

Group Dental Benefits

**Northwest Plan
Administrators, Inc.**

Freedom Schedule

G778

**CERTIFICATE OF
GROUP INSURANCE**

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Northwest Plan Administrators, Inc.

Policy Number: G778

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

Michael J Peninger

Executive Vice President

SCHEDULE

Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

Eligible Class:

For employee insurance - Each full time employee of the policyholder or an associated company:

- who is at active work, and
- who is working in the United States of America, except any temporary or seasonal worker.

For dependent insurance - Each person eligible and insured for employee insurance.

Associated Companies: None

Service Requirement:

On July 1, 2003: 90 days

After July 1, 2003: 90 days

Entry Date

Insurance will take effect on the later of (i) the date shown below, and (ii) the first of the month occurring on or after the day all eligibility requirements are met.

Effective Date of Insurance

July 1, 2003 (Subject to Entry Date)

SCHEDULE

Dental Insurance

Deductible Amount

Individual Deductible Amount Per *Policy Year* \$ 50

Individual Deductible Amount for Type IV Services per *Policy Year* None

The Individual Deductible does not apply to Type I Dental Services

Coinsurance Percentages

Type IV Services 50 %

Benefit Maximums:

Policy Year Maximum \$ 1000

Overall Benefit Maximums Type IV Services \$ 1000

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Discounts on dental care products are available. Please visit the For Members site at www.assurantemployeebenefits.com for details.

Waiting Periods

There are waiting periods which must be fulfilled before benefits will be payable for specified dental services. Please see Waiting Periods for Insured Persons Generally under the Special Limitations provision and the detailed list of waiting periods shown below.

TYPE III DENTAL SERVICES **

All Services 6 months

** These Waiting Periods for Type III Dental Services do not apply to Covered Dental Services for dentally necessary treatment of an accidental non-chewing injury sustained while insured; or Re-cementing of or repairs to inlays, onlays, crowns, or fixed partial dentures.

Type IV Dental Services

All Services (Orthodontic Services) 12 months

Note: Type IV Dental Services available only to dependent children who are under age 19.

Plan Changes

You may change your plan of insurance only during the annual enrollment period agreed upon by the *policyholder* and us, unless you undergo a change in family status. A plan change made during the annual enrollment period will take effect on the next following *policy* anniversary.

You may change your plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request.

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the termination of employment of your spouse.

The "Waiting Period for Insured Persons Generally" provision will apply to changes made during an annual enrollment period and changes made due to change in family status.

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns we, us, our, you, and your are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered dependent means an *eligible dependent* who is insured under the *policy*.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Full-time means working at least 30 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily *injury*. It does not mean intentionally self-inflicted *injury* while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group *policy* issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us and our mean Union Security Insurance Company.

You and your mean an employee or member of the *policyholder* or an *associated company* who has met all the eligibility requirements for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Accidental non-chewing injury means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Benefit year means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a dentist within the scope of that license in treating the dental condition.

Dental insurance means the group dental insurance under the policy issued by us to the policyholder.

Dentally necessary and *dental necessity* mean a service or *treatment* which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the dentist's report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required by us.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Emergency dental treatment means any *dentally necessary* treatment that is rendered as the direct result of unforeseen events or circumstances which require prompt attention.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Orthodontic treatment means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a persons ability to chew food) of the mouth. We will make the determination of the severity of the malocclusion.

Other group dental expense coverage means:

DEFINITIONS FOR DENTAL INSURANCE (continued)

- Any other group *policy* providing benefits for dental expenses; or
- Any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Policy year means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

Sound tooth means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Usual or customary (UC) charge means:

- Usual Charge is the fee regularly charged for a service or supply to the majority of a *dentists* patients and accepted as payment in full by an individual dental office. If more than one fee is charged, the fee determined to be the usual fee will not be greater than the lowest fee which is regularly charged or offered to patients.
- Customary Charge is the fee for a given service or supply which, as determined by us, does not exceed the amount ordinarily charged by the majority of *dentists* in the locality. Locality is either a county or such geographically significant area as is necessary to establish a representative base of charges for the type of service for which the charge is made. The customary charge is determined based upon the 90th percentile of data provided by an independent outside organization.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your unmarried children who are less than age 19, or less than age 25 if a full-time student.

"Children" include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the *policy* anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;
- the day a required contribution for dependent insurance was not paid; or
- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

Students

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date the child is no longer a student until the earliest of:

- the end of the 3rd calendar month following the month in which the child is no longer a student;
- the child's 25th birthday; and
- the date the child becomes eligible for other group dental expense coverage.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may have the right to continue dental insurance coverage beyond the date insurance would otherwise terminate. You should contact the policyholder concerning your right to continue coverage.

SPECIAL DENTAL CONTINUANCE PROVISIONS

These provisions apply after the expiration of any continuance available under the Consolidated Omnibus Budget Reconciliation Act.

Your spouse and any covered dependent may continue coverage under the policy if:

- you die; or
- you divorce or legally separate from your spouse.

Your spouse must be age 55 or more at the time of your death, divorce, or legal separation.

Notice

Within 60 days of legal separation or the entry of a decree of dissolution of marriage, a legally separated or divorced spouse must give the plan administrator written notice of the separation or dissolution and include the mailing address.

Within 30 days of your death, the policyholder must give the plan administrator written notice of your death and of the mailing address of the surviving spouse.

Within 14 days after receiving notice as described above, the plan administrator must notify the spouse that the insurance may be continued. The notice must include:

- a form for election to continue coverage;
- a statement of the amount of premiums to be charged and the method and place of payment; and
- instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

If the spouse does not elect coverage as described above, the right to continue coverage will end.

If the plan administrator does not notify the spouse as described above, premiums will be waived from the date the notice was required until the date notice is received by the spouse.

Premium

The first premium must be paid within 45 days after the date continued coverage is elected. The premium charged will not exceed 102% of the premium which would have applied if the spouse were a covered person.

When Continuance Ends

Insurance will end on the earliest of the following:

- the end of the grace period if premiums are not paid when due;
- the date the policy ends, unless another group policy is made available to the persons covered under this policy;
- the date the spouse becomes insured under any other group dental expense coverage; or
- the date the spouse becomes eligible for Medicare.

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay up to the Maximum Covered Expense shown in the Listing of Covered Dental Services after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of *dental treatment* already in progress on the effective date of a person's insurance. No payment will be made for *dental treatment* completed after your or a *covered dependent's* insurance under the policy ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a policy year before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*.

Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent.

Date Started and Date Completed

We consider a *dental treatment* to be started as follows:

- for a full or partial denture, the date the first impression is taken;
- for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other *treatment*, the date *treatment* is rendered.

We consider a *dental treatment* to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

(See Type IV Dental Services for start and completion dates for *orthodontic treatment*)

DENTAL INSURANCE (continued)

Pre-estimate

Whenever the expected cost of a *treatment* exceeds \$300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed \$300 in cost.

In addition to a *dental treatment plan*, before *orthodontic treatment* begins we may request any of the following information to help determine benefits payable for orthodontic services:

- full mouth dental X-rays;
- cephalometric X-rays and analysis;
- diagnostic casts (study models); and
- a statement specifying:
 - degree of overjet, overbite, crowding and open bite;
 - whether teeth are impacted, in crossbite, or congenitally missing;
 - length of *orthodontic treatment*; and
 - total orthodontic treatment charge.

Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the Maximum Covered Expense for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your dentist may decide on a more costly procedure or material than we have determined to be satisfactory for the treatment of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses include only the lesser of the dentist's actual charge or the Maximum Covered Expense for expenses incurred by you or a covered dependent. The treatment must be:

- performed by or under the direction of a dentist, or performed by a dental hygienist or dentist;
- dentally necessary; and
- started and completed while you or your covered dependent are insured, except as otherwise provided in the Limited Benefits for Transfer Insureds Services Started Under Prior Plan (if

DENTAL INSURANCE (continued)

applicable) and Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for treatment that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary treatment to be an integral part of the final treatment. The sum of the fees for temporary and final treatment will be used to determine whether the charges are more than the Maximum Covered Expense.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate treatment of your or your covered dependents dental condition according to broadly accepted standards of professional dental care as determined by us.

Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

- Minor Periodontics
 - Adjunctive Periodontal Service
 - Provisional Splinting - covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting.
 - Scaling and Root Planing - no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the usual or customary charge for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the usual or customary charge for periodontal maintenance.
 - Occlusal Adjustment - no more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).
- Other Periodontal Services
 - Periodontal Maintenance - no more than 1 time in any 6 months in a row. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction. (Frequencies combined with prophylaxis.)

TYPE I DENTAL SERVICES

DENTAL INSURANCE (continued)

DENTAL SERVICE NUMBER		MAXIMUM COVERED EXPENSE
D0120	Periodic Oral Evaluation	\$20
D0140	Limited Oral Evaluation	\$20
D0150	Comprehensive Oral Evaluation	\$30
D0160	Detailed and Extensive Oral Evaluation	\$30
	One evaluation will be allowed in a 6 month period.	
D1110	Prophylaxis - (Adult) age 14 years and over	\$41
D1120	Prophylaxis - (Child) under age 14	\$30
	One prophylaxis will be allowed in a 6 month period.	
D1203	Topical fluoride (separate code) in conjunction with prophylaxis	\$16
	One fluoride will be allowed in a 12 month period. Only for children under age 14 years	
D1351	Sealant - per tooth	\$24
	Sealants are allowed only 1 time per tooth per person. Only for permanent molar teeth. only for children under age 16 years.	
D1510	Space Maintainer - fixed - unilateral	\$150
D1515	Space Maintainer - fixed - bilateral	\$236
D1520	Space Maintainer - removable - unilateral	\$293
D1525	Space Maintainer - removable - bilateral	\$264
	Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.	
D8210	Harmful Habit Appliance removable	\$195
D8220	Harmful Habit Appliance fixed.	\$195
	Appliance is limited to once per person and only for children under age 16 years.	

TYPE II DENTAL SERVICES

DENTAL SERVICE NUMBER		MAXIMUM COVERED EXPENSE
<u>X-RAYS</u>		
D0210	Complete series, including bitewings	\$44
	Only one of these procedures will be allowed in a 60-month period. A complete mouth series is deemed to include bitewing x-rays and 10 or more periapical x-rays; or	
D0330	Panoramic film	\$36
	Payable only in connection with the removal of impacted teeth.	

DENTAL INSURANCE (continued)

D0220	Periapical film	\$8
D0230	Additional periapical film, each	\$8
	No more than 4 x-rays in any 12 months in a row	
D0240	Intraoral, occlusal film	\$13
	No more than 2 films in any 12 months in a row.	
D0250	Extraoral, first film	\$13
D0260	Extraoral, each additional film.	\$13
	No more than 2 films in any 12 months in a row.	
D0270	Bitewing, single film	\$8
D0272	Bitewings, two films	\$13
D0274	Bitewings, four films	\$19
	Bitewings are allowed only if more than 12 months have passed since a full mouth series or bitewing x-rays were taken.	

MISCELLANEOUS PROCEDURES

D0415	Bacteriologic studies	\$7
D0474	Accession of tissue, gross and microscopic examination-including assessment of surgical margins.	\$50
D9110	Palliative (Emergency) treatment of dental pain	\$30
	Deemed to be a separate Covered Dental Service only if no other Service is rendered during the visit, except x-rays.	
D9610	Therapeutic Drug Injections	\$17

RESTORATIVE (EXCLUDING INLAYS, CROWNS)

Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.

D2140	Amalgam - one surface, primary or permanent	\$36
D2150	Amalgam - two surfaces, primary or permanent	\$42
D2160	Amalgam - three surfaces, primary or permanent	\$55
D2161	Amalgam - four or more surfaces, primary or permanent	\$66

Multiple amalgam restorations on one surface are deemed to be a single restoration for benefit purposes.

DENTAL INSURANCE (continued)

D2330	Resin - one surface, anterior	\$36
D2331	Resin - two surfaces, anterior	\$42
D2332	Resin - three surfaces, anterior	\$55
D2335	Resin - four or more surfaces or involving incisal angle, anterior	\$66
D2390	Resin-based composite crown, anterior	\$94
D2391	Resin-based composite one service, posterior	\$36
D2392	Resin-based composite two surfaces, posterior	\$42
D2393	Resin-based composite three surfaces, posterior	\$55

Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal resin restorations on anterior teeth are deemed to be single surface restorations for benefit purposes.

D2410	Gold foil - one surface	\$36
D2420	Gold foil - two surfaces	\$42
D2430	Gold foil - three surfaces	\$55
D2951	Pin retention.	\$14

No more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.

MINOR ORAL SURGERY

D7111	Extraction coronal remnants deciduous tooth	\$39
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)	\$39
D7510	Incision and drainage of abscess intraoral soft tissue	\$57
D7520	Incision and drainage of abscess extraoral soft tissue	\$71

DENTAL INSURANCE (continued)

TYPE III DENTAL SERVICES

DENTAL SERVICE NUMBER		MAXIMUM COVERED EXPENSE
<u>ENDODONTICS</u>		
D3220	Pulpotomy (excluding final restoration), limited to treatment of primary teeth	\$47
D3310	Root Canal, anterior	\$215
D3320	Root Canal, bicuspid	\$251
D3330	Root Canal, molar	\$343
D3346	Retreatment of previous root canal therapy, anterior	\$215
D3347	Retreatment of previous root canal therapy, bicuspid	\$251
D3348	Retreatment of previous root canal therapy, molar	\$343

D3310 - D3348: benefits are limited to permanent teeth.
Allowance includes intraoperative films and cultures but excludes final restoration.

D3346 - D3348: service is deemed a covered dental service if more than two years have passed since the initial treatment.

D3351	Apexification/Recalcification - initial visit	\$51
D3352	Apexification/Recalcification - interim medication replacement	\$47
D3353	Apexification/Recalcification - final visit	\$329
D3410	Apicoectomy/Periradicular - anterior	\$228
D3421	Apicoectomy/Periradicular - bicuspid	\$251
D3425	Apicoectomy/Periradicular molar	\$268
D3426	Apicoectomy/Periradicular - each additional root	\$90
D3430	Retrograde filling - per root	\$56
D3450	Root amputation - per root	\$139
D3920	Hemisection (including any root removal)	\$118

PERIODONTICS

D4210	Gingivectomy - per quadrant	\$90
D4211	Gingivectomy - per tooth	\$28
D4240	Gingival flap procedure, including root planing, per quadrant	\$117
D4260	Osseous surgery (including flap entry and closure), per quadrant	\$211

D4210 - D4260 is allowed only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.

D4263	Bone replacement graft, first site in quadrant	\$211
D4264	Bone replacement grafts - each additional site in quadrant	\$98
D4270	Pedicle soft tissue graft procedure	\$156
D4271	Free soft tissue graft procedure	\$165
D4320	Provisional Splinting intracoronal	\$40
D4321	Provisional Splinting - extracoronal	\$45

Covered dental services do not include inlays, onlays, crowns, or other cast or laboratory prepared restorations made for the purpose of splinting

DENTAL INSURANCE (continued)

D4341	Scaling and root planing, per quadrant	\$45
	Scaling and root planing will be allowed no more than 1 time per area of the mouth in any 36 months in a row.	
D4910	Periodontal Maintenance	\$26
	Periodontal maintenance will be allowed no more than 1 time in any 6 months in a row. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth and oral hygiene instruction	
D7340	Vestibuloplasty - ridge extension	\$105
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$198
D9940	Periodontal appliance	
D9951	Occlusal adjustment, limited	\$98
D9952	Occlusal adjustment, complete	\$15
		\$59

Occlusal adjustment will be allowed no more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).

RESTORATIVE

D0470	Diagnostic Casts	\$17
	Diagnostic casts will be allowed no more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.	

DENTAL INSURANCE (continued)

D2510	Inlay - metallic - one surface	\$130
D2520	Inlay - metallic - two surfaces	\$130
D2530	Inlay - metallic - three surfaces	\$130
D2542	Onlay metallic -two surfaces	\$50
D2543	Onlay - metallic - three surfaces	\$50
D2544	Onlay - metallic - four or more surfaces	\$50
D2610	Inlay - porcelain/ceramic - one surface	\$130
D2620	Inlay - porcelain/ceramic - two surfaces	\$130
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$130
D2642	Onlay - porcelain/ceramic - two surfaces	\$50
D2643	Onlay - porcelain/ceramic - three surfaces	\$50
D2644	Onlay - porcelain/ceramic- four or more surfaces	\$50
D2650	Inlay - composite/resin - one surface	\$130
D2651	Inlay - composite/resin - two surfaces	\$130
D2652	Inlay - composite/resin - three surfaces	\$130
D2662	Onlay - composite/resin - two surfaces	\$50
D2663	Onlay - composite/resin - three surfaces	\$50
D2664	Onlay - composite/resin - four or more surfaces	\$50
D2710	Crown resin	\$59
D2720	Crown - resin with precious metal	\$200
D2721	Crown - resin with nonprecious metal	\$200
D2722	Crown - resin with semiprecious metal	\$200
D2740	Crown porcelain	\$200
D2750	Crown - porcelain with precious metal	\$200
D2751	Crown - porcelain with nonprecious metal	\$200
D2752	Crown - porcelain with semiprecious metal	\$200
D2780	Crown > cast with precious metal	\$200
D2781	Crown > cast with nonprecious metal	\$200
D2782	Crown > cast with semiprecious metal	\$200
D2783	Crown > porcelain	\$200
D2790	Crown - full cast precious metal	\$200
D2791	Crown - full cast with nonprecious metal	\$200
D2792	Crown - full cast with semiprecious metal	\$200

D2710-D2792: for children under age 16 years, covered dental services for crowns on vital teeth are limited to stainless steel or resin crowns.

D2910	Recement inlay	\$17
D2920	Recement crown	\$17
D2930	Stainless Steel Crown - primary tooth	\$45
D2931	Stainless Steel Crown - permanent tooth	\$48
D2932	Prefabricated Resin Crown	\$53

D2930 - D2932 is limited to children under 16 years.

D2950	Crown build-up	\$45
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Crown build-up will be allowed only under unusual circumstances when required for retention and preservation of the tooth. Service is deemed to include pins and/or prefabricated posts. Our decision is final for the purposes of determining covered dental services under the policy.

D2952	Post and Core - in addition to crown	\$68
D2953	Each additional cast post same tooth	\$59
D2954	Prefabricated Post and Core - in addition to crown	\$59
D2957	Each additional Prefabricated Post same tooth	\$59

DENTAL INSURANCE (continued)

Post and core is allowed only for endodontically treated teeth requiring crowns.

D2960	Labial veneer (lamine) chairside	\$98
D2961	Labial veneer (resin finish) laboratory	\$98
D2962	Labial veneer (porcelain laminate) - laboratory	\$98

D2960-D2962 applies to Anterior teeth only

D2980	Crown Repair	\$34
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Crown repair is allowed only if more than 6 months have passed since the initial insertion

PROSTHODONTICS REMOVABLE

D5110	Complete Upper Denture	\$240
D5120	Complete Lower Denture	\$240
D5130	Immediate Denture - maxillary	\$240
D5140	Immediate Denture - mandibular	\$240
D5211	Upper Partial Denture - resin base (including any conventional clasps, rest, and teeth	\$240
D5212	Lower Partial Denture - resin base (including any conventional clasps, rests, and teeth	\$240
D5213	Upper Partial Denture - cast metal base with resin saddles	\$240
D5214	Lower Partial Denture - cast metal base with resin saddles	\$240
D5281	Removable Unilateral Partial Denture - one piece cast metal	\$137

D5110-D5281: Complete dentures and partial dentures are deemed to include local anesthesia, all temporary restorations and appliances, and one-year follow-up care. Partial dentures are deemed to include all replacement teeth and all clasps and rests.

D5410	Adjust Complete Denture upper	\$14
D5411	Adjust Complete Denture - lower	\$14
D5421	Adjust Partial Denture upper	\$14
D5422	Adjust Partial Denture - lower	\$14

Denture adjustments are allowable no more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.

D5510	Repair broken complete denture base	\$30
D5520	Repair missing or broken teeth - complete denture (each tooth)	\$30
D5610	Repair resin denture base	\$30
D5620	Repair cast framework	\$30
D5630	Repair or replace broken clasp	\$30
D5640	Replace broken teeth - per tooth	\$30
D5650	Add tooth to existing partial denture	\$30
D5660	Add clasp to existing partial denture	\$30

Repairs to complete and partial dentures are allowable only if more than 6 months have passed since the initial insertion.

DENTAL INSURANCE (continued)

D5710	Rebase - complete upper denture	\$71
D5711	Rebase - complete lower denture	\$71
D5720	Rebase - upper partial denture	\$71
D5721	Rebase - lower partial denture	\$71
D5730	Reline complete upper denture (chairside)	\$71
D5731	Reline complete lower denture (chairside)	\$71
D5740	Reline upper partial denture (chairside)	\$71
D5741	Reline lower partial denture (chairside)	\$71
D5750	Reline complete upper denture (laboratory)	\$71
D5751	Reline complete lower denture (laboratory)	\$71
D5760	Reline upper partial denture (laboratory)	\$71
D5761	Reline lower partial denture (laboratory)	\$71

Relining or rebasing dentures are allowable no more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.

D5850	Tissue conditioning, upper	\$23
D5851	Tissue conditioning, lower	\$23

Tissue conditioning is allowable no more than 1 time in any 36 months in a row. Only if at least 12 months have passed since the initial insertion of a full or partial denture.

PROSTHODONTICS - FIXED

D6210	Pontic-cast precious metal	\$195
D6211	Pontic-cast nonprecious metal	\$195
D6212	Pontic-cast semiprecious metal	\$195
D6240	Pontic-porcelain fused to precious metal	\$195
D6241	Pontic-porcelain fused to nonprecious metal	\$195
D6242	Pontic-porcelain fused to semiprecious metal	\$195
D6245	Pontic-porcelain/ceramic	\$195
D6250	Pontic-resin with precious metal	\$195
D6251	Pontic-resin with nonprecious metal	\$195
D6252	Pontic-resin with semiprecious metal	\$195
D6545	Retainer-cast metal for resin bonded fixed prosthesis	\$65
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	\$96
D6604	Inlay-metallic-two surfaces	\$143
D6605	Inlay-metallic-three or more surfaces	\$143
D6608	Onlay-porcelain/ceramic-two surfaces	\$195
D6609	Onlay-porcelain/ceramic-three or more surfaces	\$195
D6613	Onlay-metallic three or more surfaces	\$195
D6720	Crown-resin with precious metal	\$200
D6721	Crown-resin with nonprecious metal	\$200
D6722	Crown-resin with semiprecious metal	\$200
D6740	Crown-porcelain/ceramic	\$200
D6750	Crown-porcelain fused to precious metal	\$200
D6751	Crown-porcelain fused to nonprecious metal	\$200
D6752	Crown-porcelain fused to semiprecious metal	\$200
D6780	Crown-3/4 precious metal	\$200
D6781	Crown-3/4 nonprecious metal	\$200
D6782	Crown-3/4 semiprecious metal	\$200
D6783	Crown-3/4 porcelain/ceramic	\$200
D6790	Crown-full cast precious metal	\$200
D6791	Crown-full cast nonprecious metal	\$200
D6792	Crown-full cast semiprecious metal	\$200

DENTAL INSURANCE (continued)

D6210 - D6792 two or more contiguous spans of bridgework, regardless of the number of pontics and abutments involved, are deemed to be a single bridge with benefits payable based on a single date completed. Benefits for such a bridge will not be applied to more than one policy year.

D6930	Recement fixed partial denture	\$23
D6970	Cast post and core in addition to fixed partial denture	\$58
D6971	Cast post as part of fixed partial denture	\$58
D6972	Prefabricated post and core in addition to fixed partial denture	\$58
D6973	Core build up for retainer, including any pins	\$42
D6975	Coping metal	\$105
D6976	Each additional cast post same tooth	\$59
D6977	Each additional prefabricated post same tooth	\$59
D6980	Fixed partial denture repair - by report	\$38

ORAL SURGERY

D7210	Surgical removal or erupted tooth	\$45
D7220	Removal of impacted tooth - soft tissue	\$54
D7230	Removal of impacted tooth - partially bony	\$71
D7240	Removal of impacted tooth - completely bony	\$83
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	\$96
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$39
D7260	Oroantral fistula closure	\$108
D7270	Tooth reimplantation	\$53
D7272	Tooth transplantation	\$195
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$80
D7285	Biopsy of oral tissue - hard	\$43
D7286	Biopsy of oral tissue soft	\$43
D7291	Transseptal fiberotomy, by report	\$12
D7310	Alveoloplasty in conjunction with extractions	\$35
D7320	Alveoloplasty not in conjunction with extractions	\$45
D7471	Remove of lateral exostosis (maxilla or mandible)	\$98
D7530	Removal of foreign body	\$23
D7540	Removal of reaction-producing foreign bodies	\$23
D7560	Maxillary sinusotomy	\$23
D7960	Frenulectomy (frenectomy or frenotomy)	\$76
D7970	Excision of hyperplastic tissue, per arch	\$66
D7971	Excision of pericoronal gingiva	\$30
D7980	Sialolithotomy	\$46
D7981	Excision of salivary gland, by report	\$46
D7982	Sialodochoplasty	\$46
D7983	Closure of salivary fistula	\$46

DENTAL INSURANCE (continued)

D7210 - D7983 is deemed to include local anesthesia and routine postoperative care.

ANESTHESIA

D9220	General Anesthesia first 30 minutes	\$68
D9221	General Anesthesia each additional 15 minutes	\$23
D9241	Intravenous sedation first 30 minutes	\$60
D9242	Intravenous sedation each additional 15 minutes	\$20
D9248	Non-intravenous conscious sedation	\$20

Anesthesia is deemed a separate covered dental service and allowed only when medically required, as determined by us, for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.

Type IV Dental Services

(The following services may be subject to waiting periods.)

(The following services may be subject to waiting periods)

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Minor Treatment To Control Harmful Habits

Covered dental expenses for orthodontic treatment are subject to the following:

A covered dental expense for a covered dental service for orthodontic treatment is the lesser of the provider's actual fee or the usual or customary charge. A covered dental expense for orthodontic exposure or extraction of teeth is deemed incurred on the date the service is completed and benefits are payable based on that date as stated in this provision. Covered dental expenses for orthodontic evaluation and orthodontic treatment are deemed incurred on a monthly basis beginning with the date orthodontic treatment is started and continuing throughout the course of orthodontic treatment according to the rules stated in this provision.

Covered Dental Expenses for orthodontic treatment, do not include, and we will not pay orthodontic expenses for, orthodontic evaluation or exposure or extraction of teeth which is not an essential preliminary (as determined by us) to orthodontic treatment which is actually performed. Only the services listed above will be considered to be covered dental services for orthodontic treatment. The services will only be covered if they are:

- essential, as determined by us, to correct a covered dependent child's handicapping malocclusion (or as an essential preliminary to such correction, as determined by us); and
- the covered dependent child is under age 19 years on the date the orthodontic treatment is started.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for exposure or extraction of teeth prior to and in connection with orthodontic treatment for a covered dependent child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that orthodontic treatment is started), we will calculate and pay benefits as follows:

- (a) Determine the lesser of the dentist's actual fee or the usual or customary charge for each such service completed. The result, subject to all other policy provisions, is the covered dental expense for that service.
- (b) Determine the coinsurance percentage for each such covered dental expense.

DENTAL INSURANCE (continued)

(c) Total all such coinsurance percentage to obtain the benefit for the submitted claim, subject to the Overall Benefit Maximum for Type IV Dental Services and all other policy provisions.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for orthodontic treatment and any evaluation prior to and in connection with that treatment for a covered dependent child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that orthodontic treatment is started), we will calculate and pay monthly benefits as follows:

(a) Determine the lesser of the dentist's actual fee or the usual or customary charge for each covered dental service for the entire planned course of orthodontic treatment which has started and for each covered dental service for evaluation which was completed prior to and in connection with that orthodontic treatment. Add the results.

(b) Determine 50% of the resulting total.

(c) Determine the lesser of that amount or the available Overall Benefit Maximum for Orthodontic Services remaining.

(d) If the dentist did not make a separate charge for initial insertion of the first orthodontic appliance(s), divide the result in (c) by one more than the total number of months in the entire planned course of an orthodontic treatment to get a monthly benefit amount (the same amount for the initial and each subsequent monthly benefit).

(e) If the *dentist* did make a separate charge for initial insertion of the first orthodontic appliance(s), determine 25% of the result in (c) to get an initial monthly benefit amount. Divide the remaining 75% of the result in (c) by the total number of months in the entire planned course of orthodontic treatment to get a subsequent monthly benefit amount.

(f) The initial monthly benefit is payable on the date the orthodontic treatment is started. A subsequent monthly benefit is payable on the date each month of ongoing treatment is completed in that planned course of orthodontic treatment, but only if both: (1) the month of ongoing treatment is a covered dental service; and (2) we receive proof that treatment continued during that month.

(g) All monthly benefits otherwise payable as stated above are subject to the Overall Benefit Maximum for Type IV Services and all other policy provisions.

If the dentist deliberately does not collect (that is, forgives) some or all of the amounts due from you, we will recalculate the benefits payable according to the above rules; but we will use the amount which the dentist accepted as payment in full (that is, the original fee less the amounts forgiven) as the charge actually made by the provider. You will then owe us the amount of any overpayment we may have made.

The policy year maximum does not apply to benefits payable for covered dental expenses for orthodontics. Instead, the Overall Benefit Maximum for Type IV Services shown in the Schedule applies to benefits payable for such expenses. The Overall Benefit Maximum for Type IV Services is the limit on the total amount of benefits payable for covered dental expenses incurred for a covered dependent child's covered dental services for orthodontic treatment in his lifetime. A single Overall Benefit Maximum for Type IV Services applies to a child even if his insurance has been interrupted or he has been insured both as a covered person and as a covered dependent.

The Waiting Period for orthodontic dental services is 24 months, starting on the later of: (a) the policy effective date; or (b) the covered dependent child's effective date of insurance (most recent effective date if previously insured). If the date started for orthodontic treatment is before the waiting period ends, the entire course of orthodontic treatment is excluded from being a covered dental service. If the date started for any other dental service for orthodontic treatment is before the Waiting Period ends, the service is excluded from being a covered dental service.

Orthodontic treatment is deemed started on the date the first active orthodontic appliance is first inserted. Each month of ongoing orthodontic treatment following that date is deemed completed on the monthly anniversary of that date in each following calendar month. (For orthodontic treatment deemed started on the last day of a calendar month, the monthly anniversaries are deemed to be the last day of each following calendar month.) A covered dental service for orthodontic evaluation or exposure or extraction of teeth will be considered started and completed on the date that the service is actually performed.

The entire course of orthodontic treatment, and any preliminary orthodontic evaluation or exposure or extraction of teeth, are excluded from being covered dental services (and no benefits are payable) if the date started for the orthodontic treatment is on or after the date your covered dependent child reaches age 19 years.

The entire course of orthodontic treatment is excluded from being a covered dental service (and no benefits

DENTAL INSURANCE (continued)

are payable) if the date started is before any of the following dates: (a) the effective date of this policy; or (b) the effective date of the covered dependent's insurance (most recent effective date if previously insured); or (c) the end of the waiting period.

Special Limitations

Waiting Periods for Insured Persons Generally

You and your *covered dependents* must serve a waiting period for one or more Types of Dental Services. A waiting period is a stated period of time starting on the effective date of your or a *covered dependent's* insurance. ("Effective date" means the most recent effective date of dental insurance if you or a covered dependent were previously insured.) If the date started for a service is before the applicable waiting period ends, the service is excluded from being a covered dental service. The Types of Dental Services with waiting periods and the lengths of such waiting periods are shown in the Schedule.

Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared restorations:
 - on teeth which may be restored with a direct placement filling material;
 - in the absence of extensive decay or fracture;
 - for loss of tooth structure due to attrition or abrasion; or
 - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
 - it includes the replacement of a functioning natural tooth extracted while you or your covered dependent are insured under the policy; and
 - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those natural teeth missing on the date your or your covered dependents' insurance begins.
- The initial placement of a fixed partial denture unless:
 - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*; and
 - that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependents* insurance begins.
- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
 - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
 - they are not serviceable and cannot be restored to function.

DENTAL INSURANCE (continued)

- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:
 - replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
 - the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the policy; or
 - the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.
- The replacement of a fixed partial denture unless:
 - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or
 - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*, provided that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or
 - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.
- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of your or your *covered dependents* dental condition.
- The replacement of teeth beyond the normal complement.
- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.
- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).
- Implants, insertion of implants or related appliances, or surgical removal of implants.

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the policy will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependents* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;
- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;
- Benefits are not available for any *treatment* started after the day your or your *covered dependents*

DENTAL INSURANCE (continued)

insurance ends;

- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your covered dependent's insurance still been in effect;
- Benefits are payable only if the *treatment* is completed within 31 days after the date your or your *covered dependents* insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 31 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
 - the date 31 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or
 - the date 91 days after the date your or your *covered dependents* insurance ends;
- We will not pay any benefits for treatment which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

Limited Extension of Orthodontic Benefits After Insurance Ends

Any month of ongoing *orthodontic treatment* which has a date completed after the earliest of the following dates is excluded from being a covered dental service (and no benefits are payable for that month of *orthodontic treatment*):

- the day before the *policy* is amended to exclude *orthodontic treatment* from the coverage provided to *covered dependent* children of the class of employees to which you belong; or
- the date the *covered dependent's* insurance ends.

NOTE: We will make one exception to this exclusion. If a month of ongoing *orthodontic treatment* has a date completed after the earlier of the above dates, but that month of *orthodontic treatment* began while both this coverage under the *policy* and the *covered dependent's* insurance were in effect, we will pay a benefit for that month of *orthodontic treatment* in the same amount, and subject to the same *policy* provisions, that would have applied if both this coverage and the *covered dependent's* insurance were still in effect.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits (COB) provision applies when you or a *covered dependent* has dental care coverage under more than one *plan*. *Plan* is defined below. All of the benefits provided under the *policy* are subject to *this provision*.

Definitions

Allowable expense means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you or a *covered dependent* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments on the basis of:

COORDINATION OF BENEFITS (continued)

- dentally necessary, usual and customary fees; or
- relative-value, schedule-reimbursement methodology; or
- other similar reimbursement methodology,

any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expenses*.

- If you or a covered *dependent* is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expenses*.
- If you or a *covered dependent* is covered by one *plan* that calculates its benefits or services on the basis of:
 - dentally necessary, usual and customary fees; or
 - relative-value, schedule-reimbursement methodology; or
 - other similar reimbursement methodology; and
 - another plan that provides its benefits or services on the basis of negotiated fees;

the *primary plan's* payment arrangement will be the *allowable expenses* for all *plans*.

However, if the provider has contracted with the *secondary plan* to provide:

- the benefit or service for a specific negotiated fee; or
- payment amount that is different than the *primary plan's* payment arrangement; and
- if the provider's contract permits,

the negotiated fee or payment shall be the *allowable expenses* used by the *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because you or a *covered dependent* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include:
 - any required second opinion,
 - some form of predetermination of *treatment*, and
 - preferred provider arrangements.

Birthday refers only to month and day in a calendar year and does not include the year of birth.

Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- services (including supplies); or
- payment for all or a portion of the expenses incurred; or
- combination of services or expenses shown above; or
- indemnification.

Claim period means a calendar year. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan*.

COORDINATION OF BENEFITS (continued)

Closed-panel plan is a *plan* that provides dental care benefits to you or a *covered dependent* primarily in the form of services through a panel of providers that

- have contracted with or are employed by the *plan*, and
- excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA" means coverage provided under a right of continuation compliant with federal law.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any of the following that provides benefits or services for dental care or *treatment*,

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;
- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

Plan does not include any of the following:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-dental services provided under long-term care coverage;
- Medicare supplement coverage;
- A state plan under Medicaid; or
- Coverage under a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

COORDINATION OF BENEFITS (continued)

Each contract for coverage shown above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Primary plan means the *plan* that pays or provides its benefits first, according to its terms of coverage and without regard to benefits under any other *plan*.

Except as provided below, a *plan* that does not contain a COB provision that is consistent with *this provision* is always the *primary plan* unless the provisions of both *plans* state that the *plan* with a COB provision is the *primary plan*.

Coverage that is obtained by virtue of membership in a group that is:

- designed to supplement a part of a basic package of benefits, and
- provides that this supplementary coverage,

shall be excess to any other parts of the *plan* provided by the *policyholder*.

An example of this type of situation is insurance-type coverage that is written in connection with a *closed-panel plan* to provide out-of-network benefits.

Secondary plan means the *plan* that determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expenses* incurred by you or a covered dependent during the *claim period*.

This plan means the benefits provided by the *policy*. When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions that may apply to *this provision* appear in the Definitions provisions of this *policy*.

COORDINATION OF BENEFITS (continued)

Order of Benefit Determination

When you or a *covered dependent* has dental care coverage under more than one *plan*, each *plan* determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent

The *plan* that covers the person other than as a dependent, e.g., as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*.

However, if

- you or a *covered dependent* is a Medicare beneficiary and,
- as a result of federal law,
 - Medicare is secondary to the *plan* covering the person as a dependent; and
 - primary to the *plan* covering the person as other than a dependent (e.g., a retired employee);

then, the order of benefits between the two *plans* is reversed so that

- the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
- the other *plan* is the *primary plan*.

2. Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:

- For a *covered dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
 - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.
- For a *covered dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;
 - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or
 - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;

COORDINATION OF BENEFITS (continued)

- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.
 - For a *covered dependent* child covered under more than one *plan* of individuals who are the parents of the child, benefits will be determined according to the *birthday* and longer or shorter rules, as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee

- The *primary plan* is the *plan* that covers a person as an active employee, e.g., an employee who is neither laid off nor retired.
- The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rules described in item 1 above can determine the order of benefits.

4. COBRA or State Continuation Coverage

If you or your *covered dependent* has coverage provided under

- COBRA, or
- continuation provided by state or other federal continuation law, and

is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and
- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the *birthday* rule can determine the order of benefits.

5. Longer or Shorter Length of Coverage

- The *primary plan* is the *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer.
- The *secondary plan* is the *plan* that covered the person the shorter length of time.

If none of the rules described above determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

Effect on Benefits

When *this plan* is the *secondary plan*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim period* are not more than the total *allowable expenses*.

In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*.

In addition, the *secondary plan* shall credit to its *plannedeductible* any amounts it would have credited to its

COORDINATION OF BENEFITS (continued)

deductible in the absence of other dental care coverage.

If you or a *covered dependent* is enrolled in two or more *closed-panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed-panel plans*.

If you or a *covered dependent* is covered by more than one dental benefit *plan*, you should file all your claims with each *plan*.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply the rules of *this provision* and to determine benefits payable under *this plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of:

- applying the rules of *this provision*; and
- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right Of Recovery

If we pay more than we should have paid under *this provision*, we may recover the excess from one or more of the persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for you or a *covered dependent*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits (COB) provision applies when you or a *covered dependent* has dental care coverage under more than one *plan*. *Plan* is defined below. All of the benefits provided under the *policy* are subject to *this provision*.

Definitions

Allowable expense means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you or a *covered dependent* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments

COORDINATION OF BENEFITS (continued)

on the basis of:

- dentally necessary, usual and customary fees; or
- relative-value, schedule-reimbursement methodology; or
- other similar reimbursement methodology,

any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expenses*.

- If you or a covered *dependent* is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expenses*.
- If you or a covered *dependent* is covered by one *plan* that calculates its benefits or services on the basis of:
 - dentally necessary, usual and customary fees; or
 - relative-value, schedule-reimbursement methodology; or
 - other similar reimbursement methodology; and
 - another plan that provides its benefits or services on the basis of negotiated fees;

the *primary plan's* payment arrangement will be the *allowable expenses* for all *plans*.

However, if the provider has contracted with the *secondary plan* to provide:

- the benefit or service for a specific negotiated fee; or
- payment amount that is different than the *primary plan's* payment arrangement; and
- if the provider's contract permits,

the negotiated fee or payment shall be the *allowable expenses* used by the *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because you or a covered *dependent* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include:
 - any required second opinion,
 - some form of predetermination of *treatment*, and
 - preferred provider arrangements.

Birthday refers only to month and day in a calendar year and does not include the year of birth.

Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- services (including supplies); or
- payment for all or a portion of the expenses incurred; or
- combination of services or expenses shown above; or
- indemnification.

Claim period means a calendar year. A *claim period* will not start before a person's effective date of insurance

COORDINATION OF BENEFITS (continued)

under *this plan* nor extend beyond the last day the person is covered under *this plan*.

Closed-panel plan is a *plan* that provides dental care benefits to you or a *covered dependent* primarily in the form of services through a panel of providers that

- have contracted with or are employed by the *plan*, and
- excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA" means coverage provided under a right of continuation compliant with federal law.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any of the following that provides benefits or services for dental care or *treatment*,

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;
- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

Plan does not include any of the following:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-dental services provided under long-term care coverage;
- Medicare supplement coverage;
- A state plan under Medicaid; or
- Coverage under a governmental plan, which, by law, provides benefits that are in excess of those of

COORDINATION OF BENEFITS (continued)

any private insurance plan or other non-governmental plan.

Each contract for coverage shown above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Primary plan means the *plan* that pays or provides its benefits first, according to its terms of coverage and without regard to benefits under any other *plan*.

Except as provided below, a *plan* that does not contain a COB provision that is consistent with *this provision* is always the *primary plan* unless the provisions of both *plans* state that the *plan* with a COB provision is the *primary plan*.

Coverage that is obtained by virtue of membership in a group that is:

- designed to supplement a part of a basic package of benefits, and
- provides that this supplementary coverage,

shall be excess to any other parts of the *plan* provided by the *policyholder*.

An example of this type of situation is insurance-type coverage that is written in connection with a *closed-panel plan* to provide out-of-network benefits.

Secondary plan means the *plan* that determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expenses* incurred by you or a covered dependent during the *claim period*.

This plan means the benefits provided by the *policy*. When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions that may apply to *this provision* appear in the Definitions provisions of this *policy*.

COORDINATION OF BENEFITS (continued)

Order of Benefit Determination

When you or a *covered dependent* has dental care coverage under more than one *plan*, each *plan* determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent

The *plan* that covers the person other than as a dependent, e.g., as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*.

However, if

- you or a *covered dependent* is a Medicare beneficiary and,
- as a result of federal law,
 - Medicare is secondary to the *plan* covering the person as a dependent; and
 - primary to the *plan* covering the person as other than a dependent (e.g., a retired employee);

then, the order of benefits between the two *plans* is reversed so that

- the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
- the other *plan* is the *primary plan*.

2. Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:

- For a *covered dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
 - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.
- For a *covered dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;
 - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or
 - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;

COORDINATION OF BENEFITS (continued)

- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.
 - For a *covered dependent* child covered under more than one *plan* of individuals who are the parents of the child, benefits will be determined according to the *birthday* and longer or shorter rules, as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee

- The *primary plan* is the *plan* that covers a person as an active employee, e.g., an employee who is neither laid off nor retired.
- The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rules described in item 1 above can determine the order of benefits.

4. COBRA or State Continuation Coverage

If you or your *covered dependent* has coverage provided under

- COBRA, or
- continuation provided by state or other federal continuation law, and

is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and
- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the *birthday* rule can determine the order of benefits.

5. Longer or Shorter Length of Coverage

- The *primary plan* is the *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer.
- The *secondary plan* is the *plan* that covered the person the shorter length of time.

If none of the rules described above determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

Effect on Benefits

When *this plan* is the *secondary plan*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim period* are not more than the total *allowable expenses*.

In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*.

In addition, the *secondary plan* shall credit to its *plannedeductible* any amounts it would have credited to its

COORDINATION OF BENEFITS (continued)

deductible in the absence of other dental care coverage.

If you or a *covered dependent* is enrolled in two or more *closed-panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed-panel plans*.

If you or a *covered dependent* is covered by more than one dental benefit *plan*, you should file all your claims with each *plan*.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply the rules of *this provision* and to determine benefits payable under *this plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of:

- applying the rules of *this provision*; and
- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right Of Recovery

If we pay more than we should have paid under *this provision*, we may recover the excess from one or more of the persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for you or a *covered dependent*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

We will pay dental benefits directly to the providers of dental services for treatment of you or your covered dependents, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the treatment, or to your estate.

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy.

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be \$300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision.
2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.
3. The time limit for filing a claim is 90 days after the date of the loss.
4. To decide our liability, we may require:
 - itemized bills,
 - proof of benefits from other sources, and
 - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

For dental expenses, we may require additional information to determine our liability, including, but not limited to:

- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

CLAIMS PROVISIONS (continued)

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after 6 years from the date of loss.

Incontestability

The validity of the policy cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the covered persons effective date may be reduced or denied because a disease or physical condition existed before the persons effective date, unless the condition was specifically excluded by a provision in effect on the date of loss

Overpayment

If a benefit is paid under the policy and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

Subrogation Rights

In the event of any payments for benefits provided to you or a covered dependent under the policy, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement.

Right to Reimbursement

If you or a covered dependent: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the policy, then you or your dependent must reimburse us for all payments made under the policy for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the policy for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your covered dependents are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the policy.

GENERAL PROVISIONS

Entire Contract

The policy and the policyholders application attached to it are the entire contract. Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the policyholder to give to each covered person. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the policy.

Workers Compensation

The policy is not in place of, and does not affect any states requirements for coverage by Workers Compensation insurance.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

ENDORSEMENT

At the request of the state of Oregon, the term spouse shall also mean a domestic partner. A "domestic partner" is defined by Oregon law.

HIPAA NOTICE OF PRIVACY PRACTICES

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

I. Our Commitment

Union Security Insurance Company and its affiliates* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

We use the brand name Assurant Employee Benefits to associate our products and services and to connect us with the brand of our parent company, Assurant, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) provides us and our affiliates with guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This new law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and dental or vision care operations without asking your permission. For instance, we may disclose information to a dental or vision provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the dental or vision provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of dental or vision care operations include:

- Underwriting our risk and determining rates and premiums for your dental or vision plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of dental care or other providers;
- Conducting or arranging for dental review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;

- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group dental or vision plan but only for purposes of enrollment, disenrollment, and eligibility, or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. This list will include only those disclosures made since April 14, 2003 and will only go back six years. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our website or by electronic mail, you may request a paper copy.

IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, www.hhs.gov/ocr/howtofileprivacy.htm. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address: Assurant Employee Benefits
Privacy Office
P.O. Box 419052
Kansas City, MO 64141-6052

Telephone: (800) 733-7879

Email: PrivacyOffice.AEB@assurant.com

Web Site: www.assurantemployeebenefits.com

V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the dental or vision insurance that we provide.

VI. Effective Date of This Notice: April 14, 2003

* In this notice, we, us, and our refer to Union Security Insurance Company and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

Union Security Insurance Company
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July 1, 2003