

2. **Termination of a Covered Person's Coverage for Cause.**

a. **Basis for Termination.** The Company may terminate coverage under this Benefit Certificate, including termination by rescission of all coverage retroactive to the Covered Person's original effective date, upon fifteen (15) days' written notice for:

(1) concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage; or

(2) concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by the Company, or (ii) the Company would not have issued this Benefit Certificate, would have charged a higher premium, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Benefit Certificate.

c. **Termination Effective Date**. Rescission of coverage shall become effective on the Covered Person's original effective date. If the Company elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to the Company; or (ii) the date stated in the termination notice letter to Covered Person.

d. **Appeal Procedure.** A Covered Person may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by Covered Person to Company; or (ii) the termination effective date stated in the termination notice letter to Covered Person.

3. **Refunds.** If the coverage of a Covered Person is terminated, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and the Company shall have no further liability under this Benefit Certificate. Any claims for refunds by the Employer must be made within 60 days from the effective date of termination of the Covered Person's coverage or otherwise such claims shall be deemed waived. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

4. **Termination of the Group Policy, Impact on Covered Persons.** The coverage of all Covered Persons shall terminate if the Group Policy is terminated.

D. **Continuation Rights under Federal Law.** If Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Employer, the coverage of an Employee or Dependent whose coverage ends due to a Qualifying Event may be continued while the Group Policy remains in force subject to the terms of this Section and all terms and provisions of this Benefit Certificate not inconsistent with this Section.

This provision shall not be interpreted to grant to any Covered Person any continuation rights under this Benefit Certificate in excess of those required by COBRA. If the Employer fails to comply with the provisions of the Group Policy and this Benefit Certificate concerning COBRA or the notice requirements or other standards under COBRA, the Company shall not assume the Employer's obligation to provide COBRA continued coverage under the Plan.

1. **Qualifying Events.** The following is a list of events which could result in termination of a Covered Person's coverage under this Benefit Certificate. If such should occur, for purposes of this Section, the event shall be called a Qualifying Event.
   a. An Employee's death.
   b. Termination of an Employee's employment (other than by reason of the Employee's gross misconduct), or of an Employee's eligibility due to reduction in the Employee's hours of employment.
   c. An Employee's and Spouse's divorce or legal separation.
   d. An Employee becoming entitled to Medicare.
   e. A Dependent Child ceasing to be a Dependent Child as defined in this Benefit Certificate.
2. **Requirements for COBRA Continuation**. Continuation under this Subsection is subject to a Covered Person requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:
   a. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Covered Person elects to continue coverage; and
   b. The Group, as Plan Administrator, must have provided the Covered Person an initial notice of COBRA rights at the time coverage commenced under the Plan (this Benefit Certificate); and
   c. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and
   d. The Covered Person must notify the Plan Administrator within 60 days of the happening of Qualifying Event (c) or (e) in Section D.1., above; and
   e. The Covered Person must elect to continue coverage under the Plan within 60 days of the later of:
      (1) the date the notification of election rights is sent, or
      (2) the date coverage under the Plan terminates.

   If an election is not made by the Covered Person within this 60-day period, the option to elect COBRA shall end.

   If an Employee with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Employee asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Covered Person shall include coverage for all Dependents of the Employee who were covered.
3. **Coverage Continued**. The coverage continued for a Covered Person in accordance with this Section shall be the same as otherwise provided under this Benefit Certificate for other Covered Persons in the same benefit class in which such Covered Person would have been covered had his or her coverage not terminated.
4. **Effective date.** The effective date for COBRA continuation is the date coverage under the Plan terminates due to a qualifying event.
5. **Termination.** Once in effect, COBRA continuation coverage for a Covered Person under this Section shall terminate on the earliest to occur of the following applicable dates:
   a. The date the Group Policy terminates;
   b. At the end of the last period for which premium contributions for such coverage have been made, if the Covered Person or other responsible person does not make, when due, the required premium contribution to the Employer;
   c. The date ending the maximum period. In the Case of Qualifying Event D.1.b. above (relating to

termination of employment or reduction in hours), this date shall be the date 18 months after the date of that Qualifying Event; unless the Covered Person is disabled at the time of, or within 60 days after, the Covered Person's termination or reduction in hours, in which case this date shall be 29 months after the Qualifying Event. In all other cases, such date shall be the date 36 months after the date of that Qualifying Event which applies;

d. The date the Covered Person becomes covered under any other group health plan that provides coverage for Preexisting Conditions;

e. The date the Covered Person becomes entitled to Medicare;

f. The date the Covered Person's coverage is terminated for cause. See Subsection C.2 above.

ARTICLE IV. COVERED SERVICES

IMPORTANT NOTICE

THE SERVICES OUTLINED IN THIS BENEFIT CERTIFICATE REPRESENT ALL POSSIBLE COVERED SERVICES AVAILABLE TO YOUR EMPLOYER. DEPENDING ON WHAT YOUR EMPLOYER PURCHASED, YOU MAY NOT HAVE COVERAGE FOR ALL SERVICES LISTED HEREIN. THEREFORE IT IS IMPORTANT THAT YOU TO READ YOUR SCHEDULE OF BENEFITS CAREFULLY. ONLY SERVICES LISTED ON THE SCHEDULE OF BENEFITS FOR YOUR EMPLOYER ARE COVERED.

A. **Payment for Covered Services**. Subject to all terms, conditions, exclusions and limitations of the Plan, payment for dental Covered Services will be made in accordance with this Certificate and the Schedule of Benefits. Each calendar year, before the Plan makes a benefit payment, a Covered Person must pay the cost of a Covered Service equal to the Deductible specified in the Schedule of Benefits. If the Plan provides family coverage, once three family members have met the Deductible, no further Deductible will be required for the balance of the calendar year, regardless of what member of the family incurs a claim. Once the Deductible is satisfied, a Covered Person is responsible for Coinsurance, which is a percentage of the Charge paid by the Company. All payments for Covered Services are subject to a Calendar Year Maximum stated in the Schedule of Benefits. Once the Calendar Year Maximum has been met, the Company has no further liability for the remainder of the calendar year. All remaining charges for the balance of the calendar year will be the sole responsibility of the Covered Person.

B. **Participating Dentists**. Participating Dentists have agreed to accept the Charge as payment in full for Covered Services except for the Deductible and Coinsurance if applicable. Participating Dentists will not bill a Covered Person beyond the Charge for Covered Services unless the Calendar Year Maximum has been met. The Company will pay the Coinsurance percentage of the Charge for the Covered Service stated in the Schedule of Benefits. The Covered Person is responsible for the payment of the applicable Deductible, Covered Person's Coinsurance and any charges in excess of the Calendar Year Maximum or the Lifetime Orthodontic Maximum, if applicable, stated in the Schedule of Benefits.

C. **Non-Participating Dentists.** If Covered Services are performed by a Non-Participating Dentist, the Company will pay contract benefits directly to the Employee. Any difference between the Non-Participating Dentist's billed charge and the contract benefits paid by the Company shall be the responsibility of the Employee.

D. **Treatment Plan/Predetermination**

1. The Company requires a Treatment Plan for services for which the dentist expects to bill $300.00 or more for services. When a Treatment Plan is required, the dentist must submit such Treatment Plan to the Company for predetermination prior to the performance by the dentist for any Covered Service. Substantiating material such as radiographs and perio charting must be submitted with the Treatment Plan when requested by the Company.

2. If a Treatment Plan or substantiating material requested by the Company is not submitted, the Company reserves the right to determine benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice. Any amount, predetermined by the Company, shall be subject to adjustments by the Company at the time of final payment as may be necessary to correct any mathematical errors and to comply with the Plan in effect at the time the Covered Service is provided.

3. The Company shall not be liable under this Benefit Certificate for any Covered Services, including those Covered Services predetermined by the Company, which are performed at a time the Covered Person's coverage is no longer in effect.

E. **Alternate Treatment**

Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. The Company will make payment based upon the Charge for the less expensive procedure provided that the less

expensive procedure meets accepted standards of dental treatment as determined by the Company. The Company's decision does not commit the Covered Person to the less expensive procedure. However, if the Covered Person and the dentist choose the more expensive procedure, the Covered Person is responsible for the additional charges beyond those paid or allowed by the Company.

Examples:

1. Resin fillings are covered for anterior teeth; however, resin fillings in posterior teeth are paid at amalgam allowables from the fee schedule. Resin may be used for restoration of the posterior teeth, but only the amount normally paid for an amalgam will be reimbursed. **The Covered Person is responsible for the difference in cost.**
   - D2391 is paid as D2140.
   - D2392 is paid as D2150.
   - D2393 is paid as D2160.
   - D2394 is paid as D2161.
2. If a crown is placed on a tooth when a filling would meet accepted standards of care, the amount normally reimbursed for a filling will be paid to the dentist or the Covered Person**. The Covered Person is responsible for the difference in cost.**
3. If precious metal (gold, etc.) is used for a partial denture rather than a non–precious metal or other suitable substitute, the amount normally paid for the non–precious metal or less expensive substitute will be reimbursed to the dentist or Covered Person. **The Covered Person is responsible for the difference in cost.**
4. If a bridge is provided when a partial denture could satisfactorily replace the missing teeth, the payment will be made for the partial denture. **The Covered Person is responsible for the difference in cost.** If teeth are missing in two different quadrants of the same arch, a partial denture reimbursement will be made. **The Covered Person is responsible for the difference in cost.**
   - (D6740, D6245, D6740) are paid as D5213 or D5214.
   - (D6750, D6240, D6750) are paid as D5213 or D5214.
   - (D6751, D6241, D6751) are paid as D5213 or D5214.
   - (D6752, D6242, D6752) are paid as D5213 or D5214.
   - (D6790, D6210, D6790) are paid as D5213 or D5214.
   - (D6791, D6211, D6791) are paid as D5213 or D5214.
   - (D6792, D6212, D6792) are paid as D5213 or D5214.
5. Amalgams are paid as an automatic alternate benefit for all inlay restorations and all two surface onlay restorations. **The Covered Person is responsible for the difference in cost.**
   - D2510 is paid as D2140.
   - D2520 is paid as D2150.
   - D2530 is paid as D2160.
   - D2542 is paid as D2150.
   - D2610 is paid as D2140.
   - D2620 is paid as D2150.
   - D2630 is paid as D2160.
   - D2630 is paid as D2160.
   - D2642 is paid as D2150.
   - D2650 is paid as D2140.
   - D2651 is paid as D2150.
   - D2652 is paid as D2160.
   - D2662 is paid as D2150.
6. Stainless steel crowns are paid as an alternate benefit to stainless steel crowns with resin windows, prefabricated esthetic stainless steel crowns or prefabricated resin crowns. Stainless steel crowns are covered once per tooth per lifetime for children under age 14. **The Covered Person is responsible for the difference in cost.**
   - D2932 is paid as D2930.
   - D2933 is paid as D2930.
   - D2934 is paid as D2930

7. Free soft tissue graft procedures (including donor site surgery) is the alternate treatment for the combined connective tissue and double pedicle graft. **The Covered Person is responsible for the difference in cost.**
   - D4276 is paid as D4271.
8. Pre–fabricated posts and cores are the alternate treatment to cast posts and cores for single crowns and/or bridge abutment teeth. **The Covered Person is responsible for the difference in cost.**
   - D2952 is paid as D2954.
   - D6970 is paid as D6972.

F. **Diagnostic and Preventive Services (Service Category A.)** The following American Dental Association CDT–4 Codes are Covered Services under this Benefit Certificate if the Diagnostic and Preventive Services category is listed in the Schedule of Benefits. Services performed in this category are **not** subject to a Deductible and are paid at the Coinsurance percentage set out in the Schedule of Benefits. Covered Services in this category contribute to the calculation of the Calendar Year Maximum.

Service Category	***Proc Code***	***Description***
A	D0120	PERIODIC ORAL EXAMINATION
A	D0140	LIMITED ORAL EVALUATION – PROBLEM FOCUSED
A	D0145	ORAL EVALUATION FOR A PATIENT UNDER THE AGE OF 3
A	D0150	COMPREHENSIVE ORAL EXAMINATION
A	D0160	DETAILED AND EXTENSIVE ORAL EXAM – PROBLEM FOCUSED
A	D0180	COMPREHENSIVE PERIODONTAL EVALUATION
A	D0210	INTRAORAL – COMPLETE SERIES (INCLUDING BITEWINGS)
A	D0220	INTRAORAL– PERIAPICAL–FIRST FILM
A	D0230	INTRAORAL–PERIAPICAL–EACH ADDITIONAL FILM
A	D0240	INTRAORAL–OCCLUSAL FILM
A	D0250	EXTRAORAL–FIRST FILM
A	D0260	EXTRAORAL – EACH ADDITIONAL FILM
A	D0270	BITEWING–SINGLE FILM
A	D0272	BITEWINGS – TWO FILMS
A	D0273	BITEWINGS – THREE FILMS
A	D0274	BITEWINGS – FOUR FILMS
A	D0277	VERTICAL BITEWINGS – 7 TO 8 FILMS
A	D0330	PANORAMIC FILM
A	D0460	PULP VITALITY TESTS
A	D0470	DIAGNOSTIC CASTS
A	D1110	PROPHYLAXIS – ADULTS
A	D1120	PROPHYLAXIS – CHILD
A	D1203	TOPICAL APPLICATION OF FLUORIDE (CHILD)
A	D1204	TOPICAL APPLICATION OF FLUORIDE ADULT THROUGH AGE 18
A	D1206	TOPICAL FLUORIDE VARNISH – HIGH CARIES RISK PATIENTS
A	D1351	SEALANT – PER TOOTH
A	D1510	SPACE MAINTAINER – FIXED UNILATERAL
A	D1515	SPACE MAINTAINER – FIXED - BILATERAL TYPE
A	D1550	RECEMENTATION OF SPACE MAINTAINER
A	D1555	REMOVAL OF FIXED SPACE MAINTAINER
A	D9110	PALLIATIVE EMERGENCY TREATMENT

G. **Special Limitations for Diagnostic and Preventive Services.**
1. One (1) in a calendar year:
   a. Limited evaluation, problem focused, (D0140), one per patient per dentist.
   b. Bitewings x–rays, one occurrence of two bitewings (D0272), three bitewings (D0273), four bitewings

(D0274) or eight vertical bitewings (D0277) for adults over the age of 18.

c. Detailed and extensive evaluation, problem focused (D0160), one per patient per dentist.

d. Comprehensive periodontal evaluation (D0180), one per patient per dentist

2. Two (2) in a calendar year:

a. Routine exams (D0120, D0145)

b. Routine prophylaxis (D1110, D1120)

c. Fluoride treatment for dependent children through age 18 (D1203, D1204).

d. Bitewing x–rays (D0272) for dependent children through age 18.

3. One (1) in a 24 month period:

Comprehensive evaluations (D0150) limited to one per patient per dentist. Additional comprehensive evaluations during the 24–month period will be processed as periodic evaluations (D0120).

4. One (1) in a three year period:

a. Sealants (D1351) – Dependents through age 15 on permanent first and second molars.

b. Fixed space maintainers (D1510, D1515) – Dependents through the age of 18 for premature loss of primary molars and permanent first molars, or those that have not/will not develop.

5. One (1) in a five year period:

Full mouth radiographs (D0210 & D0330).

H. **Basic Services (Service Category B.)** The following American Dental Association CDT–4 Codes are Covered Services under this Benefit Certificate if the Basic Services category is listed in the Schedule of Benefits. Services performed in this category are subject to a Deductible per calendar year and are paid at the Coinsurance percentage listed in the Schedule of Benefits. Covered Services in this category contribute to the calculation of the Calendar Year Maximum.

Service Category	***Proc Code***		***Description***
B	D2140		AMALGAM – ONE SURFACE, PRIMARY OR PERMANENT
B	D2150		AMALGAM – TWO SURFACES, PRIMARY OR PERMANENT
B	D2160		AMALGAM – THREE SURFACES, PRIMARY OR PERMANENT
B	D2161		AMALGAM – FOUR OR MORE SURFACES, PRIMARY OR PERMANENT
B	D2330		RESIN – ONE SURFACE, ANTERIOR
B	D2331		RESIN – TWO SURFACES, ANTERIOR
B	D2332		RESIN – THREE SURFACES, ANTERIOR
B	D2335		RESIN – FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)
B	D2390		RESIN – BASED COMPOSITE CROWN, ANTERIOR
B	D2391		RESIN – BASED COMPOSITE – ONE SURFACE, POSTERIOR
B	D2392		RESIN – BASED COMPOSITE – TWO SURFACES, POSTERIOR
B	D2393		RESIN – BASED COMPOSITE – THREE SURFACES, POSTERIOR
B	D2394		RESIN – BASED COMPOSITE – FOUR OR MORE SURFACES, POSTERIOR
B	D2910		RECEMENT INLAY
B	D2920		RECEMENT CROWN
B	D2930		PREFABRICATED STAINLESS CROWN – PRIMARY TOOTH
B	D2931		PREFABRICATED STAINLESS CROWN – PERMANENT TOOTH
B	D2932		PREFABRICATED RESIN CROWN
B	D2933		PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW
B	D2934		PREFABRICATED ESTHETIC COATED CROWN – PRIMARY TOOTH
B	D2950	*	CORE BUILDUP, INCLUDING ANY PINS
B	D2951	*	PIN RETENTION – PER TOOTH, IN ADDITION TO RESTORATION
B	D2954	*	PREFABRICATED POST & CORE IN ADDITION TO CROWN
B	D2980		CROWN REPAIR – BY REPORT
B	D3220		THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)
B	D3310		ROOT CANAL THERAPY – ANTERIOR (EXCLUDING FINAL RESTORATION)

Service Category	Proc Code		Description
B	D3320		ROOT CANAL THERAPY – BICUSPID (EXCLUDING FINAL RESTORATION)
B	D3330		ROOT CANAL THERAPY – MOLAR (EXCLUDING FINAL RESTORATION)
B	D3346		RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR
B	D3347		RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BISCUPID
B	D3348		RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR
B	D3351		APEXIFICATION/RECALCIFICATION – INITIAL VISIT
B	D3352		APEXIFICATION/RECALCIFICATION – INTERIM VISIT
B	D3353		APEXIFICATION/RECALCIFICATION – FINAL VISIT
B	D3410		APICOECTOMY/PERIRADICULAR SURGERY – ANTERIOR
B	D3421		APICOECTOMY/PERIRADICULAR SURGERY – BICUSPID (FIRST ROOT)
B	D3425		APICOECTOMY/PERIRADICULAR SURGERY – MOLAR (FIRST ROOT)
B	D3426		APICOECTOMY/PERIADICULAR SURGERY EACH ADDT'L ROOT
B	D3430		RETROGRADE FILLING – PER ROOT
B	D3450		ROOT AMPUTATION – PER ROOT
B	D3920		HEMISECTION (INCLUDING ANY ROOT REMOVAL)
B	D3950		CANAL PREPARATION & FITTING OF PREFORMED DOWEL OR POST
B	D4341		PERIODONTAL SCALING AND ROOT PLANING – PER QUADRANT
B	D4342		PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH, PER QUADRANT
B	D4910		PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)
B	D5410		ADJUST COMPLETE DENTURE – UPPER
B	D5411		ADJUST COMPLETE DENTURE – LOWER
B	D5421		ADJUST PARTIAL DENTURE – UPPER
B	D5422		ADJUST PARTIAL DENTURE – LOWER
B	D5510		REPAIR BROKEN COMPLETE DENTURE BASE
B	D5520		REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH)
B	D5610		REPAIR RESIN SADDLE OR BASE
B	D5620		REPAIR CAST FRAMEWORK
B	D5630		REPAIR OR REPLACE BROKEN CLASP
B	D5640		REPLACE BROKEN TEETH – PER TOOTH
B	D6080		IMPLANT MAINTENANCE
B	D6092		RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN
B	D6093		RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE
B	D6930		RECEMENT BRIDGE
B	D6972	*	PREFABRICATED POST AND CORE IN ADDITION TO BRIDGE RETAINER
B	D6973	*	CORE BUILDUP FOR RETAINER, INCLUDING ANY PINS
B	D6980		BRIDGE REPAIR – BY REPORT
B	D7111		CORONAL REMNANTS – DECIDUOUS TOOTH
B	D7140		EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT
B	D7210		SURGICAL REMOVAL OF ERUPTED TOOTH
B	D7220		REMOVAL OF IMPACTED TOOTH – SOFT TISSUE
B	D7230		REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY
B	D7240		REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY
B	D7241	*	REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY WITH COMPLICATIONS
B	D7250		SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS – CUTTING PROCEDURES
B	D7260		ORAL ANTRAL FISTULA CLOSURE

Service Category	*Proc Code*		*Description*
B	D7261		PRIMARY CLOSURE OF SINUS PERFORATION
B	D7280		SURGICAL ACCESS TO AN UNERUPTED TOOTH
B	D7310		ALVEOPLASTY IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT
B	D7311		ALVEOPLASTY IN CONJUNCTION WITH EXTRACTIONS (1-3 TEETH)
B	D7320		ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT
B	D7340	*	VESTIBULOPLASTY – RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)
B	D7350	*	VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, ETC.)
B	D7471		REMOVAL OF EXOSTOSIS – MAXILLA OR MANDIBLE
B	D7472		REMOVAL OF TORUS PALATINUS
B	D7473		REMOVAL OF TORUS MANDIBULARIS
B	D7485		SURGICAL REDUCTION OF OSSEOUS TUBEROSITY
B	D7510		INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE
B	D7530		REMOVAL OF FOREIGN BODY, SKIN, OR SUBCUTANEOUS ALVEOLAR
B	D7560		MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY
B	D7960		FRENULECTOMY – SEPARATE PROCEDURE
B	D7970		EXCISION OF HYPERPLASTIC TISSUE–PER ARCH
B	D7971		EXCISION OF PERICORONAL GINGIVA
B	D9220		DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINS
B	D9221		DEEP SEDATION/GENERAL ANESTHESIA – EACH ADD'L 15 MINS
B	D9241		IV CONSCIOUS SEDATION
B	D9242		IV CONSCIOUS SEDATION - EACH ADD'L 15 MINUTES

I. **Special Limitations for Basic Services (Service Category B.)**

1. One (1) in a six month period:
   Recementation of space maintainers, crowns or bridges, but not within six months of insertion by the same dentist.
2. One (1) in a twelve month period:
   One restoration per surface on all teeth.
3. One (1) in a five year period:
   Single crown and abutment buildups, including pins.
4. One (1) per tooth per lifetime:
   a. Stainless steel crowns (D2930, D2931) – under age 14.
   b. Stainless steel crowns with resin window (D2933) – under age 14.
   c. Prefabricated resin crowns (D2932) – under age 14.
   d. Prefabricated esthetic coated stainless steel crown (D2934) – under age 14
   e. Composite resin crown (D2390) for primary teeth only.
   f. Root canal therapy (D3310, D3320, D3330), no allowance for additional canals.
5. Two (2) in a twelve month period
   Implant maintenance procedures (D6080), including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.

J. **Major Restorative Services (Service Category C.)** The following American Dental Association CDT–4 Codes are Covered Services under this Benefit Certificate if the Major Restorative Services Category is listed in the Schedule of Benefits. Services performed in this category are subject to a Deductible per calendar year and are paid at the Coinsurance percentage listed in the Schedule of Benefits. These services may also be subject to a Waiting Period. Check your Schedule of Benefits to determine if a Waiting Period applies to these Covered Services. Covered Services in this category contribute to the calculation of the Calendar Year Maximum.

(* – Indicates that X–rays are required upon claim submission.)

Service Category	Proc Code		Description
C	D2510		INLAY – METALLIC – ONE SURFACE
C	D2520		INLAY – METALLIC – TWO SURFACES
C	D2530		INLAY – METALLIC – THREE SURFACES
C	D2542	*	ONLAY – METALLIC – TWO SURFACES
C	D2543	*	ONLAY – METALLIC – THREE SURFACES
C	D2544	*	ONLAY– METALLIC – FOUR OR MORE SURFACES
C	D2610		INLAY – PORCELAIN/CERAMIC – ONE SURFACE
C	D2620		INLAY – PORCELAIN/CERAMIC – TWO SURFACES
C	D2630		INLAY – PORCELAIN/CERAMIC – THREE SURFACES
C	D2642	*	ONLAY – PORCELAIN/CERAMIC – TWO SURFACES
C	D2643	*	ONLAY – PORCELAIN/CERAMIC – THREE SURFACES
C	D2644	*	ONLAY – PORCELAIN/CERAMIC – FOUR OR MORE SURFACES
C	D2650		INLAY – COMPOSITE/RESIN – ONE SURFACE
C	D2651		INLAY – COMPOSITE/RESIN – TWO SURFACE
C	D2652		INLAY – COMPOSITE/RESIN – THREE OR MORE SURFACES
C	D2662	*	ONLAY – COMPOSITE/RESIN – TWO SURFACES
C	D2663	*	ONLAY – COMPOSITE/RESIN – THREE SURFACES
C	D2664	*	ONLAY – COMPOSITE/RESIN – FOUR OR MORE SURFACES
C	D2740	*	CROWN – PORCELAIN/CERAMIC SUBSTRATE
C	D2750	*	CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL
C	D2751	*	CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
C	D2752	*	CROWN – PORCELAIN FUSED TO NOBLE METAL
C	D2780	*	CROWN – 3/4 CAST HIGH NOBLE METAL
C	D2781	*	CROWN – 3/4 CAST PREDOMINATELY BASE METAL
C	D2782	*	CROWN – 3/4 CAST NOBLE METAL
C	D2783	*	CROWN – 3/4 PORCELAIN/CERAMIC (NOT VENEERS)
C	D2790	*	CROWN – FULL CAST HIGH NOBLE METAL
C	D2791	*	CROWN – FULL CAST PREDOMINANTLY BASE METAL
C	D2792	*	CROWN – FULL CAST NOBLE METAL
C	D2952	*	CAST POST & CORE IN ADDITION TO CROWN
C	D2962	*	LABIAL VENEER (PORCELAIN LAMINATE) – LAB
C	D4210	*	GINGIVECTOMY/GINGIVOPLASTY – PER QUADRANT
C	D4211	*	GINGIVECTOMY/GINGIVOPLASTY– ONE TO THREE TEETH, PER QUADRANT
C	D4240		GINGIVAL FLAP, INCLUDING ROOT PLANING – PER QUADRANT
C	D4241		GINGIVAL FLAP, INCLUDING ROOT PLANING – ONE TO THREE TEETH, PER QUADRANT
C	D4249		CROWN LENGTHENING – HARD/SOFT TISSUE, BY REPORT
C	D4260	*	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE – PER QUADRANT
C	D4261	*	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE– ONE TO THREE TEETH, PER QUADRANT)
C	D4263	*	BONE REPLACEMENT GRAFT – SINGLE SITE
C	D4264	*	BONE REPLACEMENT GRAFT – EACH ADDITIONAL SITE IN QUADRANT
C	D4266		GUIDED TISSUE REGENERATION – RESORBABLE BARRIER PER SITE PER TOOTH
C	D4267		GUIDED TISSUE REGENERATION – NONRESORBABLE BARRIER PER SITE PER TOOTH
C	D4270		PEDICLE SOFT TISSUE GRAFT PROCEDURE
C	D4271		FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE)

(* – Indicates that X–rays are required upon claim submission.)

Service Category	*Proc Code*	*Description*
C	D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURE
C	D4275	SOFT TISSUE ALLOGRAFT
C	D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT
C	D5110	COMPLETE DENTURE – UPPER
C	D5120	COMPLETE DENTURE – LOWER
C	D5130	IMMEDIATE DENTURE – UPPER
C	D5140	IMMEDIATE DENTURE – LOWER
C	D5211	UPPER PARTIAL – RESIN BASE (WITH CONVENTIONAL CLASPS, RESTS & TEETH
C	D5212	LOWER PARTIAL – RESIN BASE (WITH CONVENTIONAL CLASPS, RESTS & TEETH
C	D5213	UPPER PARTIAL – CAST METAL BASE WITH RESIN SADDLES
C	D5214	LOWER PARTIAL – CAST METAL BASE WITH RESIN SADDLES
C	D5225	MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE
C	D5226	MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE
C	D5281	REMOVABLE UNILATERAL PARTIAL DENTURE –1 PIECE CAST METAL
C	D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE
C	D5660	ADD CLASP TO EXISTING PARTIAL DENTURE
C	D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAME WORK (MAXILLARY)
C	D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)
C	D5710	REBASE COMPLETE UPPER DENTURE
C	D5711	REBASE COMPLETE LOWER DENTURE
C	D5720	REBASE UPPER PARTIAL DENTURE
C	D5721	REBASE LOWER PARTIAL DENTURE
C	D5730	RELINE COMPLETE UPPER DENTURE (CHAIRSIDE)
C	D5731	RELINE COMPLETE LOWER DENTURE (CHAIRSIDE)
C	D5740	RELINE UPPER PARTIAL DENTURE (CHAIRSIDE)
C	D5741	RELINE LOWER PARTIAL DENTURE (CHAIRSIDE)
C	D5750	RELINE COMPLETE UPPER DENTURE (LAB)
C	D5751	RELINE COMPLETE LOWER DENTURE (LAB)
C	D5760	RELINE UPPER PARTIAL DENTURE (LAB)
C	D5761	RELINE LOWER PARTIAL DENTURE (LAB)
C	D6010	IMPLANT – ENDOSTEAL/ENDOSSEOUS
C	D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT
C	D6040	SURGICAL PLACEMENT: ENDOSTEAL IMPLANT
C	D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT
C	D6053	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE, EDENTULOUS ARCH
C	D6054	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE, PARTIALLY EDENTULOUS ARCH
C	D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR
C	D6056	PREFABRICATED ABUTMENT – INCLUDES PLACEMENT
C	D6057	CUSTOM ABUTMENT – INLCUDES PLACEMENT
C	D6058	ABUTMENT SUPPORTED PROCELAIN/CERAMIC CROWN
C	D6059	ABUTMENT SUPPORTED PROCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)
C	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)

(* – Indicates that X–rays are required upon claim submission.)

Service Category	Proc Code		Description
C	D6061		ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)
C	D6062		ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)
C	D6063		ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATLY BASE METAL)
C	D6064		ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)
C	D6065		IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN
C	D6066		IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)
C	D6067		IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)
C	D6068		ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD
C	D6069		ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)
C	D6070		ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATLY BASE METAL)
C	D6071		ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)
C	D6072		ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)
C	D6073		ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATLY BASE METAL)
C	D6074		ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)
C	D6075		IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD
C	D6076		IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY OR HIGH NOBLE METAL)
C	D6077		IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY OR HIGH NOBLE METAL)
C	D6078		IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY ENDENTULOUS ARCH
C	D6079		IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARITALLY ENDENTULOUS ARCH
C	D6080		IMPLANT MAINTENANCE PROEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS
C	D6090		REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT
C	D6091		REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT
C	D6094		ABUTMENT SUPPORTED CROWN – (TITANIUM)
C	D6095		REPAIR IMPLANT ABUTMENT, BY REPORT
C	D6100		IMPLANT REMOVAL, BY REPORT
C	D6194		ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM)
C	D6205		PONTIC – INDIRECT RESIN BASED COMPOSITE
C	D6210	*	PONTIC – CAST HIGH NOBLE METAL
C	D6211	*	PONTIC – CAST PREDOMINANTLY BASE METAL
C	D6212	*	PONTIC – CAST NOBLE METAL
C	D6240	*	PONTIC – PORCELAIN FUSED TO HIGH NOBLE METAL
C	D6241	*	PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
C	D6242	*	PONTIC – PORCELAIN FUSED TO NOBLE METAL
C	D6245	*	PONTIC – PORCELAIN / CERAMIC
C	D6545	*	RETAINER – CAST METAL FOR ACID ETCHED FIXED PROSTHESIS

(* – Indicates that X–rays are required upon claim submission.)

Service Category	*Proc Code*		*Description*
C	D6548	*	RETAINER – PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS
C	D6600		INLAY – PORCELAIN/CERAMIC, TWO SURFACES
C	D6601		INLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES
C	D6602		INLAY – CAST HIGH NOBLE METAL, TWO SURFACES
C	D6603		INLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES
C	D6604		INLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES
C	D6605		INLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
C	D6606		INLAY – CAST NOBLE METAL, TWO SURFACES
C	D6607		INLAY – CAST NOBLE METAL, THREE OR MORE SURFACES
C	D6608	*	ONLAY – PORCELAIN/CERAMIC, TWO SURFACES
C	D6609	*	ONLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES
C	D6610	*	ONLAY – CAST HIGH NOBLE METAL, TWO SURFACES
C	D6611	*	ONLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES
C	D6612	*	ONLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES
C	D6613	*	ONLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
C	D6614	*	ONLAY – CAST NOBLE METAL, TWO SURFACES
C	D6615	*	ONLAY – CAST NOBLE METAL, THREE OR MORE SURFACES
C	D6740	*	CROWN – PORCELAIN / CERAMIC
C	D6750	*	CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL
C	D6751	*	CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
C	D6752	*	CROWN – PORCELAIN FUSED TO NOBLE METAL
C	D6780	*	CROWN – 3/4 CAST HIGH NOBLE
C	D6781	*	CROWN 3/4 CAST PREDOMINATELY BASED METAL
C	D6782	*	CROWN 3/4 NOBLE METAL
C	D6783	*	CROWN 3/4 PORCELAIN / CERAMIC
C	D6790	*	CROWN – FULL CAST HIGH NOBLE METAL
C	D6791	*	CROWN – FULL CAST PREDOMINANTLY BASE METAL
C	D6792	*	CROWN – FULL CAST NOBLE METAL
C	D6920		CONNECTOR BAR
C	D6970	*	CAST POST & CORE IN ADDITION TO BRIDGE RETAINER
C	D9940		OCCLUSAL GUARD

K. **Special Limitations for Major Restorative Services (Service Category C.)**

1. One (1) in a three year period:
   Rebasing/ relining of full or partial dentures.
2. One (1) in a five year period:
   a. Inlays and onlays, only if treatment is for decay purposes.
   b. Single crowns, only if treatment is for decay purposes or a broken tooth. This does not include fracture–line repair in teeth. Crowns are not covered for patients under age 14 unless rationale is provided and approved by a Dental Advisor.
   c. Removable prosthetics, including complete and partial dentures.
   d. Fixed prosthetics, including pontics and abutments (These are not covered for patients under age 15 unless rationale is provided and approved by a Dental Advisor.)
   e. Partial denture retainers (D6545, D6548).
   f. Post & cores.
3. One (1) per tooth per lifetime:
   a. Crown lengthening (D4249), only covered when bone is removed.

b. Guided tissue regeneration is allowed once per site (two adjacent teeth). Dental Advisor review is required.

4. Crowns for members will include an allowance for single-tooth implants (the fixture and abutment portion) (D6010) in addition to the allowance for the crown for the implant, subject to the following:
   a. One (1) for each tooth every five (5) year period:
   b. The implant excludes third molar placement.
   c. For members age sixteen (16) or older.
5. Crowns for members will include an allowance for single-tooth implants (the fixture and abutment portion) (D6010) in addition to the allowance for the crown for the implant, subject to the following:
   a. One (1) for each tooth every five (5) year period:
   b. The implant excludes third molar placement.
   c. For members age sixteen (16) or older.

L. **Orthodontic Services and Payment Procedure (Service Category D.)** The following American Dental Association CDT–4 Codes are Covered Services under Benefit Certificate if the Orthodontic Services Category is listed in the Schedule of Benefits. The normal payment procedure for orthodontic claims is a 25% down payment of the allowable or lifetime maximum (whichever is less) and the remainder is paid out (prorated) over the number of months in the Treatment Plan. Once the Treatment Plan is submitted and the treatment begins, the monthly payment will automatically be reimbursed. These Covered Services may be subject to a Waiting Period. Check your Schedule of Benefits to determine if a Waiting Period applies to these Covered Services. All Covered Services are subject to the Orthodontic Lifetime Maximum as listed in the Schedule of Benefits. **Limited to Covered Dependent Children Through Age 18**

Service Category	***Proc Code***	***Description***
D	D0340	CEPHALOMETRIC FILM
D	D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION
D	D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D	D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D	D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION
D	D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION
D	D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D	D8070	COMPREHENSIVE ORTHO TREATMENT OF THE TRANSITIONAL DENTITION
D	D8080	COMPREHENSIVE ORTHO TREATMENT OF THE ADOLESCENT DENTITION
D	D8090	COMPREHENSIVE ORTHO TREATMENT OF THE ADULT DENTITION
D	D8210	REMOVABLE APPLIANCE THERAPY
D	D8220	FIXED APPLIANCE THERAPY
D	D8680	ORTHODONTIC RETENTION
D	D8693	REBONDING OR RECEMENTING AND /OR REPAIR AS REQUIRED OF FIXED RETAINER

M. **Calendar Year Maximum Rollover Benefit**

1. A Rollover Benefit is a portion of a Covered Person's un-used Calendar Year Maximum that may be carried over to the next calendar year, thereby increasing the next Calendar Year Maximum amount, provided the following conditions are met:
   a. the Covered Person is an active member of the Plan on the last day of the calendar year;
   b. the Covered Person submits at least one (1) claim for a Covered Service during a calendar year;
   c. the Covered Person's total claims paid during a calendar year do not exceed the Yearly Threshold Amount, as stated in the table below; and
   d. the Accumulated Rollover Maximum has not been reached.

Calendar Year Maximum Benefit Amount	Yearly Threshold Amount	Available Rollover Amount to use next year/beyond.	Accumulated Rollover Maximum
$500 - $749	$200	$150	$500
$750 - $999	$300	$200	$500
$1,000 - $1,249	$500	$350	$1,000
$1,250 - $1,499	$600	$450	$1,250
$1,500 - $1,999	$700	$500	$1,250
$2,000 - $2,499	$800	$600	$1,500
$2,500 - $2,999	$900	$700	$1,500
$3,000 or more	$1,000	$750	$1,500

2. Beginning with the second (2nd) calendar year of coverage under this Certificate, a Covered Person's Calendar Year Maximum, as shown on the Schedule of Benefits, may be increased by the amount shown on the table above if all the above listed conditions are met. If coverage under this benefit is first provided during a partial calendar year, the Rollover Benefit will be calculated as if coverage was provided for a full calendar year.

Here's an example of how the Rollover Benefit works.

Calendar Year	One (1)	Two (2)	Three (3)	Four (4)
Calendar Year Maximum shown on the Schedule of Benefits	$1,000	$1,000	$1,000	$1,000
Accumulated Rollover Amount credit from prior year	$0	$350	$700	$700
Adjusted Calendar Year Maximum	$1,000	$1,350	$1,700	$1,700
Covered Service received	Yes	Yes	No	
Total Claims Paid during Calendar Year	$275	$480	$350	
Rollover Amount	$350	$350	$0	
Accumulated Rollover Amount	$350	$700	$700	

3. The Rollover Amount can be accumulated from one calendar year to the next, up to the Accumulated Rollover Maximum, unless:
   a. the Covered Person's total claims paid during a calendar year exceed the Yearly Threshold Amount (in this instance, there will be no additional Rollover Amount for that calendar year), or
   b. no claims for Covered Services are incurred during a calendar year (in this instance, there will be no additional Rollover Amount for that calendar year).
4. If total claims paid during any one calendar year exceed the Calendar Year Maximum shown on the Schedule of Benefits, the excess amount will be deducted from the Accumulated Rollover Amount available for that calendar year. No additional Rollover Amount will be earned for that calendar year and the Accumulated Rollover Amount available for the next calendar year will be reduced by the amount deducted for the excess claim amount.
5. To properly calculate the Rollover Amount, claims should be submitted in a timely manner, as described in this Certificate.
6. Rollover Amounts are not available for the following expenses related to a Covered Person's dental services:
   a. Deductibles;
   b. Coinsurance;
   c. copayments;
   d. balance billed amounts
   e. non-covered amounts
   f. charges billed by Non-Participating Providers which exceed the allowed amount for the services rendered; or
   g. orthodontic benefits.
7. When Your Calendar Year Maximum Rollover Benefit Ends

You will lose your right to any annual rollover benefit (or accumulated rollover maximum benefit) when you lose eligibility for coverage in your Group's dental plan. The accumulated rollover benefit can be used only while you are enrolled in your Group's dental plan and while your group continues to offer the Calendar Year Maximum Rollover Benefit. This means that if you change from one Group's dental plan to another Group's dental plan, or if your Group dental plan is terminated, you lose your right to any rollover benefit that has not been used.

ARTICLE V. SPECIFIC BENEFIT LIMITATIONS

The following services will be subject to the limitations set forth below:

A. Integral Services

These services are considered part of another service. No additional allowance will be paid if billed as a separate service.

1. Supragingival scaling is Integral to a prophylaxis.
2. Prophylaxis on the same day as a periodontal maintenance visit (D4910) or periodontal treatment, including surgery.
3. Prophylaxis on the same day as scaling and root planing (D4341, D4342), regardless of the number of quadrants or teeth reported.
4. Sealants on the same day as a resin restoration.
5. Periapical x–rays taken on the same day as a panorex (D0330).
6. Periapical x–rays and /or bitewings taken on the same day as a full series (D0210).
7. Pulp vitality tests (D0460) with root canal therapy on same day.
8. Adjunctive procedures that are Integral to crowns, inlays, and onlays.
9. Intraoral I&D (D7510) with root canal therapy.
10. Diagnostic x–ray taken the same day as the initial root canal therapy is covered. Any other x–rays 30 days before or after root canal therapy are Integral.
11. Pulpotomies, in conjunction with root canal therapy by the same dentist within 45 days prior to root canal therapy completion date are Integral to root canal therapy.
12. Pulpotomy on the same date as deciduous root canal therapy.
13. Payment is made for the most extensive periodontal surgical procedure that includes any lesser procedures on the same date. If procedures are fragmented, the lesser procedures will be denied as Integral.
14. Scaling and root planing on the same date as surgical periodontal procedures.
15. Periodontal maintenance when reported with scaling and root planing on the same date regardless of the number of quadrants or teeth reported.
16. Periodontal maintenance on the same day and same dentist as surgical periodontal procedures.
17 Complete or partial denture adjustments within six months of insertion.
18. Additional clasps (billed separately) are combined to the partial denture.
19. Recementation of crowns and bridges when provided within 12 months following insertion by the same dentist (unless there is an indication of root canal therapy) and then it is covered once per 12 months thereafter.
20. Temporary cementation of crowns or bridges.
21. Frenulectomy (D7960) when provided the same date, same dentist, same area of the mouth is Integral to soft tissue grafts.
22. Apical curettage and small odontogenic cysts are denied as being Integral to apicoectomies.
23. Rebasing/relining of full or partial denture within six months of insertion by the same dentist.
24. Small cysts are denied as being Integral to extractions and surgical procedures in the same area of the mouth by the same dentist.
25. Crown lengthening on the same day by same dentist and same area as osseous surgery. The osseous surgery will be denied as being Integral to the crown lengthening.
26. Palliative emergency treatment is denied as being Integral to definitive treatment when provided on the same day.
27. Myofunctional therapy involving exercise / physical therapy is Intergral to orthodontic treatment.

28. Isolation of tooth with rubber dam.
29. Local and block anesthesia.

B. The following services are specifically limited with the following conditions:

1. Sealants (D1351) are covered for Dependent children through age 15 on permanent first and second molars, and are limited to one sealant per three year period.
2. Cephalometric x-rays (D0340) are covered once per lifetime with all others denying as an Integral Service. Cephalometric x-rays are not covered at all unless your Schedule of Benefits indicates that you have coverage for Orthodontic Services (Service Category D.).
3. If the allowance for the combination of multiple periapicals, bitewings or full series of x-rays exceeds the allowance for a full series they will be combined to a full series.
4. Vertical bitewing x-rays (7 to 8 films, D0277) are paid with the same benefit limitations as four bitewing x-rays (D0274).
5. Sedative restorations (D2940) are allowed as palliative treatment in emergency situations, otherwise they deny as not covered.
6. An allowance is made for pins (D2951) per restoration regardless of the number used, and pins without a restoration are not covered.
7. A crown must be necessary on its own merit, not just because it will support a partial.
8. Intraoral incision and drain without root canal therapy is processed as a palliative treatment. On an inquiry basis, the I&D is allowed if it was the only treatment required.
9. Four quadrants of osseous surgery reported on the same date will require a Dental Advisor review.
10. Periodontal scaling without root planing will process as a routine prophylaxis or periodontal maintenance treatment.
11. Scaling and root planing for patients under age 19 requires diagnostic material submission and a Dental Advisor review.
12. Payment for periodontal maintenance does not include an evaluation.

    If an evaluation is reported it will be processed as a separate procedure. We will decrease the allowance for D4910 by the current allowance for existing code D0120.
13. Separate restorations may be allowed on same surface for anterior teeth. Separate lines represent separate restorations. Procedures related to a restoration are not paid as separate, including repairs/replacements for 12 months.
14. Preventive resins are considered sealants.
15. Multiple posterior restorations are paid as one multi–surface restoration when provided on the same day by the same dentist regardless of being reported as separate restorations.
16. Pins and/or posts reported, in addition to a buildup or post & core, are combined to the buildup or post & core.
17. Buildups involving posts must be preceded by root canal therapy.
18. Incomplete endodontic therapy of an inoperable or fractured tooth is covered by report following review by the Dental Advisor.
19. Deciduous root canal therapy is limited through age 5 for teeth D–G and N–Q, and through age 11 for teeth A–C, H–J, K–M, and R–T.
20. Apicoectomies, in absence of root canal therapy, are denied unless the canals are calcified. Apicoectomy is not allowed within 30 days of root canal therapy.
21. The final apexification visit includes root canal therapy. If billed separately, the root canal therapy will be combined to the final visit.
22. Pulpotomies are covered only on deciduous teeth.
23. Relining and rebasing of full or partial dentures on the same day and the same dentist merges to the rebase (D5710, D5711, D5720, D5721.)
24. Surgical extractions (D7210) denied for lack of coverage remain denied if resubmitted as simple extractions (D7111, D7140) unless; on an inquiry basis, x–rays substantiate that it is a simple extraction.
25. The degree of impaction of teeth is determined via x–ray review (D7220, D7230, D7240, & D7241).
26. Complex vestibuloplasties, as well as a vestibuloplasty on the same day as other surgical procedures, requires Dental Advisor review.
27. Periodontal maintenance is covered if:
    a. the patient has periodontal coverage

b. it follows active periodontal treatment

c. a routine prophylaxis has not been allowed on the same day

d. the number of periodontal maintenance procedures does not exceed two per year.

28. Diagnostic x–rays are not covered if there is no documentation in the patient's records indicating why the radiographs were ordered and/or what was diagnosed by the dentist upon reviewing the prescribed films.

29. Root canal retreatment (D3346, D3347, D3348) is allowed only if it has been three (3) years following initial root canal therapy.

ARTICLE VI. SERVICES NOT INCLUDED

(American Dental Association CDT–4 procedure code numbers listed below are merely examples of code numbers not covered. Other code numbers may apply to services not covered. You may contact the Company to receive a full list of CDT–4 procedure codes at no cost.)

Except as specifically provided in this Policy, no coverage will be provided for:

A. a service, procedure or supply which is not Dentally Necessary or which is not listed in the Schedule of Benefits.

B. a service, procedure, or supply which is not prescribed or rendered by or under the general supervision of a dentist;

C. any treatment, service, or supply received for any illness or accidental injury arising out of, or in the course of employment or occupation for wage, profit or gain.

Nor will the Company pay benefits for injury or illness for which the Covered Person receives any benefits from motor vehicle no–fault law, regardless of any limitations in scope or coverage amount which may apply to his benefits claim under such laws.

In the event that the Company pays any claim by the Covered Person for insurance benefits under this Policy, and subsequently learn that the Covered Person had filed a claim for workers' compensation benefits as to such claim, or that the Covered Person had settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Arkansas Workers' Compensation Law, state or federal workers' compensation, Employer's liability or occupational disease law, or motor vehicle no–fault law, the Covered Person agrees to reimburse the Company to the full extent of the Company's payments on such claim;

D. conditions to which dental treatment is provided by a federal or state government agency (not including medical assistance) or are provided without cost to any Covered Person by any political subdivision or governmental authority (This does not include plans of insurance or other benefit plans provided by the federal or state governments to government Employees and Employee's dependents);

E. Services for intentional self–inflicted injuries, including Drug Overdose, where the act resulted from no medical condition (physical or mental)

F. Disease contracted or injuries sustained while serving in the military forces of any nation.

G. any condition to which services, treatment, or supplies of any kind are furnished or paid for under Title XVIII (Medicare) or the Social Security Act, as amended;

H. services, procedures or supplies with respect to congenital mouth malformations or skeletal imbalances, including, but not limited to:

1. Treatment related to cleft palate therapy;

2. Treatment related to disharmony of facial bone; or

3. Treatment related to or required as a result of orthognathic surgery; or

4. Orthodontic treatment required in orthognathic surgical cases.

I. Cosmetic Treatment, services or supplies that are cosmetic in nature or performed on an elective basis, e.g., teeth bleaching, crowns or veneers on sound teeth, etc;

J. prescription drugs;

K. local or block anesthesia, when billed separately;

L. general anesthesia (D9220, D9221) or IV conscious sedation (D9241, D9242), for a non–covered service, as well as simple extractions, or routine chair-side procedures;

M. any experimental or investigational services or supplies or for any condition or complication arising from or related to the use of such experimental or investigational services or supplies. The Company shall have full discretion to determine whether a dental treatment is experimental or investigational. Any dental treatment may be deemed experimental or investigational, in the Company's discretion, if:

1. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure is that further studies or clinical trials are necessary to determine its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
2. reliable evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure neither supports nor denies its use for a particular condition or disease.
3. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's dental records or other information from the treating Dentist(s) or from a consultant(s) regarding the patient's dental history, treatment or condition;

(b) the written protocol(s) under which the treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the treatment or procedure;

(d) published reports and articles in the authoritative dental and scientific literature, signed by or published in the name of a recognized dental expert, regarding the treatment or procedure at issue as applied to the injury, illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same dental treatment or procedure.

N. the cost to replace lost, stolen, or damaged prosthetic appliances;

O. house calls (D9410) and hospital calls (D9420) for dental services;

P. services incurred prior to the Covered Person's effective date or after the termination date of coverage with the Company;

Q. resorbable fillings (D3230, D3240) on endodontic–treated deciduous teeth;

R. any dental or medical services performed by a physician for services covered or otherwise provided to the Covered Person by a medical–surgical plan;

S. services which the Covered Person incurs at no cost;

T. services which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed Treatment Plan;

U. plaque control programs, oral hygiene or dietary instructions;

V. any procedure deemed by the Dental Advisor to be of questionable efficacy;

W. charges for broken appointments;

X. any dental services or supplies required as the result of any accidental or traumatic injury;

Y. any dental services or supplies resulting from an injury or condition caused by another party;

Z. dental procedures requiring appliances or restorations that are necessary for full mouth rehabilitation, the restoration of occlusion, or to alter vertical dimensions of occlusion (except when involving full or partial dentures);

AA. non–intravenous conscious sedation (D9248), analgesia, anxiolysis or inhalation of nitrous oxide (D9230);

AB. services by an immediate relative. "Immediate relative" means your spouse, parents, children, brother, sister, or legal guardian of the person who received the services;

AC. duplicate, interim, and temporary procedures, devices and appliances. (e.g., when a dentist begins a crown and places a temporary crown, then submits charges for a permanent crown; coverage for the temporary crown will be denied.);

AD. procedures requiring the presence of a tooth will be denied if history indicates the tooth has been extracted (e.g., a crown is being reported and the tooth is listed as extracted in history);

AE. gold foil restorations; (D2410, D2420, D2430).

AF. if a course of treatment is performed by more than one (1) dentist, the Company will pay only the charges that would have been made by a single dentist for those services;

AG. charges for the completion of any insurance forms;

AH. applications of desensitizing medicaments, sub–gingival irrigations, and the localized delivery of chemotherapeutic agents (D4381);

AI. double abutments unless there is evidence of decay noted on x–ray;

AJ. removable space maintainers (D1510, D1515) and maintainer repairs;

AK. post removal (not in conjunction with endodontic therapy);

AL. synthetic grafts placed in extraction sites.

AM. periodontal provisional splinting, intracoronal or extracoronal;

AN. any services to restore tooth structure lost in order to rebuild or maintain occlusal surfaces due to mal–aligned or maloccluded teeth, lost from wear, or for stabilizing the teeth;

AO. silicate cements;

AP. tissue conditioning (D5850, D5851);

AQ. athletic mouthguards (D9941);

AR. overdentures (D5860, D5861);

AS. precision attachments (D5862, D6950);

AT. gross debridement (D4355);

AU. fiberotomies (D7291);

AV. x–ray and intraoral imaging (D0260, D0290, D0310, D0320, D0321, D0322, D0350);

AW. tests / laboratory examinations (D0415, D0425, D0472, D0473, D0474, D0480, D0502);

AX. nutritional counseling (D1310);

AY. tobacco counseling (D1320);

AZ. replacement of fillings due to mercury sensitivity;

BA. prefabricated resin crowns, prefabricated esthetic coated crowns, stainless steel crowns or stainless steel crowns with resin windows for a primary tooth for patients age 14 and older;

BB. pulpectomy on a permanent tooth;

BC. extraoral I&D (D7520);

BD. direct (D3110) and indirect (D3120) pulp caps ;

BE. procedure for isolation of tooth with rubber dam (D3910);

BF. bleaching of teeth (D9972, D9973, & D9974) ;

BG. intentional re–implantation (D3470);

BH. dressing change (D4920) ;

BI. maxillofacial prosthetics;

BJ. precious metal for partial dentures;

BK. partial dentures are not covered for patients under age 14 unless rationale is reported and approved by the Dental Advisor;

BL. specialized procedures (D5862, D6920, D6940, D6950, D6975);

BM. alveoloplasties involving less than five teeth ;

BN. tooth transplantation (D7272) or tooth reimplantation (D7270);

BO. excision / destruction of lesions (D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461);

BP. treatment of simple and compound fractures (D7610 – D7680, D7710 – D7760, D7770, D7771, D7780);

BQ. treatment and reduction of dislocation and management of TMJ/TMD (Temporomanibular Joint / Temporomandibular Joint Dysfunction) (D7810 – D7899) including diagnostic x–rays, occlusal appliances, and/or splints;

BR. consultations (D9310);

BS. drugs, medicaments, and/or injections (D9610, D9630);

BT. behavior management (D9920);

BU. occlusal analysis (D9950) and occlusal adjustments (D9951, D9952);

BV. pulpotomy on a permanent tooth will deny as not covered unless there is an indication of an emergency in which case it is paid as a palliative treatment;

BW. bridges for patients under age 14;

BX. replacement of teeth if there is insufficient space;

BY. root recovery (D7250) not completely covered by bone, if provided by the same dentist who extracted the tooth;

BZ. splinted crowns not replacing teeth; abutment crown(s) can be allowed if the tooth is diseased or badly broken down;

CA. gross pulpal debridement (D3221);

CB. distal or proximal wedge procedure (D4274);

CC. procedures performed prior to coverage or placed after termination of coverage are not covered.

CD. pallative emergency treatment (D9110) when definitive treatment is provided by the same dentist on the same day;

CE. sedative restorations (D2940);

CF. problem focused (D0170);

CG. oral surgery procedures for jaw deformities, resections, etc. (D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7972, D7980, D7981, D7982, D7983, D7990, D7991, D7995, D7996 and D7997);

CH. no benefits will be paid for replacement of teeth missing before the effective date of coverage. This is known as the missing tooth clause.

CI. apically positioned flap procedure (D4245);

CJ. enamel microbrasion (D9970);

CK. odontoplasty (D9971);

CL. sleep apnea appliances;

CM. biologic materials to aid in soft and osseous tissues regeneration (D4265);

CN. provisional pontic (D6253);

CO. provisional retainer crown (D6793);

CP. pediatric partial denture–fixed (D6985);

CQ. mobilization of erupted or malpositioned tooth to aid eruption (D7282);

CR. cytology sample collection (D7287);

CS. a panoramic film or panorex (D0330) is not covered for Children under the age of five.

CT. fixed partial denture resin crowns, retainer or pontics on permanent teeth.

CU. hospital or anesthesia fees due to the management of the patient.

CV. hospital facility fees for dental services.

CW. biopsy of oral tissue (D7285, D7286)

CX. sutures of small wounds and complicated sutures (D7910, D7911, D7912).

ARTICLE VII. SUBROGATION

If a Covered Person is injured by a third party, the Company is subrogated to all rights the Covered Person may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided. The Covered Person must cooperate fully with the Company in its efforts to collect from the third party, and if the Covered Person fails to do so, the Company shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments or credits due under this Benefit Certificate. The Company may assert its subrogation rights independently of the Covered Person. In addition to the above-referenced subrogation rights, the Company also has reimbursement rights should the Covered Person, or the legal representative, estate or heirs of the Covered Person recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Covered Person shall promptly reimburse the Plan any monetary recovery made by the Covered Person and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source.

ARTICLE VIII. COORDINATION AGAINST OTHER DENTAL COVERAGE

A. **Definitions:**

1. **Allowable Expense** is a necessary, reasonable, and customary item of expense for dental care; when the item of expense is covered at least in part by one or more plans covering the insured for whom claim is made.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

2. **Claim Determination Period** is a Benefit Year. However, it does not include any part of a year during which a Covered Person has no coverage under this Policy.

3. **Other Dental Plan** is any form of coverage which is separate from this Certificate with which coordination is allowed. Other Dental Plans shall be any of the following which provides dental benefits

or services:

a. Group insurance or group–type coverage, whether insured or uninsured, including prepayment groups. It does not include school accident type coverage (grammar, high school and college student coverages, including athletic injury, either on a twenty–four (24) hour basis or on a "to and from school basis") or group or group type hospital indemnity benefits of $100 or less per day.

b. Individually underwritten dental plan with a coordination of benefits provision.

c. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under a., b. or c. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

4. **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits. In other words, a plan that does not have a COB provision is always the Primary Plan.

5. **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

   When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

6. **This Plan** is this Benefit Certificate.

B. **Applicability**

If either a Policyholder or Eligible Dependent are covered by any other dental benefits plan and receive services covered by both This Plan and the other plan, benefits will be coordinated. This means that one plan will be primary, while the other plan will be secondary. Each plan will provide only that portion of its benefit that is required to cover expenses. Coordination of Benefits prevents duplicate payments and overpayments.

The Company will determine the Allowable Expense in accordance with ADA guidelines on coordination of benefits.

C. **Order of Benefit Determination Rules**

1. General

   When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless;

   a. The other plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

2. Rules

   This Plan determines its order of benefits using the first of the following rules which applies:

   a. Non–Dependent/Dependent – The benefits of the plan which covers the Covered Person as an employee, member or subscriber are determined before those of the plan which covers the Covered Person as a dependent; except that: if the Covered Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

      (i) Secondary to the plan covering the Covered Person as a dependent and

      (ii) Primary to the plan covering the Covered Person as other than a dependent then the benefits of the plan covering the Covered Person as a dependent are determined before those of the plan covering that Covered Person as other than a dependent.

   b. Dependent Child/Parents Not Separated or Divorced – Except as stated in Paragraph c. below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:

      (i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

      (ii) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(iii) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

However, if the other plan does not have the rule described in (i) immediately above, but instead has a rule based on gender of the parent, and if, 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.

c. Dependent Child/Separated or Divorced – If two or more plans cover an Covered Person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) First, the plan of the parent with custody of the child;

(ii) Then, the plan of the spouse of the parent with custody;

(iii) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. Continuation Coverage – If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(i) First, the benefits of a plan covering the Covered Person as an employee, member or subscriber (or as that Covered Person's dependent);

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rules described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. Longer/Shorter Length of Coverage – If none of the above rules determine the order of benefits, the benefits of the plan which covered a, member or subscriber longer are determined before those of the Plan which covered that Covered Person for the shorter term.

D. **Effect on the Benefits of This Plan:**

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision; whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

ARTICLE IX. OTHER PROVISIONS

A. Before any benefits can be paid, you agree, as a condition of coverage under this Certificate, and authorize and direct any provider of dental services or supplies to furnish Arkansas Blue Cross and Blue Shield, its agents, or any of its subsidiaries, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you authorize the release of such records to any third party review person or entity, for purposes of dental review. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to,

your other insurance coverage, third party liability, or workers' compensation benefits and to request that any dentist or other provider to respond to all such inquiries.

You understand and agree that your failure to respond to inquiries from the Company, or failure to cooperate fully to obtain information requested by the Company from your dentist or other dental care provider shall be, by itself, grounds for denial of benefits under this Certificate.

B. Assignment of Benefits. No assignment of benefits under this Certificate shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to you.

C. Notice and Proof of Claim.

1. You must submit written proof of any services, supplies or treatment and the Charges to the Company within one hundred eighty (180) days after such services, supplies or treatment were received.
2. The Company, upon receipt of such notice, will furnish to you such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Company receives such notice, you shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.
3. Subject to all applicable statutory provisions and rules and regulations of the Arkansas Insurance Department, all benefits payable under this Certificate will be payable immediately upon receipt of written proof of loss.

D. Upon termination of your employment, cancellation of the Group Contract under which this Certificate was issued, or upon failure to remit premiums on your behalf by your Employer, all benefits, except Charges incurred prior to such events, shall cease.

E Legal Actions. Prior to initiating legal action, you must file an appeal of your claim in accordance with ARTICLE X. G. of this Certificate. No court suit shall be brought to recover on this Certificate before sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No legal action shall be brought after the expiration of three (3) years from the time written proof of loss is required to be furnished.

F. Right of Rescission. Material misrepresentation, misstatements or omissions of information may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependent.

G. How To Appeal A Claim.

1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.
2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, dental or medical information can be released to you only upon the written authorization of your dentist or physician. You or your representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim.

   You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.
3. The Company acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your insurance benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of the Company acting on behalf of the Plan with respect to all such matters, and with respect to any other matters within the scope of its authority, shall be conclusive and binding on you and the Member.

H. Despite our best efforts, we may make a claim payment which is not for a benefit provided under this Certificate, or we may make payment to you when payment should have gone directly to the provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. If the Company does not receive the full amount of the refund due, the Company will have the right to offset future payments made to you or your Provider under this Policy/Certificate or under any other Policy/Certificate you have with the Company now or in the future.

I. Insurance Department. Arkansas Blue Cross and Blue Shield is an insurance company regulated by the Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201-1904; Consumer Service

(501) 371-2640 or (800) 852-5494.

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas Consumers Information Notice

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2010 or toll free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
Telephone (501) 371-2640 or toll free (800) 852-5494
INSURANCE.CONSUMERS@ARKANSAS.GOV.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain 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 policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("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 this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

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

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- 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);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

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