



A STOCK COMPANY
LINCOLN, NEBRASKA

**CERTIFICATE
GROUP DENTAL AND EYE CARE INSURANCE**

The Policyholder **ILLINOIS PUBLIC PENSION FUND ASSOCIATION**

Policy Number **10-39499** **Insured Person**

Plan Effective Date **February 1, 2013** **Certificate Effective Date**
Refer to Exceptions on 9070.

Class Number 2

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

JoAnn M Martin

President

Notice of Grievance Procedures

In accordance with the Dental Care Patient Protection Act of the Illinois Insurance Code

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

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. If you have questions, please feel free to contact the toll-free number shown above. Also, you always have the right to contact the Illinois Department of Insurance if you have a question or concern regarding your coverage under this contract. The Illinois Department may be contacted:

In Writing: Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767-0001

Or

100 W. Randolph Street, Suite 15-100
Chicago, Illinois 60601

By toll-free phone: 877-527-9431

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

"Covered Person" means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

- (a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;
- (b) claims payment, handling, or reimbursement for health care services;
- (c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Review Process

You may ask your insurer to review its decisions involving your requests for benefit estimates or your requests to have your claims paid.

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer's control, the insurer may take up to an additional 15 working days to issue a written decision.

III. Written Decision

When a decision is issued after the review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the covered person's right to contact the Illinois Department of Insurance.

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SCHEDULE OF BENEFITS OUTLINE OF COVERAGE

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

Benefit Class

Class Description

Class 2

Member Electing The Low Plan

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	\$ 150
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Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	50%

Maximum Amount - Each Benefit Period	\$1,000*
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EYE CARE EXPENSE BENEFITS

Deductible Amount:	\$0
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Maximum Amount – Each Benefit Period	\$150*
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Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

COMBINED EXPENSE BENEFITS

*Combined Dental and Eye Care Maximum - Each Benefit Period	\$1,000
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The maximums listed with the () above are subject to the maximum amount listed here.*

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

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

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

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

CIVIL UNION. Refers to a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to Illinois law.

Illinois law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. Illinois also recognizes a marriage between persons of the same sex, a civil union, or a substantially similar legal relationship other than common law marriage legally entered into in another jurisdiction. However, insureds should note that some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union.

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

DEPENDENT refers to any of the following:

- a. an Insured's spouse, including a party to a Civil Union or Domestic Partner; or,
- b. each child less than 26 years of age, for whom the Insured, the Insured's spouse, party to a Civil Union, or the Insured's Domestic Partner, is legally responsible, or is eligible under the federal laws identified below, including:
 - i. natural born children;
 - ii. adopted children, eligible from the date of placement for adoption;
 - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this policy. Additionally, if the Policyholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Policyholder's separate medical plans will be ineligible under this Policy as well; or,

- c. An unmarried dependent child that has had their 26th birthday and has been honorably discharged from the military and is less than 30 years of age, for whom the Insured, the Insured's spouse, including a party to a Civil Union, or the Insured's Domestic Partner, is legally responsible;
- d. a grandchild that is a dependent of, and under court-ordered custody of the Insured;
- e. each child over the applicable limiting age who:
 - i. is Totally Disabled as defined below; and
 - ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

- 1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
- 2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

A member of the Eligible Class for Insurance is any member electing the low plan.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member electing the low plan and has eligible dependents.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. A Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSURED. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

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

CONTINUATION OF COVERAGE

Death, Divorce or Separation For Spouses and Dependents

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:
 - a. the death of the Insured; or
 - b. the dissolution of a marriage with, or legal separation from, the Insured.
 - c. the retirement of the Insured. (In this instance, the spouse must be at least age 55 on the date of retirement in order to elect continuation under this provision.)

provided:

- i. the spouse makes election for continuation of coverage in the required time frames; and
- ii. any required premium is paid.

2. Benefits

This continuation applies to all benefits payable under the policy.

3. How to Apply

- a. Within 30 days of the entry of judgment of divorce or legal separation, or the death or retirement of the Insured, the spouse must notify the employer, including a mailing address, if he or she wishes to elect continuation of coverage.
- b. Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the dissolution of the marriage or the death or retirement of the Insured.
- c. Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing the following:
 - i. an election form;
 - ii. the premium due;
 - iii. when and how payments must be made;
 - iv. instructions on returning the election form.
- d. The spouse must affirmatively elect continuation with payment of the first monthly premium within 30 days of the date the notice is mailed by the insurer. Failure to elect continuation of coverage during this period shall terminate any future right to continuation.

4. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent.

5. Premiums

- a. For former spouses who have not attained the age of 55 at the time coverage begins, the monthly premium shall be equal to the amount charged an employee if the former spouse were a current employee plus the amount the employer would contribute toward the premium if the former spouse were a current employee.
- b. For former spouses who have attained the age of 55 at the time coverage begins, the monthly premium shall be based on the same calculation as defined in 5.a. above. However, beginning 2 years after coverage begins, the monthly premium shall be based on this same calculation, plus an additional amount, not to exceed 20% of this calculation for costs of administration.

6. Termination

For former spouses who have not attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date that coverage would terminate under the terms of the existing policy if the Insured

- and spouse were still married to each other;
- c. the date the spouse becomes insured under another group health plan;
- d. the date the spouse remarries;
- e. the expiration of 2 years from the date coverage began;
- f. the date the policy terminates.

For former spouses who have attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date on which coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the Insured and spouse were still married to each other;
- c. the date the spouse becomes insured under another group health plan;
- d. the date the spouse remarries;
- e. the date the spouse is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;
- f. the date the policy terminates.

7. Replacement of Policy

A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

Death of the Insured Attainment of Limiting Age Dependent Children

1. The Insured's dependent child may continue coverage under this policy
 - a. in the event of the death of the Insured and the child is not eligible for coverage as a dependent under the provisions stated above; or
 - b. the dependent child has attained the limiting age under the policy.

2. This continuation applies to all benefits payable under the policy.

3. How to Apply

a. Death of the Insured

Within 30 days of the death of the Insured, the dependent child or a responsible adult acting on behalf of the child must notify the employer or the insurer if he or she wishes to elect continuation of coverage.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the death of the Insured and the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

b. Attainment of Limiting Age

In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the request to continue coverage under this provision including the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence

4. Responsibilities of the Insurer

Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing by certified mail, return receipt requested, notification to the dependent child or responsible adult that the policy may be continued. In addition, the notice will include:

- i. an election form;
- ii. the premium due;
- iii. when and how payments must be made;
- iv. instructions on returning the election form within thirty (30) days after the date it is received.

5. Electing Coverage

The dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue coverage within such 30 day period shall terminate the continuation of benefits and the right to continuation.

6. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent and benefits will continue under the terms and provisions of the policy except where the benefits in existence at the time the company's notice was to be sent are terminated as to all employees.

7. Premiums

The monthly premium will be equal to:

- a. an amount, if any, that would be charged an employee if the dependent child were a current employee of the employer, plus;
- b. an amount, if any, that the employer would contribute toward the premium if the dependent child were a current employee.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice as defined in subsection (4) of this provision terminates the continuation benefits and the right to continuation benefits.

8. Termination

Coverage under this provision will terminate upon the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date that coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the employee;
- c. the date on which the dependent child first becomes, or after the date of election, an insured employee under any other group policy; or
- d. the expiration of 2 years from the date continuation coverage began.

9. Replacement of Policy

If the group policy is cancelled and another insurance company contracts to provide group coverage to the employer, and continuation coverage is in effect for the dependent child at the time of cancellation, and the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this provision.

DENTAL EXPENSE BENEFITS

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

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the Maximum Allowable Charge ("MAC") as determined by us.
3. the Maximum Allowable Benefit ("MAB") as determined by us, if services are provided by a Non Participating Provider.

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

MAB - The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP code area. These allowances are an option for policyholders who want to offer their insured members affordable yet comprehensive coverage. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

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

We may request pre-operative dental radiographic images, 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.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforeseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

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

accepted parameters of care.

10. because of war or any act of war, declared or not.

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.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Ø Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Ø Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Ø Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Allowable Benefit

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

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

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

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

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extraoral - first radiographic image.

D0260 Extraoral - each additional radiographic image.

PERIAPICAL: D0220, D0230

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

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: 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 radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

TYPE 1 PROCEDURES

D1120 Prophylaxis - child.

D1206 Topical application of fluoride varnish.

D1208 Topical application of fluoride.

FLUORIDE: D1206, D1208

- 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 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351 Sealant - per tooth.

D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.

SEALANT: D1351, D1352

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

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Allowable Benefit

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

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

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

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

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

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

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

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

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

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

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

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown – primary tooth.

TYPE 2 PROCEDURES

- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

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

RECEMENT

- D2910 Recement inlay, onlay, or partial coverage restoration.
- D2915 Recement cast or prefabricated post and core.
- D2920 Recement crown.
- D6092 Recement implant/abutment supported crown.
- D6093 Recement implant/abutment supported fixed partial denture.
- D6930 Recement fixed partial denture.

SEDATIVE FILLING

- D2940 Protective restoration.

ENDODONTICS MISCELLANEOUS

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

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.
- D3330 Endodontic therapy, molar.
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - bicuspid.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

- D3410 Apicoectomy/periradicular surgery - anterior.
- D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
- D3425 Apicoectomy/periradicular surgery - molar (first root).
- D3426 Apicoectomy/periradicular surgery (each additional root).

SURGICAL PERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - first site in quadrant.
- D4264 Bone replacement graft - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Subepithelial connective tissue graft procedures, per tooth.
- D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Soft tissue allograft.
- D4276 Combined connective tissue and double pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft.
- D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278

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

NON-SURGICAL PERIODONTICS

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

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

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

TYPE 2 PROCEDURES

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510 Repair broken complete denture base.

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

D5610 Repair resin denture base.

D5620 Repair cast framework.

D5630 Repair or replace broken clasp.

D5640 Replace broken teeth - per tooth.

DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).

D5731 Reline complete mandibular denture (chairside).

D5740 Reline maxillary partial denture (chairside).

D5741 Reline mandibular partial denture (chairside).

D5750 Reline complete maxillary denture (laboratory).

D5751 Reline complete mandibular denture (laboratory).

D5760 Reline maxillary partial denture (laboratory).

D5761 Reline mandibular partial denture (laboratory).

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

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

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.

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

SURGICAL EXTRACTIONS

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

D7220 Removal of impacted tooth - soft tissue.

D7230 Removal of impacted tooth - partially bony.

D7240 Removal of impacted tooth - completely bony.

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.

D7250 Surgical removal of residual tooth roots (cutting procedure).

D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.

D7261 Primary closure of a sinus perforation.

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).

D7280 Surgical access of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

TYPE 2 PROCEDURES

- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Surgical reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7520 Incision and drainage of abscess - extraoral soft tissue.
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

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

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

TYPE 2 PROCEDURES

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

PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

- D9951 Occlusal adjustment - limited.
- D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

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

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

EYE CARE INSURANCE

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

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

- a. the charge for frames or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Procedures.

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

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Procedures, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

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

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

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

1. examinations performed or frames or lenses ordered before the Insured was covered under this section.
2. subject to Extension of Benefits, any examination performed or frame or lens ordered after the Insured's coverage under this section ceases.
3. sub-normal vision aids; orthoptic or vision training or any associated testing.
4. non-prescription lenses.
5. replacement or repair of lost or broken lenses or frames except at normal intervals.
6. any eye examination or corrective eyewear required by an employer as a condition of employment.
7. medical or surgical treatment of the eyes.
8. any service or supply not shown on the Schedule of Eye Care Services.
9. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
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Maximum Amount – Each Benefit Period	\$150*
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Vision Examination

May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.

Materials

Frame

Lenses

Single Vision

Bifocal

Trifocal

No line bifocal or progressive power

Lenticular

Contact Lenses

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

- c. 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 child's dental and/or eye care expenses of the Dependent child, the plan covering the Dependent child shall follow the order of benefit determination as stated in 2.b. above.
- d. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
 - i. the Plan of the Custodial Parent;
 - ii. the Plan of the spouse of the Custodial Parent;
 - iii. the Plan of the non-Custodial Parent; and then
 - iv. the Plan of the spouse of the non-Custodial Parent.

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

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

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

- g. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

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

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

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

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

If expenses were incurred by a covered person due to the negligence of a third party, we have the right to recover the payments we made for those expenses from any and all damages collected from a third party for those same expenses, whether by action at law, settlement, or compromise. We have the right to recover these payments, to the extent of the payments we made, by the covered person, covered person's parents, if the covered person is a minor, or covered persons' legal representative.

We shall have the right to reimbursement out of all funds the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses we have paid.

You are required to furnish us with any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS

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

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

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

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of nine percent per year on benefits for valid claims not paid within 30 days until the claim is settled. Interest amounting to less than one dollar will not be paid.

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

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

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

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

ACCESS TO PARTICIPATING PROVIDERS.

If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

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

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

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

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

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

We are required by law to maintain the privacy of our insured members' and their dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be provided to you directly or to your group's Plan Sponsor (usually your employer) by regular mail or e-mail with instructions to deliver a paper copy to each certificate holder.

THIS NOTICE DESCRIBES OUR PRACTICES REGARDING YOUR PROTECTED HEALTH INFORMATION MAINTAINED BY THE GROUP DENTAL AND EYE CARE LINES OF BUSINESS WITHIN THE UNIFI COMPANIES.

THIS NOTICE MORE PARTICULARLY DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Contact Information

All of the entities affiliated under the common control of the UNIFI Mutual Holding Company that pay for the cost of healthcare, including Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York, are required by federal law to maintain the privacy of your protected health information and to provide notice of the legal duties and privacy practices with respect to your protected health information. This Notice fulfills the "Notice" requirements of the Final Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about any part of this Notice of Protected Health Information Privacy Practices or desire to have further information concerning the information practices at the UNIFI Companies, please direct your inquiries to: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

THIS NOTICE IS PUBLISHED AND BECOMES EFFECTIVE: APRIL 14, 2003

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that information about you and your family is personal and we are committed to protecting your privacy and the security of your protected health information. This Notice explains the ways in which we use and disclose protected health information about you and your covered dependents and details certain obligations we have in connection with such use and disclosure. It also describes your rights with regard to your protected health information. **We are required by both law and internal policy to: make sure that protected health information that identifies you and/or your covered dependents is kept private; give you notice of our legal duties and privacy practices and your rights with respect to your protected health information; and follow the practices outlined in this Notice.**

WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE

The Protected Health Information Privacy Practices described in this Notice have been adopted and implemented by all of the divisions and associates who work directly or indirectly with your protected health information within the following UNIFI Companies: Ameritas Life Insurance Corp.; and Ameritas Life Insurance Corp. of New York. All of the associates who need access to your protected health information in order to service your products and administer your claims have received proper training about how to protect your privacy, secure your protected health information and adhere to our Privacy of Protected Health Information Policies, Practices and Procedures.

In order to keep costs of your coverage down and provide you with the best customer service, we may contract with outside carriers and/or vendors, known as "business associates," to assist us with the administration of your policy. For example, we may contract with third party administrators who process claims and collect premium payments; or paper-shredding companies who destroy records when they are no longer needed. Because these business associates need access to your protected health information in order to fulfill their obligations to us, we **require** them to agree in writing to keep **your protected health information confidential** in the same manner that we do as described in this Notice.

TYPES OF PROTECTED HEALTH INFORMATION WE MAY HAVE AND HOW WE OBTAIN IT

Protected Health Information is: Any information that identifies you that we obtain from you or others that relates to your past, present or future healthcare including the payment for such healthcare.

In the regular course of business we receive protected health information about you in order to provide you with our products and services. Some of this protected health information comes directly from you. For example, when you purchase one of our health insurance products for you and your family, you provide us with information about you and your covered dependents such as name, address, phone number, social security number, etc. Some of the protected health information we obtain about you comes from your provider. For example, as you and your covered dependents utilize your coverage, your healthcare provider sends us information about services and treatments performed so that we can process and pay your claims. All of this information we receive about you and your covered dependents is necessary in order for us to provide you and your covered dependents with quality health insurance products and to comply with legal requirements.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways we may use and disclose your protected health information without your authorization. For each category of uses and disclosures, we will explain what we mean and give an example. Not every use or disclosure in a category will be listed. All of the ways we are permitted to use and disclose information will fall within one of the identified categories.

For Payment: We may use and disclose protected health information about you and your covered dependents in order to verify your coverage to your provider, process payment for claims filed under your policy or coordinate benefits with another carrier. For example, we may need to disclose your protected health information to a provider whom you have seen or are planning to see in order to pre-approve that a particular treatment you are seeking is covered under your plan. It is also necessary for us to use the information received from your medical provider concerning the services rendered to you so the health plan can pay the provider or reimburse you for the cost of the treatment under the terms of your plan. Finally, when you have more than one insurance policy that covers some of the same procedures as your plan with us, it may be necessary for us to exchange payment information with the carrier of your other insurance plan in order to coordinate the payment of your claim with that other carrier.

For Health Care Operations: We may use and disclose protected health information about you and your covered dependents as necessary to operate your health insurance plan and promote quality service. For example, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management.

Business Associates: We may disclose protected health information to other persons or organizations, known as business associates, who provide services on our behalf under contract. However, in order to assure the protection of your private information, we require our business associates to adhere to our Privacy Policies concerning the use and disclosure of your protected health information and appropriately safeguard the information we disclose to them. We prohibit our business associates from using and disclosing any of your protected health information in any manner except for the purpose intended by the contract. Business associates are expressly prohibited from using your protected health information to create any marketing target lists.

Plan Sponsors: We may disclose your protected health information to your plan sponsor (usually your employer). It is our policy not to disclose your protected health information to your Plan's sponsor. There may be exceptional occasions that your Plan Sponsor requests protected health information. We will only disclose your protected health information to your Plan Sponsor if we have your authorization to do so, or if the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Public policy uses and disclosures of your protected health information

We may use and disclose your protected health information for public policy purposes. For example:

As Required By Law: We will disclose protected health information about you or your covered dependent when required to do so by federal, state or local law. For example, we may be required by law to disclose certain protected health information about you pursuant to a court order or subpoena served upon us.

About Victims of Abuse, Neglect or Domestic Violence: For example, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

Workers' Compensation: We may release your protected health information for workers' compensation or similar programs that provide benefits to you for work-related injuries or illness but only in a manner consistent with applicable laws.

Public Health: We may have an occasion to disclose protected health information about you or your covered dependent for public health activities to a public health authority that is permitted by law to collect or receive the information. A public health activity would be, for example, an activity conducted by a public health authority in the furtherance of preventing or controlling disease, injury or disability; reporting births, deaths or reactions to medications; or notifying people of recalls of products they may be using.

AUTHORIZED USES AND DISCLOSURES

From time to time you may request that we disclose your protected health information to other individuals or entities. For example, you may request that we disclose your claims history to an attorney that you have hired to assist you in a civil matter. **Likewise, we may ask your permission to use or disclose your protected health information.** Any disclosures, such as these that do not fit into one of the categories in the previous section require us to obtain your written authorization prior to making such disclosure. In the event that you do provide us with written authorization to use or disclose your information, you may revoke such authorization at any time by writing to the Privacy Officer at the address indicated in the "Contact" section of this Notice below.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that we maintain about you. All requests must be made in writing.

Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You have a right to receive this Notice because you are insured by a health plan offered by Ameritas Life Insurance Corp. or Ameritas Life Insurance Corp. of New York. You may ask us to give you a copy of this Notice at any time and we will comply. Even if you have agreed to receive this Notice electronically, you are entitled to a paper copy of this Notice if you so request.

Your Right to an Accounting of Disclosures: You have the right to request a listing of any disclosures of your protected health information that we have made that are required by law. This listing would exclude disclosures we made to you, or pursuant to your authorization or request, or for payment of your claims as described above, or for health care operations as described above. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically, fax etc.). The first accounting of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists during that same 12-month period. In the event that you may incur a charge, we will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Your Right to Request an Amendment: You have the right to request an amendment to the protected health information that we maintain about you if you believe that our information is incorrect or incomplete. You maintain the right to request an amendment for as long as the information is kept by or for the UNIFI Companies. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: 1) was not created by us; 2) is not part of the medical information kept by or for a UNIFI Company; 3) is not part of the information which you would be permitted to inspect and copy under the law; or 4) is accurate and complete.

Your Right to Request a Restriction: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for, payment or health plan operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for care, like a family member or friend. We are not required to agree to your request. If we do agree to a requested restriction, we will comply with your request unless the information is needed to facilitate emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about payment for your medical matters in an alternative means (such as by fax) or at an alternative location (such as to your office). To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Your Rights to Inspect and Copy: You have the right to inspect and copy protected health information that we maintain about you that may be used to make decisions about payment for your care. To inspect this protected health information you may contact the Privacy Officer. To obtain copies of such protected health information, you must submit your request in writing as indicated below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your protected health information, in most situations you may request that the denial be reviewed by a licensed health care professional who did not take part in the decision to deny access. We will comply with the outcome of the review.

Your Right to Make Complaints: If you believe that your privacy rights have been violated you may make a complaint to the UNIFI Companies Privacy Office or to the Secretary of Health and Human Resources as follows:

UNIFI Privacy Office
Attn. HIPAA Privacy
P.O. Box 81889
Lincoln, NE 68510

Secretary, Health and Human Services, Office of Civil Rights
United States Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington D.C. 20201

Any complaint you file will not cause you to suffer retaliation from our company. We will promptly investigate your complaint as soon as we receive it. When we have completed our investigation, we will notify you of our findings. If the investigation reveals that your privacy rights have indeed been violated, we will immediately take the appropriate measures to correct the violation pursuant to our Privacy Practices and Procedures.

Individual Rights Contact

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form.

Effective Date

This Notice will become effective as of April 14, 2003.

