

Voluntary Group Dental Insurance

BASIC PLAN

Employee Benefit Booklet



**BOARD OF SUPERVISORS OF LOUISIANA STATE UNIVERSITY AND AGRICULTURAL
AND MECHANICAL COLLEGE**

F019004-0001

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.
04/07/2010

FORT DEARBORN LIFE Insurance Company®

Group Dental Insurance Certificate

Fort Dearborn Life Insurance Company

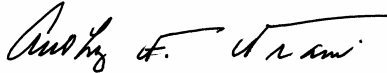
Chicago, Illinois

Administrative Office:

1020 31st Street

Downers Grove, IL 60515-5591

Fort Dearborn Life Insurance Company hereby certifies that it has issued a Group Dental Insurance Policy (herein called the "Plan") for the Employees and/or Retirees of the Policyholder named on this Certificate. Subject to the provisions of the Plan, each Employee and/or Retiree to whom a Fort Dearborn Life Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the effective date shown on the Schedule of Benefits, if the Policyholder makes timely payment of total premium due to FDL. Issuance of this Certificate by FDL does not waive the eligibility and effective date provisions stated in the Plan.



President

The Schedule of Benefits enclosed with this Certificate indicates benefit percentages, Deductibles, maximums, and other terms and conditions which apply to coverage under the **Plan**. The Schedule of Benefits specifies benefits for:

VOLUNTARY DENTAL BENEFITS

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SCHEDULE OF BENEFITS

OUTLINE OF COVERAGE

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

<u>Benefit Class</u>	<u>Class Description</u>
Class	All eligible LSU System Employees, Retirees, and their respective spouses and dependents as defined in “Eligibility” below.

Waiting Period: First day of the month following the first full calendar month of employment for newly eligible Employees; Immediate coverage for Employees transferring from prior coverage of other State agencies. All the above subject to completion and submission of all enrollment material with thirty (30) days of hire, continuation or transfer, as applicable.

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures -Once per Lifetime	\$100

Dental expenses incurred by an individual before July 1, 2010, will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to July 1, 2010; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:

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

Maximum Amount -Each Benefit Period :	Effective 7/1/2010:	\$1,000
	Effective 7/1/2011:	\$1,250
	Effective 7/1/2012:	\$1,500

DEFINITIONS

APPLICATION refers to the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied. The Application is attached to and forms a part of this Policy, and shall include any subsequent amendments to the Application.

COMPANY refers to Fort Dearborn Life Insurance Company. The words "we", "us" and "our" refer to Company.

Our Administrative Office address is
1020 31ST Street
Downers Grove, IL 60515-5591

DEPENDENT means:

1. The covered Employee's legal spouse;
2. An unmarried Child from date of birth up to 21 years of age and dependent upon the Employee for support (must be added to coverage by completing appropriate enrollment documents);
3. An unmarried Child who is a fulltime student under 24 years of age and financially dependent upon the Employee for support;
4. An unmarried Child of any age who meets the criteria for "Over- Age Dependents" in the section entitled "Overage Dependents," below.
5. The Employee may also enroll an eligible Dependent during the year if a court orders the Employee to cover an eligible Dependent (e.g., a QMCSO).
6. Grandchildren, if such children are in the legal custody of and residing with the Employee.

Overage Dependents. If a never-married Dependent Child is incapable (and became incapable prior to attainment of age 21) of self-sustaining employment by reason of mental retardation or physical incapacity, and is dependent upon the covered Employee for support, the coverage for the Dependent Child may be continued for the duration of incapacity.

1. Prior to the Dependent Child reaching age 21, an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above. The Plan Administrator, in its discretion, may consider applications and attending Physician's information submitted after the Child reaches age 21, if the application and information indicate that the Child's incapacity was present prior to the Child reaching age 21, but was not apparent or diagnosed until after the Child reached age 21.
2. Upon receipt of the application for continued coverage, the Plan Administrator may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as he may deem necessary thereafter.

EMPLOYEE refers to a full-time Employee of the Louisiana State University System ("full-time Employee" means a person employed at 75% effort or greater per pay period (average 30 hours per week), with an appointment of more than 120 days or one academic semester. No person appointed on a restricted appointment, or a temporary appointment, will be considered an eligible Employee. The term Employee includes Retiree, as defined below, whenever used.

PARTICIPANT means an Employee, Dependent, or a retired Employee whose coverage has become effective under this Plan.

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

POLICY refers to the contract between the Policyholder and FDL which provides group insurance benefits, including the attached Application and the group Certificate.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

POLICY EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Policy Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Employee is shown in the Policyholder's records.

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

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

RETIREE means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one (1) of the following categories:

1. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
2. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - a. Began employment prior to September 16, 1979, has 10 years of continuous state service, and has reached the age of 65; or
 - b. Began employment on or after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - d. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.
3. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
4. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

YOU or YOUR means the Employee or Retiree to whom this Certificate has been delivered.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

Employees and Retirees who are in a class named in the Application and their Dependents are eligible for coverage under the Policy. Only individuals who meet the following eligibility requirements may apply for coverage under the Policy.

Employee Eligibility

A full-time Employee of the Louisiana State University System ("full-time Employee" means a person employed at 75% effort or greater per pay period (average 30 hours per week), with an appointment of more than 120 days or one academic semester. No person appointed on a restricted appointment, or a temporary appointment, will be considered an eligible Employee.

Dependent Eligibility

For the purposes of this provision, an eligible Dependent includes:

1. The covered Employee's legal spouse;
2. An unmarried Child from date of birth up to 21 years of age and dependent upon the Employee for support (must be added to coverage by completing appropriate enrollment documents);
3. An unmarried Child who is a fulltime student under 24 years of age and financially dependent upon the Employee for support;
4. An unmarried Child of any age who meets the criteria for "Over- Age Dependents" in the section entitled "Overage Dependents," below.
5. The Employee may also enroll an eligible Dependent during the year if a court orders the Employee to cover an eligible Dependent (e.g., a QMCSO).
6. Grandchildren, if such children are in the legal custody of and residing with the Employee.

Overage Dependents. If a never-married Dependent Child is incapable (and became incapable prior to attainment of age 21) of self-sustaining employment by reason of mental retardation or physical incapacity, and is dependent upon the covered Employee for support, the coverage for the Dependent Child may be continued for the duration of incapacity.

1. Prior to the Dependent Child reaching age 21, an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above. The Plan Administrator, in its discretion, may consider applications and attending Physician's information submitted after the Child reaches age 21, if the application and information indicate that the Child's incapacity was present prior to the Child reaching age 21, but was not apparent or diagnosed until after the Child reached age 21.
2. Upon receipt of the application for continued coverage, the Plan Administrator may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as he may deem necessary thereafter.

Retiree Eligibility

An eligible retiree is defined as an individual, who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one (1) of the following categories:

1. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
2. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - a. Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or

- b. Began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - d. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.
3. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
 4. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

Note: No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee. If a covered spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage.

Eligibility Date

The Eligibility Date is the date a person becomes eligible to be covered under the Plan, as follows for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

1. For newly eligible Employees, coverage will be effective on the 1st of the month following the first full calendar month of employment. For example, an Employee hired on July 1st will have an effective date of August 1st; an Employee hired on July 18th will have an effective date of September 1st.
2. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will not be able to enroll again until the following Annual Enrollment.
3. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will not be able to enroll again until the following Annual Enrollment.
4. For a Dependent of an eligible Employee acquired while he is covered under the Plan, the date the Employee acquires the Dependent, as follows:
 - a. the date of marriage,
 - b. the date of birth,
 - c. the date of placement for adoption;
 - d. the date of issuance of a court order requiring the Employee to maintain financial responsibility for health coverage for a Dependent spouse or child.

WHEN DOES COVERAGE BEGIN?

The effective date is the date coverage for a Participant actually begins. It may be different from the Eligibility Date.

Employee Effective Dates of Coverage (New Employee and Transferring Employee). Coverage for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

1. For newly eligible Employees, coverage will be effective the 1st of the month following the first full calendar month of employment. For example, an Employee hired on July 1st will have an effective date of August 1st; an Employee hired on July 18th will have an Effective Date of September 1st.
2. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will not be able to enroll again until the following Annual Enrollment.
3. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will not be able to enroll again until the following Annual Enrollment.

Dependents of Employees Effective Dates of Coverage. Coverage for each Dependent will be effective on the date the Employee becomes eligible for Dependent Coverage.

Dependents of Retirees Effective Dates of Coverage. Coverage for Dependents of Retirees will become effective as follows:

1. Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were covered immediately prior to retirement.
2. Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the date of marriage for new Spouses, the date of birth for newborn Children, or the Date Acquired for other classifications of Dependents. Application must be made within 30 days of the date of eligibility for coverage.

ANNUAL ENROLLMENT

If You are eligible, You may enroll for dental insurance, apply for additional coverage, or request changes to Your current dental benefits only during Annual Enrollment.

REPORTING CHANGES IN YOUR FAMILY

You should notify the Policyholder promptly if any of the following events take place:

1. You marry or divorce,
2. A child is acquired, by marriage, new birth or adoption,
3. A child marries or reaches the age limit described below,
4. A Participant in Your family dies, or
5. You receive a court order to provide health coverage for Your child or spouse.

You should promptly notify FDL by filling out a form which has been furnished to the Policyholder. If You are adding a Dependent, You must submit an application and the coverage will become effective as described in the Dependent Coverage effective date provision above.

WHEN DOES COVERAGE END?

FDL is not required to give You notice of termination of coverage. FDL will not always know of the events causing termination until after the events have occurred.

Termination of Coverage

Insurance coverage will end for You on the earliest of:

1. the last day of the month following the date You are no longer a member of a covered class; or
2. the date the Policy is canceled; or
3. the effective date of an amendment to this Policy which terminates insurance for the class to which You belong; or
4. the last day of the month following the date You stop making any required contribution toward payment of premiums; or
5. the last day of the month during which You are no longer an eligible Employee; and
6. for Dependents, the last day of the month following the date a Dependent child or spouse is no longer eligible for coverage as defined in this Certificate.

If coverage for a Dependent terminates because of loss of eligibility as listed above, coverage ends automatically and benefits for expenses incurred after termination are not available. If We pay benefits prior to our receiving notification of Your termination, We will request a refund. If Your coverage or that of Your Dependents ends, You may be eligible to continue coverage at Your own expense. Review carefully the **CONTINUATION OF COVERAGE RIGHTS UNDER COBRA** Notice at the back of this Certificate.

TERMINATION OF GROUP

The coverage of all Participants will terminate in accordance with the terms of the Policy if the group is terminated.

LOSS OF ELIGIBILITY

If Your coverage ends due to loss of eligibility, You must meet all the requirements of a new Employee if You are rehired at a later date.

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

DEPENDENT INSURANCE: An Employee is required to contribute to the payment of insurance premiums for his or her dependents.

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

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

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

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

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Employee. You have the freedom of choice to receive treatment from any Provider.

DENTAL NETWORK OF AMERICA PPO DENTISTS

FDL has an arrangement with certain Preferred Providers (herein called Dental Network of America Dentists) to discount their charges for Covered Dental Services. You have the option of selecting a Preferred Provider or a non-Preferred Provider. By choosing a Dental Network of America Dentist, Your out-of-pocket expenses are generally less than the amount owed if Non-Preferred Providers had been used.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

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

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

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

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

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

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

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

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the Participant is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.
2. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
3. for any procedure begun after this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after this contract terminates.
4. to replace lost or stolen appliances.
5. for any treatment which is for cosmetic purposes.
6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits.
8. for which the Employee is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
9. for charges which the Participant is not liable or which would not have been made had no insurance been in force.
10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Policy Year. A Policy Year runs from July 1 through June 30.
- Benefit Period means the period from July 1 of any year through June 30 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through June 30 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (i.e. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- B/R means By Report.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Voluntary Group Dental Coverage Schedule
Scheduled Benefit Plan

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PREFERRED PROVIDERS - Usual and Customary

PAYMENT BASIS - PREFERRED PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Policy Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

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

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

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

TYPE 1 PROCEDURES

BITEWING FILMS

D0270 Bitewing - single film.

D027 2 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

D1120 Prophylaxis - child.

D1203 Topical application of fluoride (prophylaxis not included) - child.

D1204 Topical application of fluoride (prophylaxis not included) - adult.

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

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 13 and over. A child prophylaxis (cleaning) is considered for individuals age 12 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.
- An additional adult prophylaxis (cleaning) is considered for a Pregnant Participant 1 per benefit period.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

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

TYPE 1 PROCEDURES

SPACE MAINTAINERS

- D1510 Space maintainer - fixed - unilateral.
- D1515 Space maintainer - fixed - bilateral.
- D1520 Space maintainer - removable - unilateral.
- D1525 Space maintainer - removable - bilateral.
- D1550 Re-cementation of space maintainer.
- D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Benefits are considered for persons age 12 and under.
- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

- D8210 Removable appliance therapy.
- D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

PAYMENT BASIS – NON PREFERRED PROVIDERS - Maximum Covered Expense

PAYMENT BASIS - PREFERRED PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Policy Year

For Additional Limitations - See Limitations

	Maximum Covered
LIMITED ORAL EVALUATION	Expense
D0140 Limited oral evaluation - problem focused.	\$20.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$20.00
LIMITED ORAL EVALUATION: D0140	
Included with exam frequency limitations 0120, 0145, 0150 & 0180	
LIMITED ORAL RE-EVALUATIONS: D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$24.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$48.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$48.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$35.00
D2150 Amalgam - two surfaces, primary or permanent.	\$44.00
D2160 Amalgam - three surfaces, primary or permanent.	\$54.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$64.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation. 	

TYPE 2 PROCEDURES

	Maximum Covered Expense
RESIN RESTORATIONS (FILLINGS)	
D2330 Resin-based composite - one surface, anterior.	\$43.00
D2331 Resin-based composite - two surfaces, anterior.	\$54.00
D2332 Resin-based composite - three surfaces, anterior.	\$67.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$74.00
D2391 Resin-based composite - one surface, posterior.	\$47.00
D2392 Resin-based composite - two surfaces, posterior.	\$59.00
D2393 Resin-based composite - three surfaces, posterior.	\$74.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$82.00
D2410 Gold foil - one surface.	\$35.00
D2420 Gold foil - two surfaces.	\$44.00
D2430 Gold foil - three surfaces.	\$54.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	
GOLD FOIL RESTORATIONS: D2410, D2420, D2430	
<ul style="list-style-type: none"> • Gold foils are considered at an alternate benefit of an amalgam/composite restoration. 	
STAINLESS STEEL CROWN (PREFABRICATED CROWN)	
D2390 Resin-based composite crown, anterior.	\$90.00
D2930 Prefabricated stainless steel crown - primary tooth.	\$76.00
D2931 Prefabricated stainless steel crown - permanent tooth.	\$80.00
D2932 Prefabricated resin crown.	\$90.00
D2933 Prefabricated stainless steel crown with resin window.	\$90.00
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.	\$90.00
STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 12 month(s). 	
RECEMENT	
D2910 Recement inlay, onlay, or partial coverage restoration.	\$28.00
D2915 Recement cast or prefabricated post and core.	\$14.00
D2920 Recement crown.	\$27.00
D6092 Recement implant/abutment supported crown.	\$27.00
D6093 Recement implant/abutment supported fixed partial denture.	\$27.00
D6930 Recement fixed partial denture.	\$38.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
SEDATIVE FILLING	
D2940 Sedative filling.	\$26.00
FULL MOUTH DEBRIDEMENT	
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$43.00
FULL MOUTH DEBRIDEMENT: D4355	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). 	
PERIODONTAL MAINTENANCE	
D4910 Periodontal maintenance.	\$44.00
PERIODONTAL MAINTENANCE: D4910	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D1110, D1120, also contribute(s) to this limitation. • Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure. 	
DENTURE REPAIR	
D5510 Repair broken complete denture base.	\$44.00
D5520 Replace missing or broken teeth - complete denture (each tooth).	\$37.00
D5610 Repair resin denture base.	\$44.00
D5620 Repair cast framework.	\$52.00
D5630 Repair or replace broken clasp.	\$54.00
D5640 Replace broken teeth - per tooth.	\$39.00
DENTURE RELINES	
D5730 Reline complete maxillary denture (chairside).	\$82.00
D5731 Reline complete mandibular denture (chairside).	\$81.00
D5740 Reline maxillary partial denture (chairside).	\$73.00
D5741 Reline mandibular partial denture (chairside).	\$73.00
D5750 Reline complete maxillary denture (laboratory).	\$121.00
D5751 Reline complete mandibular denture (laboratory).	\$119.00
D5760 Reline maxillary partial denture (laboratory).	\$121.00
D5761 Reline mandibular partial denture (laboratory).	\$122.00
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	
<ul style="list-style-type: none"> • Coverage is limited to service dates more than 6 months after placement date. 	

TYPE 2 PROCEDURES

	Maximum Covered Expense
NON-SURGICAL EXTRACTIONS	
D7111 Extraction, coronal remnants - deciduous tooth.	\$39.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$39.00
SURGICAL EXTRACTIONS	
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$75.00
D7220 Removal of impacted tooth - soft tissue.	\$94.00
D7230 Removal of impacted tooth - partially bony.	\$125.00
D7240 Removal of impacted tooth - completely bony.	\$146.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$166.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$78.00
OTHER ORAL SURGERY	
D7260 Oroantral fistula closure.	\$184.00
D7261 Primary closure of a sinus perforation.	\$184.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$111.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$111.00
D7280 Surgical access of an unerupted tooth.	\$173.00
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.	\$124.00
D7283 Placement of device to facilitate eruption of impacted tooth.	\$52.00
D7310 Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$65.00
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$33.00
D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	\$82.00
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$41.00
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).	\$119.00
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$296.00
D7410 Excision of benign lesion up to 1.25 cm.	\$118.00
D7411 Excision of benign lesion greater than 1.25 cm.	\$151.00
D7412 Excision of benign lesion, complicated.	\$166.00
D7413 Excision of malignant lesion up to 1.25 cm.	\$159.00
D7414 Excision of malignant lesion greater than 1.25 cm.	\$117.00
D7415 Excision of malignant lesion, complicated.	\$128.00
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.	\$159.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm. \$117.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm. \$118.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm. \$151.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm. \$118.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm. \$151.00
D7465	Destruction of lesion(s) by physical or chemical method, by report. \$36.00
D7471	Removal of lateral exostosis (maxilla or mandible). \$105.00
D7472	Removal of torus palatinus. \$105.00
D7473	Removal of torus mandibularis. \$105.00
D7485	Surgical reduction of osseous tuberosity. \$171.00
D7490	Radical resection of maxilla or mandible. \$159.00
D7510	Incision and drainage of abscess - intraoral soft tissue. \$52.00
D7520	Incision and drainage of abscess - extraoral soft tissue. \$61.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue. \$48.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system. \$133.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone. \$133.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body. \$175.00
D7910	Suture of recent small wounds up to 5 cm. \$23.00
D7911	Complicated suture - up to 5 cm. \$26.00
D7912	Complicated suture - greater than 5 cm. \$38.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. \$127.00
D7963	Frenuloplasty. \$158.00
D7970	Excision of hyperplastic tissue - per arch. \$97.00
D7972	Surgical reduction of fibrous tuberosity. \$155.00
D7980	Sialolithotomy. \$146.00
D7983	Closure of salivary fistula. \$47.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth). \$158.00
D7286	Biopsy of oral tissue - soft. \$85.00
D7287	Exfoliative cytological sample collection. \$43.00
D7288	Brush biopsy - transepithelial sample collection. \$43.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
PALLIATIVE	
D9110 Palliative (emergency) treatment of dental pain - minor procedure.	\$29.00
PALLIATIVE TREATMENT: D9110	
<ul style="list-style-type: none"> • Not covered in conjunction with other procedures, except diagnostic x-ray films. 	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$112.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$37.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$74.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$18.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none"> • Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered. 	
PROFESSIONAL CONSULT/VISIT/SERVICES	
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$30.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$20.00
D9440 Office visit - after regularly scheduled hours.	\$36.00
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.	\$22.00
CONSULTATION: D9310	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 provider. 	
OFFICE VISIT: D9430, D9440	
<ul style="list-style-type: none"> • Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater. 	
MISCELLANEOUS	
D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	\$24.00
D2951 Pin retention - per tooth, in addition to restoration.	\$13.00
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$43.00
DESENSITIZATION: D9911	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PREFERRED PROVIDERS - Maximum Covered Expense

PAYMENT BASIS – PREFERRED PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Policy Year

For Additional Limitations - See Limitations

	Maximum Covered
INLAY RESTORATIONS	Expense
D2510 Inlay - metallic - one surface.	\$114.00
D2520 Inlay - metallic - two surfaces.	\$136.00
D2530 Inlay - metallic - three or more surfaces.	\$147.00
D2610 Inlay - porcelain/ceramic - one surface.	\$126.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$137.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$150.00
D2650 Inlay - resin-based composite - one surface.	\$131.00
D2651 Inlay - resin-based composite - two surfaces.	\$129.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$134.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.	\$148.00
D2543 Onlay - metallic - three surfaces.	\$165.00
D2544 Onlay - metallic - four or more surfaces.	\$172.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$148.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$166.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$171.00
D2662 Onlay - resin-based composite - two surfaces.	\$139.00
D2663 Onlay - resin-based composite - three surfaces.	\$143.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$152.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783,
- D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

TYPE 3 PROCEDURES

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

CROWNS SINGLE RESTORATIONS	Maximum Covered Expense
D2710 Crown - resin-based composite (indirect).	\$65.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$161.00
D2720 Crown - resin with high noble metal.	\$165.00
D2721 Crown - resin with predominantly base metal.	\$126.00
D2722 Crown - resin with noble metal.	\$155.00
D2740 Crown - porcelain/ceramic substrate.	\$179.00
D2750 Crown - porcelain fused to high noble metal.	\$174.00
D2751 Crown - porcelain fused to predominantly base metal.	\$149.00
D2752 Crown - porcelain fused to noble metal.	\$160.00
D2780 Crown - 3/4 cast high noble metal.	\$165.00
D2781 Crown - 3/4 cast predominantly base metal.	\$144.00
D2782 Crown - 3/4 cast noble metal.	\$150.00
D2783 Crown - 3/4 porcelain/ceramic.	\$179.00
D2790 Crown - full cast high noble metal.	\$165.00
D2791 Crown - full cast predominantly base metal.	\$144.00
D2792 Crown - full cast noble metal.	\$150.00
D2794 Crown - titanium.	\$165.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins.	\$36.00
D6973 Core build up for retainer, including any pins.	\$36.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
POST AND CORE	
D2952 Post and core in addition to crown, indirectly fabricated.	\$57.00
D2954 Prefabricated post and core in addition to crown.	\$48.00
FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980 Crown repair, by report.	\$29.00
D6980 Fixed partial denture repair, by report.	\$32.00
D9120 Fixed partial denture sectioning.	\$32.00
ENDODONTICS MISCELLANEOUS	
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$23.00
D3221 Pulpal debridement, primary and permanent teeth.	\$23.00
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$30.00
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$26.00
D3333 Internal root repair of perforation defects.	\$37.00
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$37.00
D3352 Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	\$25.00
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$74.00
D3430 Retrograde filling - per root.	\$29.00
D3450 Root amputation - per root.	\$69.00
D3920 Hemisection (including any root removal), not including root canal therapy.	\$59.00
ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920	
<ul style="list-style-type: none"> • Procedure D3333 is limited to permanent teeth only. 	
PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240	
<ul style="list-style-type: none"> • Procedure D3220 is limited to primary teeth. 	
ENDODONTIC THERAPY (ROOT CANALS)	
D3310 Anterior (excluding final restoration).	\$104.00
D3320 Bicuspid (excluding final restoration).	\$122.00
D3330 Molar (excluding final restoration).	\$160.00
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$61.00
D3346 Retreatment of previous root canal therapy - anterior.	\$129.00
D3347 Retreatment of previous root canal therapy - bicuspid.	\$149.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D3348 Retreatment of previous root canal therapy - molar.	\$185.00
ROOT CANALS: D3310, D3320, D3330, D3332	
<ul style="list-style-type: none"> • Benefits are considered on permanent teeth only. • Allowances include intraoperative films and cultures but exclude final restoration. 	
RETREATMENT OF ROOT CANAL: D3346, D3347, D3348	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • D3310, D3320, D3330, also contribute(s) to this limitation. • Benefits are considered on permanent teeth only. • Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration. 	
 SURGICAL ENDODONTICS	
D3410 Apicoectomy/periradicular surgery - anterior.	\$107.00
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).	\$123.00
D3425 Apicoectomy/periradicular surgery - molar (first root).	\$133.00
D3426 Apicoectomy/periradicular surgery (each additional root).	\$48.00
 SURGICAL PERIODONTICS	
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$68.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$34.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$93.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$47.00
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$170.00
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$85.00
D4263 Bone replacement graft - first site in quadrant.	\$56.00
D4264 Bone replacement graft - each additional site in quadrant.	\$42.00
D4265 Biologic materials to aid in soft and osseous tissue regeneration.	\$28.00
D4270 Pedicle soft tissue graft procedure.	\$125.00
D4271 Free soft tissue graft procedure (including donor site surgery).	\$133.00
D4273 Subepithelial connective tissue graft procedures, per tooth.	\$155.00
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$75.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D4275 Soft tissue allograft.	\$133.00
D4276 Combined connective tissue and double pedicle graft, per tooth.	\$155.00
BONE GRAFTS: D4263, D4264, D4265	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of each of these procedures per 2 year(s). • Coverage is limited to treatment of periodontal disease. 	
GINGIVECTOMY: D4210, D4211	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of each of these procedures per 2 year(s). • Coverage is limited to treatment of periodontal disease. 	
OSSEOUS SURGERY: D4240, D4241, D4260, D4261	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of each of these procedures per 2 year(s). • Coverage is limited to treatment of periodontal disease. 	
TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of any of these procedures per 2 year(s). • Coverage is limited to treatment of periodontal disease. 	
 CROWN LENGTHENING	
D4249 Clinical crown lengthening - hard tissue.	\$102.00
 NON-SURGICAL PERIODONTICS	
D4341 Periodontal scaling and root planing - four or more teeth per quadrant.	\$35.00
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.	\$17.00
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$26.00
CHEMOTHERAPEUTIC AGENTS: D4381	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of any of these procedures per 12 month(s). • A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure. 	
PERIODONTAL SCALING & ROOT PLANING: D4341, D4342	
<ul style="list-style-type: none"> • Each quadrant is limited to 1 of each of these procedures per 12 month(s) with 1 additional for a pregnant Participant. 	
 PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)	
D5110 Complete denture - maxillary.	\$185.00
D5120 Complete denture - mandibular.	\$179.00
D5130 Immediate denture - maxillary.	\$200.00
D5140 Immediate denture - mandibular.	\$194.00
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$133.00
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$154.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$214.00
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$214.00
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$133.00
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$154.00
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$115.00
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).	\$133.00
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).	\$154.00
D5810 Interim complete denture (maxillary).	\$82.00
D5811 Interim complete denture (mandibular).	\$86.00
D5820 Interim partial denture (maxillary).	\$72.00
D5821 Interim partial denture (mandibular).	\$75.00
D5860 Overdenture - complete, by report.	\$185.00
D5861 Overdenture - partial, by report.	\$214.00
D6053 Implant/abutment supported removable denture for completely edentulous arch.	\$185.00
D6054 Implant/abutment supported removable denture for partially edentulous arch.	\$214.00
D6078 Implant/abutment supported fixed denture for completely edentulous arch.	\$185.00
D6079 Implant/abutment supported fixed denture for partially edentulous arch.	\$214.00

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

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

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

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

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.	\$10.00
D5411 Adjust complete denture - mandibular.	\$10.00
D5421 Adjust partial denture - maxillary.	\$11.00
D5422 Adjust partial denture - mandibular.	\$10.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

TYPE 3 PROCEDURES

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

	Maximum Covered Expense
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$24.00
D5660 Add clasp to existing partial denture.	\$28.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$67.00
D5711 Rebase complete mandibular denture.	\$71.00
D5720 Rebase maxillary partial denture.	\$64.00
D5721 Rebase mandibular partial denture.	\$68.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$19.00
D5851 Tissue conditioning, mandibular.	\$20.00
PROSTHODONTICS – FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$154.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$168.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$168.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$154.00
D6062 Abutment supported cast metal crown (high noble metal).	\$168.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$168.00
D6064 Abutment supported cast metal crown (noble metal).	\$182.00
D6065 Implant supported porcelain/ceramic crown.	\$154.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$154.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$168.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$168.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$154.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$168.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$168.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$182.00
D6075 Implant supported retainer for ceramic FPD.	\$154.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$168.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$168.00
D6094	Abutment supported crown - (titanium).	\$168.00
D6194	Abutment supported retainer crown for FPD - (titanium).	\$168.00
D6205	Pontic - indirect resin based composite.	\$139.00
D6210	Pontic - cast high noble metal.	\$168.00
D6211	Pontic - cast predominantly base metal.	\$168.00
D6212	Pontic - cast noble metal.	\$182.00
D6214	Pontic - titanium.	\$168.00
D6240	Pontic - porcelain fused to high noble metal.	\$168.00
D6241	Pontic - porcelain fused to predominantly base metal.	\$168.00
D6242	Pontic - porcelain fused to noble metal.	\$154.00
D6245	Pontic - porcelain/ceramic.	\$154.00
D6250	Pontic - resin with high noble metal.	\$168.00
D6251	Pontic - resin with predominantly base metal.	\$154.00
D6252	Pontic - resin with noble metal.	\$182.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$56.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$56.00
D6600	Inlay - porcelain/ceramic, two surfaces.	\$137.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	\$151.00
D6602	Inlay - cast high noble metal, two surfaces.	\$123.00
D6603	Inlay - cast high noble metal, three or more surfaces.	\$136.00
D6604	Inlay - cast predominantly base metal, two surfaces.	\$107.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$117.00
D6606	Inlay - cast noble metal, two surfaces.	\$112.00
D6607	Inlay - cast noble metal, three or more surfaces.	\$123.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$148.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$163.00
D6610	Onlay - cast high noble metal, two surfaces.	\$136.00
D6611	Onlay - cast high noble metal, three or more surfaces.	\$149.00
D6612	Onlay - cast predominantly base metal, two surfaces.	\$117.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	\$129.00
D6614	Onlay - cast noble metal, two surfaces.	\$123.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$136.00
D6624	Inlay - titanium.	\$136.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6634 Onlay - titanium.	\$149.00
D6710 Crown - indirect resin based composite.	\$139.00
D6720 Crown - resin with high noble metal.	\$168.00
D6721 Crown - resin with predominantly base metal.	\$87.00
D6722 Crown - resin with noble metal.	\$140.00
D6740 Crown - porcelain/ceramic.	\$154.00
D6750 Crown - porcelain fused to high noble metal.	\$182.00
D6751 Crown - porcelain fused to predominantly base metal.	\$168.00
D6752 Crown - porcelain fused to noble metal.	\$154.00
D6780 Crown - 3/4 cast high noble metal.	\$182.00
D6781 Crown - 3/4 cast predominantly base metal.	\$168.00
D6782 Crown - 3/4 cast noble metal.	\$154.00
D6783 Crown - 3/4 porcelain/ceramic.	\$154.00
D6790 Crown - full cast high noble metal.	\$168.00
D6791 Crown - full cast predominantly base metal.	\$168.00
D6792 Crown - full cast noble metal.	\$154.00
D6794 Crown - titanium.	\$168.00
D6940 Stress breaker.	\$47.00

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

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

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

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

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

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

TYPE 3 PROCEDURES

- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

	Maximum Covered
CAST POST AND CORE FOR PARTIALS	Expense
D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$50.00
D6972 Prefabricated post and core in addition to fixed partial denture retainer.	\$50.00
OCCLUSAL ADJUSTMENT	
D9951 Occlusal adjustment - limited.	\$13.00
D9952 Occlusal adjustment - complete.	\$68.00
OCCLUSAL ADJUSTMENT: D9951, D9952	
<ul style="list-style-type: none"> • Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease. 	

COORDINATION OF BENEFITS

The availability of benefits specified in this Policy is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has dental coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group dental service plans and other group prepayment coverage;
 - d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
 - e. governmental plans, or coverage required or provided by law.

Plan does not include:

- a. any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of dental insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each Policy or other arrangement for coverage 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.

2. **This Plan** means the part of this Policy that provides benefits for dental expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, 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.

4. **Allowable Expense** means 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 Participant for whom claim is made.
5. **Claim Determination Period** means a Policy Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
6. **We or Us** means Fort Dearborn Life Insurance Company (FDL).

Order of Benefit Determination Rules

1. *General Information*

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 Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant 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 Participant as a Dependent; and
 - ii. primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant 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 parents:
 - i. The benefits of the Plan of the parent whose birthday falls earlier in a Policy Year are determined before those of the Plan of the parent whose birthday falls later in that Policy 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.

However, if the other Plan does not have the rule described in this paragraph b, 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/Parents Separated or Divorced*** – If two or more Plans cover a Participant 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, if applicable;
 - 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 dental 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 c does not apply with respect to any Policy 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. **Active/Inactive Employee** – The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph e does not apply.
- f. **Continuation Coverage** – If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:
 - i. First, the benefits of a Plan covering the Participant as an Employee, member, or subscriber (or as that Participant's Dependent);
 - ii. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph f does not apply.
- g. **Longer/Shorter Length of Coverage** – If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

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**

- a. The benefits of This Plan will be reduced when the sum of:
 - i. the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
 - ii. 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.
- b. If This Plan is a Secondary Plan, the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are the lessor of:
 - i. the benefits that would be payable under This Plan without applying the Coordination of Benefits Provision; and
 - ii. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions.

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.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information We need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give Us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

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

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons we have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Dentists; or
4. any other person or organization.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 12 months after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Participant's name, and policy number. If it was not reasonably possible to give written notice within the 12-month period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

PROOF OF LOSS. Written proof of loss must be given to us within 12 months after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 12-month period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

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

PAYMENT OF BENEFITS. All benefits will be paid to the Employee unless you authorize us in writing to make payment to the Provider providing the services or supplies.

FACILITY OF PAYMENT. If an Employee or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Employee, then we may, at our option, pay the benefit up to an amount not to exceed \$5,000, to any relative by blood or connection by marriage of the Employee who is considered by us to be equitably entitled to the benefit.

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

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

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

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

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

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

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

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer's group health **plan** (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to You and Your family, and
- What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the Certificate or Certificate of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage *may* last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan

Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.



Home Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

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