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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA,

Applicant,

v.

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY, a California corporation,

Respondent.

Case No. BS123005
Assigned to Hon. David P. Yaffe, Dept. 86

CONSERVATOR'S REPLY MEMORANDUM IN SUPPORT OF HIS MOVING PAPERS AND APPLICATION RE: ORDER TO SHOW CAUSE AND FOR ORDERS APPROVING REHABILITATION PLAN OF GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY AND AUTHORIZING CONSERVATOR TO ENTER INTO RELATED AGREEMENTS WITH IA AMERICAN LIFE INSURANCE COMPANY:

(1) AGREEMENT AND PLAN OF REHABILITATION;
(2) ASSUMPTION REINSURANCE AGREEMENT;
(3) SERVICE AGREEMENT; AND
(4) NOVATION AGREEMENT

[Filed concurrently with Second Declaration of Joseph B. Holloway, Jr.]

Date: June 24, 2010
Time: 9:30 a.m.
Dept: Dept 86
Judge: Honorable David P. Yaffe

I. INTRODUCTION.

This Reply responds to the issues raised in the June 9, 2010 letter from Austin C. Moore, III, who writes as President of Golden State Mutual Life Alumni Association ("Alumni Association"). The Conservator also received a June 7, 2010 letter from Gloria Bell Edwards opposing the Rehabilitation Plan due to the non-receipt of a Quarterly Statement from IA American's affiliate corporation as to a policy she holds with a different IA affiliate. Copies of the letters are attached in Exhibit 9. The Conservator is not aware of any other responses or oppositions filed with the Court.

The Conservator provides the following information in response to the issues raised in the letters in an effort to reassure affected persons, policyholders and claimants that the Rehabilitation Plan is in their best interests and that claims against Golden State will be handled appropriately and consistently in accordance with Insurance Code § 1010 *et seq*. The issues raised in the letters are addressed in three categories: (1) obligations pursuant to policies issued or assumed by Golden State which will be assumed by IA American, another insurer or appropriately addressed through the Rehabilitation Plan; (2) obligations of Golden State not pursuant to policies issued or assumed by Golden State which will not be assumed by IA American and instead will be addressed through the Rehabilitation Plan; and (3) concerns that can not be satisfied due to the impaired condition of Golden State.

II. RESPONSES TO ISSUES RAISED IN THE LETTERS.

A. Obligations Pursuant To Policies Issued Or Assumed By Golden State Which Will Be Assumed By IA American, Another Insurer Or Appropriately Addressed Through The Rehabilitation Plan.

1. Current and retired employees' life insurance.

The life insurance discussed by the Alumni Association is term insurance issued to employees under a Golden State group policy. Golden State can terminate the group policy, and therefore terminate the term insurance, at the start of any month on 30 days notice. Under the terms of the group policy, employees, if eligible, may convert their term insurance within 31 days of termination to a whole life insurance policy or other applicable Golden State insurance product

at the premium rate applicable to that policyholder's age, without further underwriting, provided the employee pays the required premium; however, Golden State is impaired and cannot issue such converted policies. The Conservator intends to terminate the group policy under the Rehabilitation Plan. To the extent any current or retired employees eligible to do so seek to convert their insurance to a whole life policy or other product within the 31 days of termination, the Conservator intends to request that IA American treat this insurance as in-force business to be assumed by IA American, and thus request that IA American or another insurer accept any conversions. If for any reason IA American or another insurer does not accept the conversions, the Conservator will treat the converted insurance under the Rehabilitation Plan, to the extent allowable, as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. It is anticipated that any converted insurance would be valued as a Priority 2 claim under Insurance Code § 1033(a)(2). (Second Declaration of Joseph B. Holloway, Jr. ("Holloway Dec."), ¶¶ 8 and 9 and Exhibit 10.)

2. Long-term disability insurance.

Similar to the employees' life insurance, the employees currently receiving long-term disability benefits are receiving the benefits under policies issued or assumed by Golden State which can be terminated on 30 days notice. Any policyholders with claims in benefit status now will be addressed appropriately under the Rehabilitation Plan, either as in-force policies requested to be assumed by IA American or another insurer or, to the extent allowable, as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. The total benefits remaining to the employees under the long-term disability insurance are approximately $88,542, net of reinsurance recoverables. Upon termination, which the Conservator intends to do under the Rehabilitation Plan, the Conservator will address any allowable unpaid benefits appropriately under the Rehabilitation Plan as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. It is anticipated that any remaining long-term disability benefits owed would be valued as a Priority 2 claim under Insurance Code § 1033(a)(2). Sufficient funds are likely to exist in the

retained estate to pay any allowable unpaid Priority 2 claims. (Holloway Dec., ¶¶ 10 and 11 and Exhibit 11.)

B. Obligations Of Golden State Not Pursuant To Policies Issued Or Assumed By Golden State Which Will Not Be Assumed By IA American And Instead Will Be Addressed Through The Rehabilitation Plan.

1. Dental insurance.

The dental insurance provided to some employees is not a policy to be assumed by IA American under the Rehabilitation Plan as the dental insurance is not provided through a policy issued or assumed by Golden State. The policy is issued by Ameritas Life Insurance Corp. Under the Rehabilitation Plan, Golden State intends to cancel the policy with Ameritas. The current or retired employees will then be required to make their own arrangements for the purchase of dental insurance. To the extent any current or retired employees allege damages resulting from this, the current or retired employees will retain their rights, if any, to assert claims against Golden State's retained estate subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. (Holloway Dec., ¶ 12 and Exhibit 12.)

2. Retired employees' early retirement benefits.

The retired employees' early retirement benefits are non-policy obligations of Golden State, which are subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq*. These benefits are not provided through a policy issued or assumed by Golden State and, as such, will not be assumed by IA American. The retired employees' receipt of early retirement benefits will not be negatively affected by the proposed assumption transaction with IA American. To the contrary, the $11 million ceding commission to be credited to Golden State through the assumption transaction is likely to benefit the retired employees because the commission is projected to afford the Conservator the best prospect to continue to pay, among other obligations, the retired employees' early retirement benefits and fund the under-funded portion of the employee retirement plan, which is currently $3,298,332 as of December 31, 2009. (Holloway Dec., ¶ 13.)

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3. Certificate of contribution holders.

Any payments to the certificate of contribution holders will be made subject to the claim priority and asset distribution procedures set forth in Insurance Code § 1010 *et seq*. including § 1033. The face value of outstanding certificates of contribution is approximately $2,142,649. As discussed in the Conservator's Moving Papers, following the closing of this assumption transaction with IA American, it is likely that further orders of conservation and/or liquidation will be requested for Golden State, and a proof of claims process and claims bar date will be established in accordance with Insurance Code § 1010 *et seq.* While no time-table has been proposed, the Conservator anticipates applying to the Court for further orders within twelve months of closing of the transactions with IA American. (Holloway Dec., ¶ 14.)

4. Future dividends under policies assumed by IA American.

IA American intends to continue to provide for the payment of dividends under the Golden State policies assumed by IA American; however, the provisions in Golden State's policies relating to dividends or the calculation or payment of dividends will be amended to read as follows: "As long as your life insurance policy is in force, except as Extended Term Insurance, the Company will determine the annual dividend payable under your life insurance policy, if any, on the life policy anniversary, if you have paid all premiums due before that date." (Assumption Endorsement, attached to Assumption Reinsurance Agreement previously submitted as Exhibit 4.)

C. Concerns Which Can Not Be Satisfied Due To The Impaired Condition Of Golden State.

The issues of whether IA American will maintain a presence in Golden State's current locations of operation, whether general agents will be appointed by IA American, and whether policy and annuity holders will surrender their policies upon assumption by IA American, are solely within the determinations of and consequences to IA American. The Conservator requested, and IA American agreed, to work with the Conservator to identify any employees of Golden State whom IA American wishes to hire to work for IA American. (Holloway Dec., ¶ 15.)

However, the Conservator can not dictate to IA American how it is to handle its assumed Golden State business. Golden State is in conservation and without the assumption of Golden State's in-force policies by IA American, Golden State would most likely require immediate liquidation. An immediate liquidation of Golden State is not a better alternative to the Rehabilitation Plan because without the $11 million ceding commission, it is likely that fewer of the company's obligations would be paid since Golden State would not have any remaining money to satisfy its obligations to pay creditors or to pay anything toward lesser priority claims such as the claims of certificate of contribution holders, and certainly would not be able to maintain a presence in any of its current locations of operation. (Holloway Dec., ¶ 16.)

As to surrenders of policy and annuity contracts, surrenders will not likely result in the transfer of any surplus to IA American because IA American is paying a ceding commission for the purchase of the policies, such that transferred assets are less than the policies' surrender values. (Holloway Dec., ¶ 17.)

Finally, as to Ms. Edwards' non-receipt of a Quarterly Statement from IA American's affiliate corporation, IA American has advised the Conservator that Ms. Edwards has surrendered her policy. The Conservator has forwarded Ms. Edwards' letter to IA American to determine if any further communication is appropriate. (Holloway Dec., ¶ 18.)

III. CONCLUSION.

As discussed in the Conservator's Moving Papers, the Conservator recommends this Rehabilitation Plan and related agreements with IA American because the Rehabilitation Plan and the agreements comprising the Rehabilitation Plan are fair, rational and in the best interests of Golden State's policyholders and creditors. The Conservator's recommendation is based on the facts that: (1) IA American's bid and $11 million ceding commission are greater than the bids submitted by the other bidders, which, in turn, will increase the potential that Golden State's creditors, certificate of contribution holders, mutual policyholders and all others who may have an interest in Golden State will be paid; (2) by the assumption and transfer to IA American of Golden State's insurance policies and annuity contracts, Golden State's in-force policyholders and annuity contract holders are assured that their existing policies and annuity contracts will be

maintained, thereby allowing Golden State's policyholders and annuity contract holders to enjoy continuous coverage and benefits without having to re-enter the insurance and annuity markets at presumably higher age and therefore higher price points; (3) due to IA American's financial strength, Golden State's in-force policyholders and annuity contract holders are assured that 100% of their policy and annuity contract benefits including death benefits, annuity payments and health and disability payments, will be paid; and (4) an immediate liquidation of Golden State is not a better alternative to the Rehabilitation Plan because without the $11 million ceding commission, it is unlikely 100% of Golden State's policy liabilities payable under Golden State's policies would be paid, which in turn means that Golden State would not have any remaining money to satisfy it's obligations to fully fund it employee retirement plan, to pay creditors, to repay its certificate of contribution holders, and to pay its other obligations. (Previously submitted Declaration of David E. Wilson, ¶¶ 17 and 33.)

The Rehabilitation Plan and related agreements for which Court approval is here requested is the best solution for Golden State. The issues raised by Mr. Moore will be handled appropriately under the Rehabilitation Plan consistent with the Conservator's duties and authorities and subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. The Conservator's Rehabilitation Plan and assumption agreement ensure that in-force policyholders maintain their coverage, funds remain with Golden State to pay creditors' claims, and creditors receive the value of Golden State's book of insurance business in the form of a ceding commission paid by IA American.

In sum, the Court should approve this plan to protect Golden State, its policyholders, its creditors, its certificate of contribution holders, and all other persons and entities which may have an interest in Golden State.

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Dated: June 17, 2010

EDMUND G. BROWN JR.
Attorney General of California
FELIX LEATHERWOOD
W. DEAN FREEMAN
Supervising Deputy Attorneys General
MARTA L. SMITH
Deputy Attorney General

MARTA L. SMITH
Deputy Attorney General

Attorneys for Applicant
Insurance Commissioner of the State of California

SECOND DECLARATION OF JOSEPH B. HOLLOWAY, JR.

I, Joseph B. Holloway, Jr., declare as follows:

1. I am over 18 years of age and have personal knowledge of the facts and circumstances set forth in this declaration, and if called upon to do so, I could and would competently testify thereto.

2. I have a Bachelor of Arts degree in accounting from North Carolina State University, and hold the designation of Certified Financial Examiner from the Society of Financial Examiners.

3. From 2005 through the present, I have been employed as a consultant by INS Consultants, Inc., assigned to work with the Insurance Commissioner's Conservation & Liquidation Office ("CLO"). From 1985 to 2005, I worked for the North Carolina Department of Insurance as an examiner, regulatory specialist and then as chief forensic accountant. Through my employment with the North Carolina Department of Insurance, INS Consultants, Inc. and my assigned work with the CLO, I have more than 25 years of experience working with financially troubled insurance companies, including without limitation companies in supervision, conservation, rehabilitation and liquidation.

4. Starting on September 30, 2009, and continuing through March 2010, I was the On-Site Manager for the Special Deputy Insurance Commissioner on behalf of the Insurance Commissioner in his Statutory Capacity as Conservator ("Conservator") of Golden State Mutual Life Insurance Company ("Golden State"). Since March 2010 and continuing to the present, I have remained as a consultant involved in the conservation and rehabilitation plan for Golden State. As the On-Site Manager of Golden State, I was responsible for the on-site supervision and management of all matters pertaining to the conservation and business of Golden State, including without limitation Golden State's day-to-day operations, the marshalling of Golden State's assets, the reducing of Golden State's expenses and liabilities, and other numerous functions and duties of the Conservator.

5. Based on my duties as the On-Site Manager of Golden State and as a consultant for the CLO involved in the conservation and rehabilitation plan for Golden State, I am very

familiar with Golden State's financial condition, the Conservator's conservation and rehabilitation efforts, the proposed rehabilitation plan for Golden State, and the events leading up to the proposed plan and rehabilitation agreements. My experience with financially troubled insurance companies, coupled with my experience as On-Site Manager of Golden State gives me hands-on knowledge to analyze the financial effect of the Conservator's proposed rehabilitation plan and, specifically, the four agreements comprising the rehabilitation plan, which are exhibits attached to the previously submitted Declaration of David E. Wilson, which are: (1) Agreement and Plan of Rehabilitation, (2) Assumption Reinsurance Agreement, (3) Service Agreement and (4) Novation Agreement. The four agreements are collectively referred to herein as the "Rehabilitation Plan."

6. I have read the Conservator's Reply Memorandum In Support Of His Moving Papers And Application Re: Order To Show Cause And For Orders Approving Rehabilitation Plan Of Golden State Mutual Life Insurance Company And Authorizing Conservator To Enter Into Related Agreements With IA American Life Insurance Company.

7. Based on my on-site supervision and management of matters pertaining to Golden State, my experience with financially troubled insurance companies, my review and understanding of the events related to the conservation of Golden State and the proposed rehabilitation plan and agreements for Golden State, my review of the Conservator's Reply, and my qualifications stated above, I state the following:

Current and retired employees' life insurance.

8. The life insurance discussed by the Alumni Association is term insurance issued to employees under a Golden State group policy. Golden State can terminate the group policy, and therefore terminate the term insurance, at the start of any month on 30 days notice. Under the terms of the group policy, employees, if eligible, may convert their term insurance within 31 days of termination to a whole life insurance policy or other applicable Golden State insurance product at the premium rate applicable to that policyholder's age, without further underwriting, provided the employee pays the required premium; however, Golden State is impaired and cannot issue such converted policies. Attached hereto and incorporated herein by this reference as Exhibit 10

is a true and correct copy of Golden State's Group Life Insurance Policy.

9. The Conservator intends to terminate the group policy under the Rehabilitation Plan. To the extent any current or retired employees eligible to do so seek to convert their insurance to a whole life policy or other product within the 31 days of termination, the Conservator intends to request that IA American treat this insurance as in-force business to be assumed by IA American, and thus request that IA American or another insurer accept any conversions under the Assumption Reinsurance Agreement. If for any reason IA American or another insurer does not accept the conversions, the Conservator will treat the converted insurance under the Rehabilitation Plan, to the extent allowable, as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. It is anticipated that any converted insurance would be valued as a Priority 2 claim under Insurance Code § 1033(a)(2).

Long-term disability insurance.

10. Similar to the employees' life insurance, the employees currently receiving long-term disability benefits are receiving the benefits under policies issued or assumed by Golden State which can be terminated on 30 days notice. Attached hereto and incorporated herein by this reference as Exhibit 11 is a true and correct copy of Golden State's Group Long Term Disability Insurance Policy.

11. Any policyholders with claims in benefit status now will be addressed appropriately under the Rehabilitation Plan, either as in-force policies requested to be assumed by IA American or another insurer or, to the extent allowable, as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. The total benefits remaining to the employees are approximately $88,542, net of reinsurance recoverables. Upon termination, which the Conservator intends to do under the Rehabilitation Plan, the Conservator will address any allowable unpaid benefits appropriately under the Rehabilitation as a claim subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033. It is anticipated that any remaining long-term disability benefits owed would be valued as a Priority 2 claim under Insurance Code § 1033(a)(2). Sufficient funds

are likely to exist in the retained estate to pay any allowable unpaid Priority 2 claims.

Dental insurance.

12. The dental insurance provided to some employees is not a policy to be assumed by IA American under the Rehabilitation Plan as the dental insurance is not provided through a policy issued or assumed by Golden State. The policy is issued by Ameritas Life Insurance Corp., a true and correct copy of which is attached hereto and incorporated herein by this reference as Exhibit 12. Under the Rehabilitation Plan, Golden State intends to cancel the policy with Ameritas. The current or retired employees will then be required to make their own arrangements for the purchase of dental insurance. To the extent any current or retired employees allege damages resulting from this, the retired employees will retain their rights, if any, to assert claims against Golden State's remaining assets subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq.* including § 1033.

Retired employees' early retirement benefits.

13. The retired employees' early retirement benefits are non-policy obligations of Golden State, which are subject to the claim priority and distribution procedures set forth in Insurance Code § 1010 *et seq*. These benefits are not provided through a policy issued or assumed by Golden State and, as such, will not be assumed by IA American. The retired employees' receipt of early retirement benefits will not be negatively affected by the proposed assumption transaction with IA American. To the contrary, the $11 million ceding commission to be credited to Golden State through the assumption transaction is likely to benefit the retired employees because the commission is projected to afford the Conservator the best prospect to continue to pay, among other obligations, the retired employees' early retirement benefits and fund the under-funded portion of the employee retirement plan, which is currently $3,298,332 as of December 31, 2009.

Certificate of contribution holders.

14. Any payments to the certificate of contribution holders, which hold certificates with face values totaling approximately $2,142,649, will be made subject to the claim priority and asset distribution procedures set forth in Insurance Code § 1010 *et seq*. including § 1033. As

discussed in the Conservator's Moving Papers, following the closing of this assumption transaction with IA American, it is likely that further orders of conservation and/or liquidation will be requested for Golden State, and a proof of claims process and claims bar date will be established in accordance with Insurance Code § 1010 *et seq.* While no time-table has been proposed, the Conservator anticipates applying to the Court for further orders within twelve months of closing of the transactions with IA American.

Concerns Which Can Not Be Satisfied Due To The Impaired Condition Of Golden State

15. The issues of whether IA American will maintain a presence in Golden State's current locations of operation, whether general agents will be appointed by IA American, and whether policy and annuity holders will surrender their policies upon assumption by IA American, are solely within the determinations of and consequences to IA American. The Conservator requested, and IA American agreed, to work with the Conservator to identify any employees of Golden State whom IA American wishes to hire to work for IA American.

16. However, the Conservator cannot dictate to IA American how it is to handle its assumed Golden State business. Golden State is in conservation and without the assumption of Golden State's in-force policies by IA American, Golden State would most likely require immediate liquidation. An immediate liquidation of Golden State is not a better alternative to the Rehabilitation Plan because without the $11 million ceding commission, it is likely that fewer of the company's obligations would be paid since Golden State would not have any remaining money to satisfy its obligations to pay creditors or to pay anything toward lesser priority claims such as the claims of certificate of contribution holders, and certainly would not be able to maintain a presence in any of its current locations of operation.

17. As to surrenders of policy and annuity contracts, surrenders will not likely result in the transfer of any surplus to IA American because IA American is paying a ceding commission for the purchase of the policies, such that in aggregate transferred assets are less than the policies' surrender values.

18. As to Ms. Edwards' non-receipt of a Quarterly Statement from IA American's affiliate corporation, IA American has advised me on behalf of the Conservator that Ms. Edwards

has surrendered her policy. I on behalf of the Conservator had Ms. Edwards' letter forwarded to IA American to determine if any further communication is appropriate.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on this 17th day of June, 2010, at San Francisco, California.

Joseph B Holloway, Jr.

JOSEPH B. HOLLOWAY, JR.

EXHIBIT 9

June 9, 2010

Superior Court of the State of California
For the County of Los Angeles
111 North Hill Street, Dept. 86
Los Angeles, CA 90012

Re: Case No. BS123005
Insurance Commissioner of the State of California v.
Golden State Mutual Life Insurance Company

TO WHOM IT MAY CONCERN:

In response to your "Notice of Order to Show Cause", we submit the following concerns of the employees and retirees of Golden State Mutual Life Insurance Company:

I represent the Golden State Mutual Life Alumni Association. A group of former employees, most of which had tenure for twenty plus years, represented in most of the states of operation, wherefore we have former agents, corporate secretary, actuaries, agency directors, chairmen and presidents, policyholders and others who are concerned members of the community.

Our questions are questions of concern for ourselves, our former policyholders and our communities for the impact this acquisition will have on our life long dedication to this company and the community that supported us as we supported it. The following questions need to be addressed prior to the closure of this proposed acquisition by I. A. American.

Upon retirement some employees were provided dental insurance and what was promised as, paid-up life insurance in varying amounts of $5,000; $10,000 and $50,000 with the option to purchase additional amounts for a premium. It is clear to us now that we were not given paid-up insurance but were simply continued as part of the company's employee group life insurance program; what is not clear is what will happen to our insurance coverage at this point. It is obvious that this is an older group and that it would be a tremendous hardship if this insurance, which we all depend on, were to be discontinued at this point in our lives.

We pray for a solution that would continue this important benefit as promised to this group of retirees.

Some twenty plus years ago GSM instituted an early retirement program that allowed a select group of employees to retire at their then attained age and receive a benefit equal to their age sixty-five benefit. This resulted in this group of retirees receiving their earned

benefit from the company's pension plan and the additional benefit being paid directly from the company.

It is not clear how this additional benefit currently being paid by the company will be paid going forward. This benefit is obviously an important part of this group's total benefit and is counted on for their daily livelihood. We are seeking clarification of this important issue.

There are several employees currently receiving long- term disability benefits due to continue until their age sixty-five. The company had this group insured with an outside carrier who has reportedly paid the company the present value of the future benefits of this liability. The company currently pays this group of employees on a monthly basis. We are not sure how this stream of payments will continue to be made to this group of employees. We are seeking information that would provide answers to this important question.

According to company records there are 271 certificate of contribution holders all concerned about the status of their investments. We would like to know if and when this group's investment will be settled and if it will include accrued interest.

Will I. A. American Life Insurance Company maintain a presence in our major locations of operation?

The purchase of Golden State Mutual Life Insurance Company policies by I. A. American Life Insurance Company without maintaining the current management and staff will result in a large number of cash surrenders, lapses and loss of administrative services that are currently being provided to policyholders. (Cash surrenders will infuse the surplus earnings into the coffers of I. A. American. I don't understand.)

Current agents, particularly general agents if not appointed by I. A. American Life Company, will lose contact with their clients and thus their influence to maintain the policies will be lost.

Will I. A. American honor dividends provided by Golden State Mutual Life Insurance Company life policies?

Respectfully submitted,

Austin C. Moore, III, CLU, President
Golden State Mutual Life Alumni Association
P. O. Box 2094, Pomona, CA 91788-2094
(909) 821-5533

Gloria Bell Edwards
1429 Thousand Oaks Blvd.
Albany, CA 94706
June 07, 2010

Golden State Mutual Life Insurance Company,
In Conservation
P.O. Box 512332
Los Angeles, California 90051-0332

RE: Choice of Rehabilitation Plan and Agreement with
IA American Life Insurance Company

I am strongly opposed to a subsidiary of Industrial Alliance Insurance and Financial Services being responsible for the policies I hold with GSM.

I am very anxious about the operation of IA American because I have other funds with an Industrial Alliance subsidiary or branch in Greenville, South Carolina. The Canadian office alerted me of this new service center's September 1, 2009 opening in July, 2009. I had received my last Quarterly Statement in June, 2009; therefore, I anticipated receiving the next Quarterly report (September 24.2009) as usually and was curious which office would send it. (I also withdrew funds in August, 2009 hoping to see that activity on the September statement)

I have yet to receive a Quarterly Statement from either office. I have called the Greenville office regarding this in January 2010, and in March, 2010. In May, 2010 I called to surrender the policy because I am over 701/2 years old, I have a financial emergency, and mostly, because I have lost confidence about the care of my remaining funds. Although they are able to tell me of the current balances (from their computer screen) there are still excuses for not producing a Quarterly report in the past ten months.

Therefore, I am very concerned for IA American, a subsidiary of Industrial Alliance Insurance and Financial Services to handle additional funds and/or policies.

Sincerely,

Gloria Bell Edwards

Affected policies: 682008350, 690905620, 690905610, 739103270, 739103260

EXHIBIT 10

READ YOUR POLICY CAREFULLY

This Policy is a Legal Contract between the Policyholder and the Company.

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 1999 W. ADAMS BOULEVARD • LOS ANGELES, CALIFORNIA 90018 • (213) 731-1131

In return for your Application, and for the payment of premiums as set forth in this Policy, we agree to pay the benefits described in this Policy. These benefits are subject to all of the terms of this Policy, including any riders, endorsements and amendments.

This Policy goes into effect on the Policy Effective Date, at 12:01 a.m., at your address. The Policy will stay in force as long as the premium is paid, until terminated by you or us.

This contract shall be governed by the laws of the state in which it is delivered.

IN WITNESS WHEREOF, We have signed this Policy at Los Angeles, California.

SECRETARY

PRESIDENT

COUNTERSIGNED

GROUP LIFE INSURANCE POLICY
(Participating)

This is a contract between us, GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY, and you,

_____

(the Policyholder)

SCHEDULE OF BENEFITS

Group Policy No._____ Policy Delivered In:_____

Policy Effective Date:_____ Policy Anniversary Date:_____

PLAN TYPE: ☐ Contributory ☐ Non-Contributory

INSURANCE COVERAGE:	MONTHLY PREMIUM
Life Insurance	$
Accidental Death and Dismemberment Coverage	$
Waiver of Premium	$
Other	
_____	$
_____	$
_____	$

TABLE OF CONTENTS

DEFINITIONS

When we use the following words, this is what we mean:

We, our or *us* refers to Golden State Mutual Life Insurance Company.

You, your or *yours* refers to the Policyholder.

ACTIVELY AT WORK: *Actively at work* means the Employee's attendance in person at the usual and customary place of business, acting in the full-time performance of the duties of that person's employment by the Policyholder for wages or profit.

AMOUNTS OF INSURANCE: The initial amounts of insurance for an Employee are shown in the Policy Application.

APPLICATION: The application for Group Insurance signed by the Policyholder. It is attached to this Policy.

BENEFICIARY: The person the Employee chooses to receive benefits under the Group Policy if he dies.

CHANGE IN AMOUNTS: Amounts of insurance may change at a certain age or time. They may also change if the Employee's class changes, or if the Plan is amended. Such changes in the amount of insurance will take effect as shown in the Application.

CONTRIBUTORY INSURANCE: The insured Employee pays part or all of the premium.

DISABILITY, DISABLED, TOTAL DISABILITY, TOTALLY DISABLED: An Employee will be considered Totally Disabled if, because of injury or sickness, he is unable to perform all the essential duties of his occupation. After 24 months, an Employee will be considered totally disabled only if, because of injury or sickness, he is unable to perform all the essential duties of any occupation for which he is or may reasonably become qualified based on his education, training or experience.

EFFECTIVE DATE: The Employee's insurance will become effective on the date shown in the Application as long as he is eligible under the Policy and he is actively at work on that date; or if not, then on the date he returns to work. For employees becoming eligible after the Policy Effective Date, insurance starts on the date first eligible. If the Policy is contributory, the Employee must enroll in writing. We may ask for proof of his insurability at his expense if:

1. he applies more than 31 days from the date he becomes eligible; or

2. his insurance stopped because he did not pay the last required premium due. In this case the Employee's insurance will become effective on the first day of the month coincident with or next following the date we approve the proof of his insurability provided he is then actively at work.

ELIGIBILITY: A member of the Eligible Class is any full-time permanent, active employee working at least 30 hours per seek for this Policyholder.

ELIGIBILITY DATE: This is the date that the Employee first becomes eligible for insurance under this Policy. The conditions for eligibility are shown in the Policy Application.

EMPLOYEE: A full time, active employee in the service of the Policyholder.

HE, HIS: Wherever the masculine pronouns he, his are used they shall also refer to the feminine pronouns she and her.

NON-CONTRIBUTORY INSURANCE: The Policyholder pays all of the premiums.

POLICY: The Group Life Insurance policy we issued to the Group Life Insurance Policyholder.

POLICYHOLDER: The Policyholder named on the Schedule of Benefits page.

POLICY MONTH: The period that starts on a premium due date and ends on the day prior to the next premium due date.

POLICY YEAR: The first policy year starts on the Effective Date. If the Policy is renewed, future plan years start on the same date in each year after that.

POLICY BENEFITS

LIFE INSURANCE

If the Employee dies while insured, we will need to receive satisfactory proof of his death and will pay the Beneficiary the amount of life insurance in force under the Plan. This will be called the Life Amount. The initial Life Amount for each class of employees is shown in the Policy Application.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

If this insurance is included and if the Employee has an accident:

1. while he is insured;
2. and suffers a loss shown below, we will pay:
   a. the full AD&D Amount for the loss of:

      life;
      both hands or both feet;
      sight of both eyes;
      one hand and one foot;
      one hand and sight of one eye;
      one foot and sight of one eye; or

b. one-half the AD&D Amount for the loss of:

one hand or one foot; or
sight of one eye.

The initial AD&D Amount for each class of employee is shown in the Policy Application. The loss of hands or feet must be by severance at or above the wrists or ankles. The loss of sight must be total and not recoverable.

We will pay the AD&D Amount to the Beneficiary for the loss of life or to the Employee for any other loss. We will not pay more than the full AD&D Amount for any one or more losses for the same accident.

We must receive satisfactory proof that the loss occurred:

1. as a result of an accidental bodily injury and independently of all other causes; and
2. within 90 days after a covered loss starts or as soon as reasonably possible.

We will not pay any AD&D Amount if the loss results from:

1. bodily injury which occurred before the Employee was insured by the Policy;
2. intentionally self-inflicted injury or suicide;
3. voluntary taking of any drugs (except those prescribed by a doctor); poison, gas or fumes voluntarily administered, absorbed or inhaled.
4. committing or attempting to commit a felony;
5. travel in or descent from any moving aircraft aboard which:
   a. the Employee is giving or receiving training;
   b. the Employee has any duties; or
   c. the Employee is being flown for the purpose of his descent from such aircraft while it is in flight;
6. war or any act of war, whether declared or not;
7. disease or infirmity of the body or mind or from its medical or surgical treatment;
8. bacterial infection unless the result of an accident.

RIGHT TO EXAMINE

We, at our expense, have the right to examine the Employee's person:

1. as often as it is reasonably required;
2. while a claim is pending.

We may require an autopsy:

1. in case of death;
2. unless it is not allowed by law.

WAIVER OF PREMIUM

If this insurance is included, premium for an Employee will be waived if the Employee becomes totally disabled while he is insured under the Policy and prior to age 60.

We will keep his Life Insurance in force subject to the terms of this clause. We will need to receive proof of his disability. The proof must be received by us:

1. at our Home Office;
2. in writing;
3. while the Employee is still disabled.

Satisfactory proof of the claim must be received within one year from the start of the disability. Once we approve a claim, his Life Insurance will be kept in force:

1. with no further premium cost to him or the Policyholder;
2. for the Life Amount in effect at that time;
3. for as long as he is disabled;
4. whether or not the Policy remains in force.

Premiums will not be waived for the first six months of total disability.

If the Plan states that his Life Amount would:

1. stop; or
2. reduce at a certain age or time, then the same will be true under this disability clause.

We have the right to have proof that he is still disabled:

1. at any reasonable time during the first two years of disability; and
2. once a year after that.

His insurance will stop under this clause if:

1. he fails to give us the proof we ask for;
2. he ceases to be disabled; or
3. he converts his Group Life Insurance.

RIGHT TO CONVERT

A. **If the Policy is still in force**, the Employee has the right to convert his Group Life insurance:

1. if all or part of it stops for any reason; unless
2. it stops because the Employee or Employer did not pay any required premium.

The Employee will not have to give us proof of his health at that time.

To convert his Group Life insurance, he must apply to us:

1. in writing;
2. by paying the first premium for the new policy;
3. within 31 days from when it stops.

The new policy will be an individual conversion Whole Life policy (not Term). This individual policy will not have waiver of premium, AD&D or Term insurance coverages.

The new policy the Employee chooses will be issued:

1. as of the end of the 31st day after his insurance stops;
2. on a form we use as of its effective date for:
   a. his age last birthday at that time; and
   b. the amount he applied for.

The amount the Employee may apply for may not be more than:

1. the Life Amount then in force; or
2. that part of the Life Amount which has stopped, whichever is less.

B. **If the Policy stops**, the Employee may still convert his insurance:

1. if he has been insured continuously under this Policy for at least 5 years;
2. for $2,000

The Employee will not have to give us proof of his health at that time.

To convert his Group Life insurance, he must apply to us:

1. in writing;
2. by paying the first premium for the new policy;
3. within 31 days from when it stops.

The new policy will be an individual conversion Whole Life policy (not Term). This individual policy will not have Waiver of Premium, AD&D or Term insurance coverages.

The new policy the Employee chooses will be issued:

1. as of the end of the 31st day after his insurance stops;
2. on a form we use as of its effective date for:
   a. his age last birthday at that time; and
   b. the amount he applied for.

C. Death Benefit During Right to Convert Period:

We will pay the Life Amount:

1. if the Employee dies within the 31 day right to convert period;
2. whether or not he has applied to us.

TERMINATION OF BENEFITS

The Employee's insurance will stop on the first of the following dates:

1. when the Policy stops;
2. when he chooses the Policy to stop;
3. when he is no longer eligible for insurance under the Policy;
4. at the end of the 31st day from when the last premium was paid if the Employee is required to pay part or all of the cost of his insurance;
5. when he leaves his job.

If the Employee is in active service in the armed forces of a country at war, declared or not, his insurance will stop.

We may stop all coverage under the Policy at the start of any insurance month by giving 30 days written notice to the Policyholder.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Contract is made up of: (1) the Policy; (2) the Application of the Policyholder, a copy of which is attached; and (3) if required, the individual application of the Insured Person.

The Policy is a legal contract. Nothing else which has been said or written is part of it unless it is attached. Only our President, Vice President or Secretary may agree to a change. The change must be in writing.

All statements made in the Application, except for fraud, are representations and not warranties. We will not use any statement to void the Policy nor to deny a claim unless such statements are contained in the Application(s).

OWNER OF THIS INSURANCE

The Policy is owned by the Policyholder. Each Employee owns his or her own insurance unless we are told otherwise in writing by the Employee.

Ownership of an Employee's insurance can be changed at any time. It must be done on our form and sent to us. The form must be signed by the current owner of that insurance. We will record the change, and it will take effect on the date the form was signed. A change of owner does not change the Beneficiary.

BENEFICIARY DESIGNATION

The Beneficiary is named by the Employee on our records to receive benefits with the Employee dies. If, when the Employee dies, there is no Beneficiary, or he did not name one, then we may pay benefits to one of the classes of survivors in the following order:

1. current spouse;
2. surviving children in equal shares;
3. mother or father;
4. brother or sister; or
5. the estate.

CHANGE OF BENEFICIARY

The Beneficiary may be changed at any time before the Employee dies. A change must be done on our form and sent to us. The form must be signed by the Employee. If the change is approved by us, it will take effect on the date it was signed. An irrevocable beneficiary must consent to the change.

PREMIUMS

Premiums are payable at our Home Office. They are due by the first day of each month. Premiums start on the Policy Effective Date for all persons insured on that date; or on the first premium date on or after the date insurance starts for all others. Premiums for a person will stop on the first premium due date on or after the date the insurance stops for that person.

We have the right to change the premium rate. We will not make a change before the Policy is one year old. We will write and tell the Policyholder 31 days before the change takes place.

GRACE PERIOD

If a premium is not paid when due, there is a 31-day Grace Period. If a premium is not paid in that time, this insurance will stop.

ASSIGNMENT

The Insured may assign his rights in the Policy while he is alive. We will not be bound by the assignment until the original has been filed at our Home Office. When it is filed, it will affect his rights and the rights of any beneficiary. We are not responsible for the validity of any assignment.

PROOF OF CLAIM

Written proof of a Life Insurance claim, Accidental Death and Dismemberment Insurance claim or a Waiver of Premium claim must be given to us in accordance with the **Policy Benefits** section of this Policy.

INCONTESTABILITY

We will not contest this Policy after it has been in force for two years from its Effective Date, except for non-payment of premium.

MISSTATEMENT OF AGE

If an Employee's age has been misstated, the amount payable will be what the premiums paid would have bought at the correct age. Premiums will be changed to those at the true age of the Employee.

STATE LAW CONTROL

The Policy is ruled by the laws of the state where the Policyholder's Application was signed. If part of it does not follow that law, it will be treated as if it did.

INDIVIDUAL CERTIFICATES

We will give the Policyholder a Certificate to be given to each insured Employee which will show:

1. the insurance benefits; and
2. the conversion privileges.

If there is any change to the Policy affecting the Employee's benefits, a notice of change will be issued. Any conflict between terms of the Certificate and the Policy will be decided in favor of the Policy.

EXHIBIT 11

GOLDEN STATE MUTUAL LIFE

HOME OFFICE: 1999 W. ADAMS BOULEVARD - LOS ANGELES, CALIFORNIA 90018
A MUTUAL LEGAL RESERVE COMPANY

Group Policy No. GA0510042

Policy Delivered in: California

Policy Effective Date: September 1, 1989

Policy Anniversary Date: September 1

This is a contract between Golden State Mutual Life Insurance Company, the Company, and you, the Employee.

In return for your application, the Company agrees to pay the benefits described in this Policy. These benefits are subject to all of the terms of this Policy, including any riders, endorsements and amendments.

This Policy goes into effect on the Policy Effective Date at 12:01 a.m.

This Contract shall be governed by the laws of the state in which it is delivered.

IN WITNESS WHEREOF, we have signed this Policy at Los Angeles, California.

Gloria A. McDowell

SECRETARY

Jarbin Tooley

PRESIDENT

Group Long Term Disability Insurance Policy — Non-Contributory

CONTENTS

DEFINITIONS

ACTIVE SERVICE — An Employee will be considered in Active Service with the Employer on a day which is the one of the Employer's scheduled work days if he is performing in the usual way all the regular duties of his work for the Employer on a full time basis on that day, either at one of the Employer's places of business or at some location to which the Employer's business requires him to travel. An Employee will be deemed in Active Service on a day which is not one of the Employer's scheduled work days only if he was in Active Service on the preceding scheduled work day.

BASIC EARNINGS — The term Basic Earnings means the Employee's rate of pay reported by the Employer. It does not include overtime, bonus, additional compensation or pay for more than 36 hours in a week.

For an Employee who is paid in whole or in part by commissions, the term Basic Earnings will also include commissions based on an average of the commissions paid by the Employer or the 24 months immediately preceding the onset of Total Disability. If such Employee was not in the employ of the Employer during the entire preceding 24 month period, his commissions will be based on an average of the total number of months he was so employed.

Basic Earnings are determined initially on the date the Employee becomes insured. A change in the amount of Basic Earnings will be considered effective on the date of such change. If the Employee is not in Active Service on that day, no increase in Basic Earnings will be considered effective until he returns to Active Service for one full day. In no event will an increase in an Employee's Basic Earnings be considered effective if it occurs:

1. between separate periods of Total Disability which are considered one period under Successive Periods of Disability; or
2. during a Benefit Waiting Period.

EMPLOYEE — The term Employee means a full time employee of the Employer, but does not include employees who are part time or temporary or who normally work less than 30 hours a week for the Employer.

EMPLOYER — Golden State Mutual Life Insurance Company.

INJURY — The term Injury means an accidental bodily injury.

REHABILITATIVE WORK — An Employee will be considered engaged in Rehabilitative Work if: ([a] while Totally Disabled, he returns to any work for wage or profit; and [b] that work is approved by the Insurance Company.)

RETIREMENT PLAN — The term Retirement Plan means any defined benefit plan or defined contribution plan including a profit sharing plan funded in whole or in part by the Employer. It does not include:

1. an individual deferred compensation agreement;
2. a profit sharing or any other retirement or savings plan that is maintained in addition to a defined benefit or defined contribution pension plan; or
3. any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401 [k] plan.

SICKNESS — The term Sickness means a physical or mental illness. It also includes pregnancy.

TOTAL DISABILITY — An Employee will be considered Totally Disabled if, because of Injury or Sickness, he is unable to perform all the essential duties of his occupation.

After Monthly Benefits have been payable for 24 months, an Employee will be considered Totally Disabled only if, because of Injury or Sickness, he is unable to perform all the essential duties of any occupation for which he is or may reasonably become qualified based on his education, training or experience.

ELIGIBILITY FOR EMPLOYEE INSURANCE

Each Employee in one of the Classes of Eligible Employees on following page will become eligible for Employee Insurance on the day he completes the Waiting Period, if any. An Employee who was previously insured and whose insurance ceased must satisfy the Waiting Period to become insured again. If the insurance on an Employee ceased because he was no longer employed in a Class of Eligible Employees, he is not required to satisfy any Waiting Period if he again becomes a member of a Class of Eligible Employees within one year after his insurance ceased.

WAITING PERIOD — Five [5] years from date of employment.

CLASSES OF ELIGIBLE EMPLOYEES — District Managers I, District Managers II, Staff Managers, Agents and all Salaried Employees.

EFFECTIVE DATE OF EMPLOYEE INSURANCE

Each Employee will become insured for Employee Insurance on the date he becomes eligible for it. If an Employee is not in Active Service on the date his insurance would otherwise become effective, it will become effective on the date he returns to Active Service.

SCHEDULE

BENEFIT WAITING PERIOD — 180 days of continuous Total Disability.

A period of Total Disability will be considered continuous even if the disabled Employee temporarily returns to work for up to a total of 30 days during that Benefit Waiting Period. The Benefit Waiting Period will be extended by the number of days the Employee temporarily returned to work.

MONTHLY BENEFIT

Employee Class	Monthly Income Benefit
District Manager I	$1,000.00
District Manager II & Staff Managers	750.00
Agents	The lesser of $600 or 80% of the average of the previous 12 months' earnings
Salaried Employees	66 2/3% of their immediate monthly salary up to a maximum of $3,000 per month

Monthly Benefits are reduced by the amount of all Other Benefits for that month.

OTHER BENEFITS — Other benefits include:

1. any amount which the Employee or his dependents receive on account of his disability under:
   a. any group or franchise insurance or similar plan for persons in a group:
   b. any local, state, provincial or federal government disability or retirement plan or law;
   c. any salary or wage continuance plan of the Employer;
   d. the Jones Act or any workers compensation, occupational disease or similar law including all permanent as well as temporary disability benefits;
   e. any work loss provision in the mandatory part of any "No-Fault" auto insurance policy;
2. any disability or Old Age benefits under the Federal Social Security Act which the Employee receives or is assumed to receive* on his own behalf;
3. any disability or Old Age benefits under the Federal Social Security Act which the Employee receives or is assumed to receive* on behalf of his dependents or which his dependents receive or are assumed to receive* on account of the Employee's receipt or assumed receipt* of such benefits; and
4. any retirement benefits which the Employee receives under a Retirement Plan funded in whole or in part by the Employer.

*See the assumed Receipt of Social Security Benefits provision.

INCREASES IN OTHER BENEFITS — The Company will not consider any cost of living increase in any Other Benefits which is effective after:

1. the first payment of such Other Benefit becomes due; and
2. Monthly Benefits become payable under the policy.

ASSUMED RECEIPT OF SOCIAL SECURITY BENEFITS — If an Employee is covered under the Federal Social Security Act for any disability or Old Age benefits for himself and his dependents, if applicable, he will be assumed to be receiving such benefits. These assumed benefits will be in an amount the Insurance Company estimates he and his dependents, if applicable is eligible to receive. This assumption will not be made if the Employee gives the Company proof that:

1. he has applied for these benefits; and
2. payments were denied.

However, if payments for disability were denied solely because the disability was not expected to last at least 12 consecutive months, the Employee will be assumed to be receiving such benefits after his disability has continued for 12 consecutive months. This assumption will not be made if he gives the Company proof that:

1. he has reapplied for benefits; and
2. payments were again denied.

LUMP SUM PAYMENTS — Any Other Benefits paid in a lump sum except as shown below will be deemed to be paid in monthly amounts prorated over the time for which the sum was paid. If no such time is stated, the lump sum will be prorated monthly over the expected life span of the Employee. The Company will determine that expected life span.

Lump Sum Payments under:

1. a Retirement Plan will be deemed to be paid in the monthly amount which:
   a. is provided by the standard annuity option under the Plan, as identified by the Policyholder; or
   b. is prorated under a standard annuity table over the expected life span of the Employee if the Plan does not have a standard annuity option;
2. the Jones Act or any workers compensation, occupational disease or similar law which includes

benefits paid under a Compromise and Release will be deemed to be paid monthly:

a. at the rate stated in the award;

b. at the rate paid prior to the lump sum if no rate is stated in the award; or

c. at the maximum rate set by the law if no rate is stated and the Employee did not receive a periodic award.

RECOVERY OF OVERPAYMENTS — If the Monthly Benefit for any month is overpaid, the Company will have the right to recover the amount overpaid by either of the following methods:

1. a deduction of the overpaid amount from any future payments by the Company;

2. a lump sum repayment by the Employee of the overpaid amount.

REHABILITATION BENEFIT — The Monthly Benefit for any month during which the Employee engages in Rehabilitative Work will be reduced by 50% of the amount which the Employee earns from that Rehabilitative Work during that month.

The Rehabilitation Benefit will continue until the earlier of the following dates:

1. the date the Employee ceases to be engaged in Rehabilitative Work;

2. the date Monthly Benefits are no longer payable.

The Company will, from time to time, review the Employee's status and may require an account of his earnings and proof of his continued Total Disability.

INSURING PROVISIONS LONG TERM DISBILITY BENEFITS

COMMENCEMENT OF BENEFITS — The Company will begin paying Monthly Benefits in amounts determined from The Schedule when it receives due proof that:

1. the Employee became Totally Disabled while insured for this Long Term Disability Insurance; and

2. his Total Disability has continued for a period longer than the Benefit Waiting Period shown in The Schedule.

DURATION OF MONTHLY BENEFITS — The Company will stop paying Monthly Benefits on the earliest following date:

1. the date the Employee ceases to be Totally Disabled;

2. the Employee's 65th birthday if he becomes Totally Disabled before his 60th birthday;

3. the earlier of the following dates if the Employee becomes Totally Disabled on or after his 60th birthday but before his 69th birthday;

   a. the end of 5 years from the date the Employee becomes Totally Disabled;

   b. the Employee's 70th birthday or, if 12 Monthly benefits have not become payable as of that date, the date the 12th Monthly Benefit is payable;

4. the date the 12th Monthly Benefit is payable if the Employee becomes Totally Disabled on or after his 69th birthday.

SUCCESSIVE PERIODS OF DISABILITY — Separate periods of Total Disability resulting from the same or related causes will be considered one period of Total Disability unless separated by the Employee's return to Active Service for at least (6) consecutive months.

Separate periods of Total Disability resulting from unrelated causes will be considered one period of Total Disability unless separated by the Employee's return to Active Service for at least one full day.

These provisions do not apply:

1. to the Benefit Waiting Period; or

2. when the Employee becomes eligible for benefits under any other group long term disability policy.

MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE LIMITATION — The Company will pay Monthly Benefits for no more than 24 months during an Employee's lifetime for Total Disability caused or contributed to by mental illness, alcoholism or drug abuse while the Employee is not confined in a hospital. An Employee will be considered confined in a hospital only if he is confined continuously for at least 14 days in a hospital licensed to provide care and treatment for the condition causing the Total Disability.

PRE-EXISTING CONDITION LIMITATION — The Company will not pay Monthly Benefits for any period of Total Disability which results directly or indirectly from an Injury or Sickness for which the Employee during the 3 months prior to the most recent effective date of his insurance: (1) incurred expenses; (2) received medical treatment; (3) took prescribed drugs or medicines; or (4) consulted a physician. This limitation will not apply to a period of Total Disability which begins more than 12 months after the most recent effective date of the Employee's insurance.

CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITION LIMITATION — The Pre-existing Condition Limitation will be waived for an Employee who was insured on the day before the Effective Date of this policy under a group long term disability policy: (a) sponsored by the Employer, and (b) replaced by this policy, provided such Employee:

1. is in Active Service on the Effective Date of this policy; and

2. has fulfilled the requirements of any Pre-existing Condition Limitation of the replaced policy.

However, if such Employee:

1. is in Active Service on the Effective Date of this policy; and

2. has not fulfilled the requirements of any Pre-existing Condition Limitation of the replaced policy because the time period required from the start of Total Disability has not been satisfied,

any portion of time which may have been satisfied under such Pre-existing Condition Limitation will be applied toward the satisfaction of that time period requirement of the Pre-existing Condition Limitation of this policy.

If Monthly Benefits are determined to be payable, they will be paid according to the provisions of this policy.

DISABILITIES NOT COVERED — No Monthly Benefits will be paid if the Employee's Total Disability results, directly or indirectly, from:

1. Injuries intentionally self-inflicted while sane or insane;

2. any act or hazard of a declared or undeclared war;

No Monthly Benefits will be paid for a period of Total Disability when the Employee is not under the care of a licensed physician.

TERMINATION OF INSURANCE

The insurance on an Employee will cease on the earliest date below:

1. the date the Employee ceases to be in a Class of Eligible Employees or ceases to qualify as an Employee;

2. the date this policy is cancelled;

3. the date the Employee's Active Service ends, except as set forth below:

   a. If the Employee's Active Service ends due to Total Disability for which Monthly Benefits are or may become payable, the insurance will continue while that Total Disability continues during the Benefit Waiting Period and thereafter but only for as long as Monthly Benefits are payable.

   b. If the Employee returns to Active Service in a Class of Eligible Employees as soon as Total Disability ceases, the insurance will be reinstated when the Company pays the premium for him.

EXTENSION OF BENEFITS AFTER CANCELLATION

Payment of Monthly Benefits will not be affected by cancellation of this policy as long as the Total Disability begins while this policy is in force.

CANCELLATION OF POLICY

NOTICE OF CANCELLATION — The Company may cancel the policy by giving written notice at least (31) days in advance of the cancellation date.

PAYMENT OF BENEFITS

TO WHOM PAYABLE — Any benefits that are payable for disability will be paid to the Employee. Family Benefits, if any, will be paid to the eligible survivor(s) according to the terms of that section.

If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, the Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any of his disability benefits remain unpaid, the Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters, or the executors or administrators of the Employee's estate.

Payment in the manner described above will release the Company from all liability to the extent of any payment made.

TIME OF PAYMENT — Any disability benefits will be paid at regular intervals or not more than one month. Any balance which remains unpaid at the end of any period for which the Company is liable will be paid at that time.

GENERAL PROVISIONS

ENTIRE CONTRACT — The entire contract will be made up of the policy and the applications, if any, of the Employees.

POLICY CHANGES — Changes may be made in the policy only by amendment signed by the Company acting through its President, Vice-President, Assistant Vice-President or Director.

STATEMENTS NOT WARRANTIES — All statements made by an insured Employee will, in the absence

of fraud, be deemed representations and not warranties. No statement made by the Employee will be used to void or reduce the insurance unless it is made in writing and is signed by the Employee and a copy is sent to the Employee or his Beneficiary.

NOTICE OF CLAIM — Written notice of claim must be given to the Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS — When the Company receives the notice of claim, it will give to the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS — Written proof of loss must be given to the company within 90 days after the date of the loss which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible. Upon request, written proof of continued Total Disability and of regular attendance of a physician must be given to the Company within 30 days of such request.

PHYSICAL EXAMINATION — The Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

LEGAL ACTIONS — No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS — If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

PHYSICIAN/PATIENT RELATIONSHIP — The Employee will have the right to choose any physician who is practicing legally. The Company will in no way disturb the physician/patient relationship.

CERTIFICATES — The Company will issue to each insured Employee an individual certificate. The certificate will show the benefits provided under the policy. It will set forth any changes in benfits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

MISCELLANEOUS PROVISIONS

MALE PRONOUN — The male pronoun as used herein will be deemed to include the female.

NOT IN LIEU OF WORKERS' COMPENSATION — The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

LONG TERM DISABILITY FOR FULL TIME REGULAR QUALIFYING EMPLOYEES

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY

LONG TERM DISABILITY

PLAN

The Long Term Disability Plan is an employee benefit that Golden State Mutual provides to protect the financial welfare of career employees in cases of extended illness.

ELIGIBILITY

All full-time regular qualifying employees with five or more years of continuous service are eligible to participate in the Plan. Employees are automatically enrolled after five years of service.

BENEFITS

The LTD benefit is based on an established monthly amount minus an offset of any social security or disability benefit that the employee may receive. Periodic submission of a Gsm disability claim and medical verification of the disability is required for continued benefits.

INTENT

The LTD Plan is basically an extension of the GSM Sick Leave Program for tenured qualified employees. Benefits may be provided to the disabled employee until the disability ends, the employee returns to work, attains age 65 or elects to retire.

LONG TERM DISABILITY CERTIFICATE OF INSURANCE

POLICYHOLDER/EMPLOYER

Golden State Mutual Life Insurance Company

EFFECTIVE

The first day of the month on or next following the date the Employee becomes eligible for coverage. If an Employee is not actively at work on the eligible date, coverage will begin on the date when full time active work resumes.

ELIGIBILITY

All Employees who have completed five years of full time continuous employment with the Employer are eligible.

SCHEDULE OF BENEFITS

Employee Class	*Monthly Income Benefit*
Officers, Managers and Hourly & Salaried Employees	66 2/3 of the immediate monthly salary up to $3,000 Maximum
District Managers I	$1,000
District Managers II and Staff Managers	$750
Agents	The lesser of $600 or 80% of the average of the previous 12 months earnings

Long Term Disability benefit payments will stop as of the earlier of:

1. The day on which the employee is no longer totally disabled, or
2. The first day of the month following the employee's 65th birthday, or upon employee's retirement.

ELIMINATION PERIOD

Employee must be totally disabled for a period of six months before Long Term Disability benefits can begin.

Other Income Benefits

Benefits will be reduced by one or more of the following sources:

1. Payments from the Employer;
2. Any Group plan toward which the Employer shall have contributed or made payroll deductions;
3. Any Pension or Railroad Annuity;
4. The Federal Social Security Act;
5. The Railroad Retirement Act;
6. The Veteran Administration or any other Federal, State, Municipal or Governmental Agency; or
7. Any Worker's Compensation or Employer's Liability or similar law.

LIMITATIONS AND EXCLUSIONS

Benefits will not be paid for total disability:

1. due to war or any act of war, declared or undeclared;
2. incurred while in the armed services of any country or international authority;
3. resulting from self-inflicted injury or attempted suicide;
4. resulting from participation in a riot or the commission of a felony or assault, or engagement in an illegal occupation;
5. caused by an accident occurring or sickness commencing prior to the effective date of insurance;
6. due to mental or functional nervous disorder in excess of 24 months unless confined in a hospital; or
7. caused by or resulting from pregnancy.

TERMINATION OF INSURANCE

An employee's insurance shall automatically terminate upon the earliest of the following dates:

1. The date the Policy terminates;
2. The date of the employee's termination of employment with the employer; or
3. The date the employee is ineligible for insurance coverage.

NOTICE OF PROOF OF CLAIM AND EXAMINATION

Written notice of claim must be given to the Home Office Claims Department within 20 days of the date of commencement of the first loss for which benefits may be claimed or as soon thereafter as is reasonably possible.

The Company will furnish claim forms to the employee within 15 days after receipt of the notice of claim. In event of failure to supply claim forms within the prescribed time, written proof may be submitted covering the occurrence, character and extent of loss. This will be sufficient for proof of loss if furnished the Company not later than 90 days after the date of commencement of such loss.

INDEPENDENT MEDICAL EXAMINATIONS

The Company shall have the right and opportunity to require independent medical examinations of any employee whose illness is the basis of a claim, as it may reasonably require during the period of such claim.

PAYMENT OF CLAIM

Is subject to proof of loss. The accrued monthly benefits will be paid each month during any period for which the Company is liable upon receipt of due proof. Any balance remaining unpaid at the termination of such period will be paid immediately.

THE BENEFITS DESCRIBED IN THIS CERTIFICATE ARE SUBJECT TO THE GROUP POLICY ISSUED TO THE POLICYHOLDER. THE BENEFITS AND PROVISIONS APPLICABLE TO THE INSURED EMPLOYEE ARE DESCRIBED IN THIS CERTIFICATE AND ARE EFFECTIVE ONLY IF THE EMPLOYEE IS ELIGIBLE FOR THE INSURANCE.

EXHIBIT 12

AMERITAS LIFE INSURANCE CORP.
A UNIFI Company

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**GOLDEN STATE MUTUAL LIFE INSURANCE CO**		
		Policy Number	**10-9694**
State of Delivery	**California**	**Plan Effective Date**	**October 1, 1982**
		Plan Change Effective Date	**September 1, 2005**
Premium Due Date 1st of each month.		**Renewal Date**	**September 1, 2008**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

AMERITAS LIFE INSURANCE CORP.

Jan M. Connolly
Secretary

JoAnn M Martin
President

IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, please contact your agent or feel free to contact us at the following:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1-800-366-5933

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)

California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Guarantee Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

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

Policyholders with additional questions should first contact their insurer or agent or may then contact

Executive Director California Life and Health Insurance Guarantee Association P.O. Box 17319 Beverly Hills, CA 90209-3319	or	Alegra Willison, Staff Counsel California Department of Insurance 45 Fremont Street, 24th Floor San Francisco, CA 94105

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

(please turn over)

* Their insurer was not authorized to do business in this state when it issued the policy or contract:

* Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

* They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

* Unallocated annuity contract; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;

* Employer and association plans, to the extent they are self funded or uninsured;

* Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

* Any policy of reinsurance unless an assumption certificate was issued;

* Interest rate yields that exceed an average rate;

* Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

* 80% of what the life insurance company would owe under a policy or contract up to

* $100,000 in cash surrender values,

* $100,000 in present value of annuities, or

* $250,000 in life insurance death benefits.

* A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

* A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

Thank you for choosing Ameritas Group for your dental care coverage. As a member, you always have complete freedom of choice in choosing your dental provider; however, by choosing a PPO network provider, you may reduce your out-of-pocket expenses due to the discounted fees on covered dental procedures.

Please read the following information so you will know from whom or what group of providers dental care may be obtained.

For the most current and complete provider listing and information, please visit the ***Plan Member*** section of our website, **www.ameritasgroup.com** and click on the ***Find a Provider*** tab. Additional information available online includes driving directions to the provider's office and how to nominate a dentist or specialist for our network.

If you do not have access to the Internet and are in need of dental participating provider information, contact our provider relations department at 1-800-755-8844.

For questions regarding your dental benefit coverage, contact our customer relations department at 1-800-487-5553 Monday-Thursday, 7:00am - midnight and Friday, 7:00am - 6:30 pm Central Time.

When scheduling your appointment, please verify the provider is an active network participant.

TABLE OF CONTENTS

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 1	All Eligible Employees

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:

When a Participating Provider is used:
Combined Type 1, Type 2, and Type 3 Procedures - Each Benefit Period $60

When a Non-Participating Provider is used:
Combined Type 1, Type 2, and Type 3 Procedures - Each Benefit Period $60

Maximum Deductible per Benefit Period $60

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required.

If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and

ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, 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. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	90%	80%
Type 2 Procedures	90%	80%
Type 3 Procedures	55%	50%

When a Non-Participating Provider is used:
Maximum Amount - Each Benefit Period $1,000

When a Participating Provider is used:
Maximum Amount - Each Benefit Period $1,000

INCREASED DENTAL MAXIMUM BENEFIT

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

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

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

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

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

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	$35.32 per Insured Person
	$47.24 per Dependent Unit

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 12 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

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

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

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

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

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner.

b. each unmarried child less than 19 years of age, for whom the Insured, the Insured's spouse, or the Insured's Registered Domestic Partner is legally responsible, 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.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured, the Insured's spouse, or the Insured's Registered Domestic Partner for support and maintenance.

d. each unmarried child age 19 or older 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.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 36 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 36 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

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

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur following the eligibility period of 6 month(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

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

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

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

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

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

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

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

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

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

Labor Dispute
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

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 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.

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.

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

may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

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

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

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

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

2. for 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 insured person 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.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

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

TABLE OF DENTAL PROCEDURES

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

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

- 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 X-ray films, 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 - Usual and Customary

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.

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 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.

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.

MISCELLANEOUS

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

TYPE 1 PROCEDURES

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

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
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.

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.

BITEWING FILMS

D0270 Bitewing - single film.
D0272 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.

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.

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 2 PROCEDURES

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, 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.

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

- 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.
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, 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 Sedative filling.

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

TYPE 2 PROCEDURES

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 elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
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).

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.
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.

TYPE 2 PROCEDURES

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.
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 (frenectomy or frenotomy) - separate procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

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 films.

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

- 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.

MISCELLANEOUS

D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

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.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic substrate.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

TYPE 3 PROCEDURES

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- 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.
D6973 Core build up for retainer, including any pins.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

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.
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 - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, 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.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Anterior (excluding final restoration).
D3320 Bicuspid (excluding final restoration).
D3330 Molar (excluding final restoration).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.

TYPE 3 PROCEDURES

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 films 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 films and cultures but exclude final restoration.

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 bounded teeth spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth 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.
D4271 Free soft tissue graft procedure (including donor site surgery).
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.

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, D4271, D4273, D4275, D4276
- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

TYPE 3 PROCEDURES

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).
- 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

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

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.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

TYPE 3 PROCEDURES

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.

TYPE 3 PROCEDURES

D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6600 Inlay - porcelain/ceramic, two surfaces.
D6601 Inlay - porcelain/ceramic, three or more surfaces.
D6602 Inlay - cast high noble metal, two surfaces.
D6603 Inlay - cast high noble metal, three or more surfaces.
D6604 Inlay - cast predominantly base metal, two surfaces.
D6605 Inlay - cast predominantly base metal, three or more surfaces.
D6606 Inlay - cast noble metal, two surfaces.
D6607 Inlay - cast noble metal, three or more surfaces.
D6608 Onlay - porcelain/ceramic, two surfaces.
D6609 Onlay - porcelain/ceramic, three or more surfaces.
D6610 Onlay - cast high noble metal, two surfaces.
D6611 Onlay - cast high noble metal, three or more surfaces.
D6612 Onlay - cast predominantly base metal, two surfaces.
D6613 Onlay - cast predominantly base metal, three or more surfaces.
D6614 Onlay - cast noble metal, two surfaces.
D6615 Onlay - cast noble metal, three or more surfaces.
D6624 Inlay - titanium.
D6634 Onlay - titanium.
D6710 Crown - indirect resin based composite.
D6720 Crown - resin with high noble metal.
D6721 Crown - resin with predominantly base metal.
D6722 Crown - resin with noble metal.
D6740 Crown - porcelain/ceramic.
D6750 Crown - porcelain fused to high noble metal.
D6751 Crown - porcelain fused to predominantly base metal.
D6752 Crown - porcelain fused to noble metal.
D6780 Crown - 3/4 cast high noble metal.
D6781 Crown - 3/4 cast predominantly base metal.
D6782 Crown - 3/4 cast noble metal.
D6783 Crown - 3/4 porcelain/ceramic.
D6790 Crown - full cast high noble metal.
D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- 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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- 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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.

D6972 Prefabricated post and core in addition to fixed partial denture retainer.

OTHER ORAL SURGERY

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

D7311 Alveoplasty 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.

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).

D7471 Removal of lateral exostosis (maxilla or mandible).

D7472 Removal of torus palatinus.

TYPE 3 PROCEDURES

D7473 Removal of torus mandibularis.
D7485 Surgical reduction of osseous tuberosity.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

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.

TYPE 1 PROCEDURES

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.

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 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.

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.

MISCELLANEOUS

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

TYPE 1 PROCEDURES

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

TYPE 2 PROCEDURES

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.

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.

BITEWING FILMS

D0270 Bitewing - single film.
D0272 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.

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.

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 2 PROCEDURES

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, 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.

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

- 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.
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, 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 Sedative filling.

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

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

TYPE 2 PROCEDURES

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 elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
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).

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.
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.

TYPE 2 PROCEDURES

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.
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 (frenectomy or frenotomy) - separate procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

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 films.

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

- 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.

MISCELLANEOUS

D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

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.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic substrate.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

TYPE 3 PROCEDURES

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- 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.
D6973 Core build up for retainer, including any pins.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

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.
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 - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, 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.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Anterior (excluding final restoration).
D3320 Bicuspid (excluding final restoration).
D3330 Molar (excluding final restoration).

TYPE 3 PROCEDURES

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 films 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 films and cultures but exclude final restoration.

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 bounded teeth spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth 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.
D4271 Free soft tissue graft procedure (including donor site surgery).
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.

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, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

D4249 Clinical crown lengthening - hard tissue.

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

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.

TYPE 3 PROCEDURES

D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.

TYPE 3 PROCEDURES

D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6600 Inlay - porcelain/ceramic, two surfaces.
D6601 Inlay - porcelain/ceramic, three or more surfaces.
D6602 Inlay - cast high noble metal, two surfaces.
D6603 Inlay - cast high noble metal, three or more surfaces.
D6604 Inlay - cast predominantly base metal, two surfaces.
D6605 Inlay - cast predominantly base metal, three or more surfaces.
D6606 Inlay - cast noble metal, two surfaces.
D6607 Inlay - cast noble metal, three or more surfaces.
D6608 Onlay - porcelain/ceramic, two surfaces.
D6609 Onlay - porcelain/ceramic, three or more surfaces.
D6610 Onlay - cast high noble metal, two surfaces.
D6611 Onlay - cast high noble metal, three or more surfaces.
D6612 Onlay - cast predominantly base metal, two surfaces.
D6613 Onlay - cast predominantly base metal, three or more surfaces.
D6614 Onlay - cast noble metal, two surfaces.
D6615 Onlay - cast noble metal, three or more surfaces.
D6624 Inlay - titanium.
D6634 Onlay - titanium.
D6710 Crown - indirect resin based composite.
D6720 Crown - resin with high noble metal.
D6721 Crown - resin with predominantly base metal.
D6722 Crown - resin with noble metal.
D6740 Crown - porcelain/ceramic.
D6750 Crown - porcelain fused to high noble metal.
D6751 Crown - porcelain fused to predominantly base metal.
D6752 Crown - porcelain fused to noble metal.
D6780 Crown - 3/4 cast high noble metal.
D6781 Crown - 3/4 cast predominantly base metal.
D6782 Crown - 3/4 cast noble metal.
D6783 Crown - 3/4 porcelain/ceramic.
D6790 Crown - full cast high noble metal.
D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

TYPE 3 PROCEDURES

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- 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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.

D6972 Prefabricated post and core in addition to fixed partial denture retainer.

OTHER ORAL SURGERY

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

D7311 Alveoplasty 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.

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).

TYPE 3 PROCEDURES

D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Surgical reduction of osseous tuberosity.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

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.

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, trusteed 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 (TitleXVIII 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 coverage.

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

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

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

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

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

1. Release any information with respect to your coverage and benefits under the policy; and

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	199

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

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

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

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

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

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

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

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it. We will provide you written notice regarding the payment under the claim within at least 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

REVIEW PROCEDURE

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within at least 60 days after we receive your request for review we will send you a written decision on review.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgement we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for claim review should be sent to:

Quality Control, P.O. Box 82629, Lincoln, NE 68501-2629.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: GOLDEN STATE MUTUAL LIFE INSURANCE CO

whose main office address is: 1999 W ADAMS BLVD
LOS ANGELES, CA 90018-3514

for Group Policy No. 10-9694

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

GOLDEN STATE MUTUAL LIFE INSURANCE CO

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

PROOF OF SERVICE

STATE OF CALIFORNIA)
) **ss.**
COUNTY OF LOS ANGELES)

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 777 S. Figueroa Street, Suite 4950, Los Angeles, California 90017.

On June 17, 2010, I served the following document described as: **CONSERVATOR'S REPLY MEMORANDUM IN SUPPORT OF HIS MOVING PAPERS AND APPLICATION RE: ORDER TO SHOW CAUSE AND FOR ORDERS APPROVING REHABILITATION PLAN OF GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY AND AUTHORIZING CONSERVATOR TO ENTER INTO RELATED AGREEMENTS WITH IA AMERICAN LIFE INSURANCE COMPANY:(1) AGREEMENT AND PLAN OF REHABILITATION; (2) ASSUMPTION REINSURANCE AGREEMENT**; (3) SERVICE AGREEMENT; AND (4) NOVATION AGREEMENT, by placing [ ] the original [X] a true copy thereof **(as indicated on the attached service list)** enclosed in a sealed envelope(s) addressed as follows: **SEE ATTACHED SERVICE LIST,**

[] **By Mail.** I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation or postage meter date is more than one day after date of deposit for mailing in affidavit.

[ ] **By Fax.** I transmitted the foregoing document by telecopier transmission to the addressee(s) at the facsimile number(s) listed on the attached Service List, and received confirmation that the transmission was received at the facsimile number(s) listed on the attached Service List.

[ ] **By Personal Service.** I caused such envelope(s) to be personally delivered via messenger service to the addressee(s) indicated on the attached Service List.

[ ] **By Email.** I forwarded a copy of the above-described document(s) via e-mail to each of the individuals set forth above at the email addresses indicated therefor.

[X] **By Federal Express.** I caused such envelope(s) to be deposited at a facility regularly maintained by FedEx at 777 S. Figueroa Street, Los Angeles, California 90017, with arrangements made for payment in full of the required charges, to the party(ies) listed on the attached Service List.

Executed on **June 17, 2010,** at Los Angeles, California.

[✓] (State) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

[ ] (Federal) I am employed by a member of the Bar of the State of California. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Mary Ellen Bolton

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY

SERVICE LIST

Ms. Lisa Von Eschen
Abelson Herron LLP
333 South Grand Avenue, Suite 1550
Los Angeles, CA 90071
Counsel for Community Impact Development/Dudley Ventures

Pension Benefit Guaranty Corporation
Attn: Jon Chatalian
1200 K Street NW
Washington D.C. 20005

Austin C. Moore, III, CLU
President
Golden State Mutual Life Alumni Association
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