Group Dental Insurance

RFP No.: DMS 16/17-016

Attachment 1

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder	**STATE OF FLORIDA**		
Policy Number	**10-350557**	**Insured Person**	
Plan Effective Date	**January 1, 2008**	**Certificate Effective Date** **Refer to Exceptions on 9070**	
		Plan Change Effective Date	**January 1, 2017**
		Class Number 1	

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

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

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

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

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 877-721-2224.

JoAnn M Martin

President

FLORIDA IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Control
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

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

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:

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

Maximum Amount - Each Benefit Period $1,000

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

DEPENDENT refers to:

a. an Insured's spouse.

b. each child through the end of the calendar year in which they turn age 26, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code.

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

c. each child age 26 or older who:

   i. is Totally Disabled due to mental or physical reasons; and

   ii. becomes Totally Disabled while insured as a dependent under b. above.

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

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

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

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

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

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

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

For persons who become members after the Plan Effective Date of the policy, qualification will occur the first of the month following the collection of one full month's premium.

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

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

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

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

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

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

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he

or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

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

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

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

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

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

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

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

DENTAL EXPENSE BENEFITS

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as covered under your plan.

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

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

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

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

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

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

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

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

2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

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

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

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

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

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

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

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

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

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

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Ø Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Ø B/R means By Report.
- Ø We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$14.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$11.00
D0150	Comprehensive oral evaluation - new or established patient.	$22.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$22.00

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

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

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - complete series of radiographic images.	$45.00
D0330	Panoramic radiographic image.	$36.00

COMPLETE SERIES/PANORAMIC: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first radiographic image.	$8.00
D0230	Intraoral - periapical each additional radiographic image.	$6.00
D0240	Intraoral - occlusal radiographic image.	$11.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$15.00
D0251	Extra-oral posterior dental radiographic image.	$15.00

PERIAPICAL: D0220, D0230
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS		
D0270	Bitewing - single radiographic image.	$7.00
D0272	Bitewings - two radiographic images.	$13.00
D0273	Bitewings - three radiographic images.	$15.00
D0274	Bitewings - four radiographic images.	$20.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$30.00

BITEWINGS: D0270, D0272, D0273, D0274
- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$30.00

TYPE 1 PROCEDURES

Code	Procedure	Maximum Covered Expense
D1120	Prophylaxis - child.	$21.00
D1206	Topical application of fluoride varnish.	$11.00
D1208	Topical application of fluoride-excluding varnish.	$11.00
D9932	Cleaning and inspection of removable complete denture, maxillary.	$30.00
D9933	Cleaning and inspection of removable complete denture, mandibular.	$30.00
D9934	Cleaning and inspection of removable partial denture, maxillary.	$30.00
D9935	Cleaning and inspection of removable partial denture, mandibular.	$30.00

FLUORIDE: D1206, D1208

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

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Not allowed when done on the same date as periodontal services.

SEALANT

Code	Procedure	Maximum Covered Expense
D1351	Sealant - per tooth.	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$17.00
D1353	Sealant repair - per tooth.	$17.00

SEALANT: D1351, D1352, D1353

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

SPACE MAINTAINERS

Code	Procedure	Maximum Covered Expense
D1510	Space maintainer - fixed - unilateral.	$106.00
D1515	Space maintainer - fixed - bilateral.	$174.00
D1520	Space maintainer - removable - unilateral.	$166.00
D1525	Space maintainer - removable - bilateral.	$202.00
D1550	Re-cement or re-bond space maintainer.	$22.00
D1555	Removal of fixed space maintainer.	$30.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

Code	Procedure	Maximum Covered Expense
D8210	Removable appliance therapy.	$160.00
D8220	Fixed appliance therapy.	$160.00

APPLIANCE THERAPY: D8210, D8220

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

OCCLUSAL GUARD

Code	Procedure	Maximum Covered Expense
D9940	Occlusal guard, by report.	$101.00

OCCLUSAL GUARD: D9940

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$15.00

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$18.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$35.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$35.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$25.00
D2150	Amalgam - two surfaces, primary or permanent.	$32.00
D2160	Amalgam - three surfaces, primary or permanent.	$38.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$46.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$30.00
D2331	Resin-based composite - two surfaces, anterior.	$38.00
D2332	Resin-based composite - three surfaces, anterior.	$48.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$53.00
D2391	Resin-based composite - one surface, posterior.	$33.00
D2392	Resin-based composite - two surfaces, posterior.	$42.00
D2393	Resin-based composite - three surfaces, posterior.	$53.00
D2394	Resin-based composite - four or more surfaces, posterior.	$58.00
D2410	Gold foil - one surface.	$25.00
D2420	Gold foil - two surfaces.	$32.00
D2430	Gold foil - three surfaces.	$38.00
D2990	Resin infiltration of incipient smooth surface lesions.	$30.00

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$60.00

TYPE 2 PROCEDURES

Code	Procedure	Maximum Covered Expense
D2930	Prefabricated stainless steel crown - primary tooth.	$54.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$58.00
D2932	Prefabricated resin crown.	$65.00
D2933	Prefabricated stainless steel crown with resin window.	$65.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$65.00

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

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

RECEMENT

Code	Procedure	Maximum Covered Expense
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	$10.00
D2920	Re-cement or re-bond crown.	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$48.00
D6092	Re-cement or re-bond implant/abutment supported crown.	$20.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	$20.00
D6930	Re-cement or re-bond fixed partial denture.	$27.00

SEDATIVE FILLING

Code	Procedure	Maximum Covered Expense
D2940	Protective restoration.	$18.00
D2941	Interim therapeutic restoration - primary dentition.	$14.00

ENDODONTICS MISCELLANEOUS

Code	Procedure	Maximum Covered Expense
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$34.00
D3221	Pulpal debridement, primary and permanent teeth.	$34.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$51.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$39.00
D3333	Internal root repair of perforation defects.	$55.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$38.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$110.00
D3357	Pulpal regeneration - completion of treatment.	$110.00
D3430	Retrograde filling - per root.	$43.00
D3450	Root amputation - per root.	$103.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$87.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

Code	Procedure	Maximum Covered Expense
D3310	Endodontic therapy, anterior tooth.	$154.00
D3320	Endodontic therapy, bicuspid tooth.	$182.00
D3330	Endodontic therapy, molar.	$238.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$91.00
D3346	Retreatment of previous root canal therapy - anterior.	$192.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$221.00
D3348	Retreatment of previous root canal therapy - molar.	$275.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.

TYPE 2 PROCEDURES

Maximum Covered Expense

- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

Code	Procedure	Maximum Covered Expense
D3355	Pulpal regeneration - initial visit.	$55.00
D3356	Pulpal regeneration - interim medication replacement.	$38.00
D3410	Apicoectomy - anterior.	$159.00
D3421	Apicoectomy - bicuspid (first root).	$183.00
D3425	Apicoectomy - molar (first root).	$198.00
D3426	Apicoectomy (each additional root).	$71.00
D3427	Periradicular surgery without apicoectomy.	$143.00

SURGICAL PERIODONTICS

Code	Procedure	Maximum Covered Expense
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$138.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$69.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$253.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$127.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant.	$83.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant.	$62.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$41.00
D4270	Pedicle soft tissue graft procedure.	$186.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	$230.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	$111.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.	$197.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$230.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.	$198.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$79.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$230.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$89.00

BONE GRAFTS: D4263, D4264, D4265
- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 2 PROCEDURES

		Maximum Covered Expense
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$52.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$26.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$38.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$31.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$32.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$32.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$26.00
D5610	Repair resin denture base.	$31.00
D5620	Repair cast framework.	$37.00
D5630	Repair or replace broken clasp-per tooth.	$39.00
D5640	Replace broken teeth - per tooth.	$28.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$58.00
D5731	Reline complete mandibular denture (chairside).	$58.00
D5740	Reline maxillary partial denture (chairside).	$52.00
D5741	Reline mandibular partial denture (chairside).	$53.00
D5750	Reline complete maxillary denture (laboratory).	$87.00
D5751	Reline complete mandibular denture (laboratory).	$85.00
D5760	Reline maxillary partial denture (laboratory).	$87.00
D5761	Reline mandibular partial denture (laboratory).	$87.00

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

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

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$28.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$28.00
SURGICAL EXTRACTIONS		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$54.00
D7220	Removal of impacted tooth - soft tissue.	$67.00
D7230	Removal of impacted tooth - partially bony.	$89.00
D7240	Removal of impacted tooth - completely bony.	$104.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$119.00
D7250	Removal of residual tooth roots (cutting procedure).	$56.00
D7251	Coronectomy-intentional partial tooth removal.	$104.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$132.00

TYPE 2 PROCEDURES

Code	Procedure	Maximum Covered Expense
D7261	Primary closure of a sinus perforation.	$132.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$80.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$80.00
D7280	Exposure of an unerupted tooth.	$123.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$89.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$37.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$46.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$23.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$59.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$30.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$85.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$211.00
D7410	Excision of benign lesion up to 1.25 cm.	$84.00
D7411	Excision of benign lesion greater than 1.25 cm.	$108.00
D7412	Excision of benign lesion, complicated.	$119.00
D7413	Excision of malignant lesion up to 1.25 cm.	$114.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$83.00
D7415	Excision of malignant lesion, complicated.	$92.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$114.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$83.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$25.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$75.00
D7472	Removal of torus palatinus.	$75.00
D7473	Removal of torus mandibularis.	$75.00
D7485	Reduction of osseous tuberosity.	$122.00
D7490	Radical resection of maxilla or mandible.	$114.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$38.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$43.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$35.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$95.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$95.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$125.00
D7910	Suture of recent small wounds up to 5 cm.	$17.00
D7911	Complicated suture - up to 5 cm.	$19.00
D7912	Complicated suture - greater than 5 cm.	$27.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	$90.00
D7963	Frenuloplasty.	$113.00
D7970	Excision of hyperplastic tissue - per arch.	$70.00
D7972	Surgical reduction of fibrous tuberosity.	$111.00
D7980	Sialolithotomy.	$104.00
D7983	Closure of salivary fistula.	$33.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

Code	Procedure	Maximum Covered Expense
D7285	Incisional biopsy of oral tissue - hard (bone, tooth).	$113.00
D7286	Incisional biopsy of oral tissue - soft.	$61.00
D7287	Exfoliative cytological sample collection.	$30.00
D7288	Brush biopsy - transepithelial sample collection.	$30.00

TYPE 2 PROCEDURES

Code	Procedure	Maximum Covered Expense
PALLIATIVE		
D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$21.00

PALLIATIVE TREATMENT: D9110

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

Code	Procedure	Maximum Covered Expense
ANESTHESIA-GENERAL/IV		
D9219	Evaluation for deep sedation or general anesthesia.	$16.00
D9223	Deep sedation/general anesthesia - each 15 minute increment.	$32.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.	$27.00

GENERAL ANESTHESIA: D9223, D9243

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9223 or D9243) will be considered.

Code	Procedure	Maximum Covered Expense
PROFESSIONAL CONSULT/VISIT/SERVICES		
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$21.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$15.00
D9440	Office visit - after regularly scheduled hours.	$26.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$16.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

Code	Procedure	Maximum Covered Expense
OCCLUSAL ADJUSTMENT		
D9951	Occlusal adjustment - limited.	$20.00
D9952	Occlusal adjustment - complete.	$100.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

Code	Procedure	Maximum Covered Expense
MISCELLANEOUS		
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	$18.00
D2951	Pin retention - per tooth, in addition to restoration.	$10.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$30.00

DESENSITIZATION: D9911

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

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$103.00
D2520	Inlay - metallic - two surfaces.	$123.00
D2530	Inlay - metallic - three or more surfaces.	$132.00
D2610	Inlay - porcelain/ceramic - one surface.	$114.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$123.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$135.00
D2650	Inlay - resin-based composite - one surface.	$118.00
D2651	Inlay - resin-based composite - two surfaces.	$116.00
D2652	Inlay - resin-based composite - three or more surfaces.	$120.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$133.00
D2543	Onlay - metallic - three surfaces.	$149.00
D2544	Onlay - metallic - four or more surfaces.	$155.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$133.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$149.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$154.00
D2662	Onlay - resin-based composite - two surfaces.	$125.00
D2663	Onlay - resin-based composite - three surfaces.	$129.00
D2664	Onlay - resin-based composite - four or more surfaces.	$137.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$58.00
D2712	Crown - 3/4 resin-based composite (indirect).	$145.00
D2720	Crown - resin with high noble metal.	$149.00
D2721	Crown - resin with predominantly base metal.	$114.00
D2722	Crown - resin with noble metal.	$139.00
D2740	Crown - porcelain/ceramic substrate.	$161.00
D2750	Crown - porcelain fused to high noble metal.	$156.00
D2751	Crown - porcelain fused to predominantly base metal.	$134.00
D2752	Crown - porcelain fused to noble metal.	$144.00
D2780	Crown - 3/4 cast high noble metal.	$149.00
D2781	Crown - 3/4 cast predominantly base metal.	$129.00
D2782	Crown - 3/4 cast noble metal.	$135.00

TYPE 3 PROCEDURES

Code	Description	Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$161.00
D2790	Crown - full cast high noble metal.	$149.00
D2791	Crown - full cast predominantly base metal.	$129.00
D2792	Crown - full cast noble metal.	$135.00
D2794	Crown - titanium.	$149.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

Code	Description	Maximum Covered Expense
D2950	Core buildup, including any pins when required.	$32.00

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

Code	Description	Maximum Covered Expense
D2952	Post and core in addition to crown, indirectly fabricated.	$51.00
D2954	Prefabricated post and core in addition to crown.	$43.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

Code	Description	Maximum Covered Expense
D2980	Crown repair necessitated by restorative material failure.	$26.00
D2981	Inlay repair necessitated by restorative material failure.	$21.00
D2982	Onlay repair necessitated by restorative material failure.	$21.00
D2983	Veneer repair necessitated by restorative material failure.	$21.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$29.00
D9120	Fixed partial denture sectioning.	$29.00

CROWN LENGTHENING

Code	Description	Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$92.00

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

Code	Description	Maximum Covered Expense
D5110	Complete denture - maxillary.	$166.00
D5120	Complete denture - mandibular.	$161.00
D5130	Immediate denture - maxillary.	$180.00
D5140	Immediate denture - mandibular.	$174.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00

TYPE 3 PROCEDURES

Code	Description	Maximum Covered Expense
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$120.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$139.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$103.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$120.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$139.00
D5810	Interim complete denture (maxillary).	$73.00
D5811	Interim complete denture (mandibular).	$77.00
D5820	Interim partial denture (maxillary).	$65.00
D5821	Interim partial denture (mandibular).	$68.00
D5863	Overdenture - complete maxillary.	$166.00
D5864	Overdenture - partial maxillary.	$193.00
D5865	Overdenture - complete mandibular.	$166.00
D5866	Overdenture - partial mandibular.	$193.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary.	$166.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular.	$166.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary.	$193.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular.	$193.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary.	$166.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular.	$166.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	$193.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	$193.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

Code	Description	Maximum Covered Expense
D5410	Adjust complete denture - maxillary.	$9.00
D5411	Adjust complete denture - mandibular.	$9.00
D5421	Adjust partial denture - maxillary.	$10.00
D5422	Adjust partial denture - mandibular.	$9.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

Code	Description	Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$21.00
D5660	Add clasp to existing partial denture-per tooth.	$25.00

DENTURE REBASES

Code	Description	Maximum Covered Expense
D5710	Rebase complete maxillary denture.	$61.00
D5711	Rebase complete mandibular denture.	$64.00
D5720	Rebase maxillary partial denture.	$58.00
D5721	Rebase mandibular partial denture.	$61.00

TISSUE CONDITIONING

Code	Description	Maximum Covered Expense
D5850	Tissue conditioning, maxillary.	$17.00
D5851	Tissue conditioning, mandibular.	$18.00

PROSTHODONTICS - FIXED

TYPE 3 PROCEDURES

Code	Procedure	Maximum Covered Expense
D6058	Abutment supported porcelain/ceramic crown.	$139.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$151.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$151.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$139.00
D6062	Abutment supported cast metal crown (high noble metal).	$151.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$151.00
D6064	Abutment supported cast metal crown (noble metal).	$164.00
D6065	Implant supported porcelain/ceramic crown.	$139.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$139.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$151.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$151.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$139.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$151.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$151.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$164.00
D6075	Implant supported retainer for ceramic FPD.	$139.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$151.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$151.00
D6094	Abutment supported crown - (titanium).	$151.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$151.00
D6205	Pontic - indirect resin based composite.	$125.00
D6210	Pontic - cast high noble metal.	$151.00
D6211	Pontic - cast predominantly base metal.	$151.00
D6212	Pontic - cast noble metal.	$164.00
D6214	Pontic - titanium.	$151.00
D6240	Pontic - porcelain fused to high noble metal.	$151.00
D6241	Pontic - porcelain fused to predominantly base metal.	$151.00
D6242	Pontic - porcelain fused to noble metal.	$139.00
D6245	Pontic - porcelain/ceramic.	$139.00
D6250	Pontic - resin with high noble metal.	$151.00
D6251	Pontic - resin with predominantly base metal.	$139.00
D6252	Pontic - resin with noble metal.	$164.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$50.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$50.00
D6549	Resin retainer - for resin bonded fixed prosthesis.	$50.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces.	$123.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.	$136.00
D6602	Retainer inlay - cast high noble metal, two surfaces.	$111.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces.	$122.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces.	$96.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.	$105.00
D6606	Retainer inlay - cast noble metal, two surfaces.	$101.00
D6607	Retainer inlay - cast noble metal, three or more surfaces.	$111.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces.	$133.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.	$147.00
D6610	Retainer onlay - cast high noble metal, two surfaces.	$122.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces.	$134.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces.	$105.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.	$116.00
D6614	Retainer onlay - cast noble metal, two surfaces.	$111.00
D6615	Retainer onlay - cast noble metal, three or more surfaces.	$122.00
D6624	Retainer inlay - titanium.	$122.00
D6634	Retainer onlay - titanium.	$134.00
D6710	Retainer crown - indirect resin based composite.	$125.00
D6720	Retainer crown - resin with high noble metal.	$151.00
D6721	Retainer crown - resin with predominantly base metal.	$78.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6722	Retainer crown - resin with noble metal.	$126.00
D6740	Retainer crown - porcelain/ceramic.	$139.00
D6750	Retainer crown - porcelain fused to high noble metal.	$164.00
D6751	Retainer crown - porcelain fused to predominantly base metal.	$151.00
D6752	Retainer crown - porcelain fused to noble metal.	$139.00
D6780	Retainer crown - 3/4 cast high noble metal.	$164.00
D6781	Retainer crown - 3/4 cast predominantly base metal.	$151.00
D6782	Retainer crown - 3/4 cast noble metal.	$139.00
D6783	Retainer crown - 3/4 porcelain/ceramic.	$139.00
D6790	Retainer crown - full cast high noble metal.	$151.00
D6791	Retainer crown - full cast predominantly base metal.	$151.00
D6792	Retainer crown - full cast noble metal.	$139.00
D6794	Retainer crown - titanium.	$151.00
D6940	Stress breaker.	$42.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

TYPE 3 PROCEDURES

Maximum Covered Expense

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

COORDINATION OF BENEFITS

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

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

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

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

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

   a. Any group or blanket insurance policy.

   b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

   c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

   d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

   a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

   b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

   a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

   b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      i. the parents are married;

      ii. the parents are not separated (whether or not they ever have been married); or

      iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

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

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

      i. the Plan of the Custodial Parent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

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

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

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

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

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

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

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

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

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-877-721-2224.

B. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

C. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

D. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

E. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member’s Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

   a. The date of the Qualifying Event; or
   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

   a. The date of the disability determination;

   b. The date of the Qualifying Event; or

   c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary’s family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up

to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

F. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights
If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

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

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

CLAIMS FOR BENEFITS

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

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

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

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

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

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

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

APPEAL PROCEDURE

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

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

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

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

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

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

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

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

Ameritas Privacy Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

YOUR RIGHTS
YOU HAVE THE RIGHT TO:

Get a copy of your claims records

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa /complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends**.
  At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation**.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

  Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-877-721-2224 and request the appropriate form.

Group Dental Benefits

State of Florida

Advance Plan, Amended
1/1/2014

A896

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: State of Florida

Policy Number: A896

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

President and Chief Executive Officer

NOTICE

If you have any questions about your insurance, please contact us at:

1-800-733-7879

Union Security Insurance Company
Customer Relations
P.O. Box 419596
Kansas City, Missouri 64141-9958

When contacting us, please have your policy number or participation number available.

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 January 1, 2014: None

After January 1, 2014: None

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

January 1, 2014 (Subject to Entry Date)

SCHEDULE

Dental Insurance

Deductible Amount

Individual Deductible Amount Per *Policy Year*	$ 50
Maximum Family Deductible per *policy year*	2 persons
Individual Deductible Amount for Type IV Services per *Policy Year*	None

The Individual Deductible does not apply to Type I Dental Services

Coinsurance Percentages

COINSURANCE PERCENTAGE PER PERSON PER INDIVIDUAL BENEFIT YEAR	DENTAL SERVICES TYPE1	TYPE II	TYPE III	TYPE IV
DURING THE 1st YEAR	100%	80%	50%	0%
DURING THE 2ND YEAR	100%	80%	50%	50%
THEREAFTER:	100%	80%	50%	50%

The deductible amount does not apply and coinsurance percentages are 100% for all covered dental expenses received for treatment of crime-related injuries of a covered person or covered dependent determined eligible under the Florida Crimes Compensation Act.

Benefit Maximums:

Policy Year Maximum	$ 1250
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.

<u>Type IV Dental Services</u>

All Services (Orthodontic Services)	12 months

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

Vision Plan

You and your *covered dependents* are eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

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 20 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.

Allowable charge means a charge that is based on the general level of charges made by other providers in the area for like *treatment.* Our determination of what is an *allowable charge* is final for the purpose of determining benefits payable under the *policy*.

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:

- 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.

Exception to Effective Date

If you are not at *active work* on the day you would otherwise become insured, your insurance will not take effect until you return to *active work.* If the day your coverage would normally take effect is not a regular work day for you, your coverage will take effect on that day if you are able to do your regular job.

When Your Insurance Ends

Your insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for your *eligible class;*
- the last day of the month in which you are no longer in an *eligible class;*
- the last day of the month in which you stop *active work;*
- the day a required contribution was not paid; or
- the day you become 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.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your eligible dependents are:

- your lawful spouse, and
- your children who are less than age 19 and who are dependent upon you for support and maintenance, or
- your children who are less than age 26 if a full-time or part-time student and dependent upon you for support and maintenance, or less than age 26 if living in your home and dependent upon you for support and maintenance. Children meeting these requirements may be covered for *dental insurance* until the end of the calendar year in which the child reaches age 26.

Children are covered for dental insurance from birth. Children" include any adopted children. A child will be considered adopted on the date of placement in your home. However, if you agreed in writing to adopt the child before birth, dental insurance will begin on the date of birth. 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.

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 your dependent spouse is no longer eligible;
- the end of the calendar year on or after the date the dependent child 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.

If we deny a claim because the child has attained an age limit, we must receive proof of the above within 120 days after the child attains the age limit.

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 calendar year following the month in which the child is no longer a student, unless the child has not reached the end of the calendar year in which the child reaches age 26 and the child is living in your home and dependent upon you for support and maintenance;
- the end of the calendar year in which the child reaches age 26; 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.

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 the coinsurance percentage shown in the Schedule 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 dependents* 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,* . except as stated in the Maximum Family Deductible Section.

Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in your family unit who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *policy year* , we will consider the deductible to be satisfied for each person in your family unit for that policy year. We will pay benefits for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount.

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*)

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 *allowable charge* 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 *dentists* actual charge or the *allowable charge* 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 denturist;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Extension of Benefits After Insurance Ends provision.

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 an *allowable charge.*

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.

Type I Dental Services

- Clinical Oral Evaluations
  - No more than 1 time in any 6 months in a row. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 1 time in any 6 months in a row (frequency combined with periodontal maintenance procedure). Total number of combined dental prophylaxis services and periodontal maintenance procedures not to exceed 4 in a 12-month period.
- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants

- No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.

- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.

- Treatment To Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.

- Radiographs-Diagnostic Imaging
  - Bitewings no more than 1 time in any 12 months in a row.

- Genetic Test for Susceptibility to Oral Diseases
  - No more than 1 test per lifetime. Limited to persons over age 18.

Type II Dental Services

- Radiographs-Diagnostic Imaging
  - Complete Series (Including Bitewings) or Panoramic Film -- No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film
    - One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
  - Periapical -- No more than 4 x-rays in any 12 months in a row.
  - Occlusal Film -- No more than 2 films in any 12 months in a row.
  - Extraoral -- No more than 2 films in any 12 months in a row.
  - Sialography

- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - 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.
    - The service is deemed to include local anesthesia.
    - Multiple restorations on one surface are deemed to be a single restoration.
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.

- Other Restorative Services
  - Pin Retention -- No more than 1 time per restoration. Deemed to be a covered dental service only

in conjunction with amalgam or resin restoration.

- Oral Surgery
  - Minor Oral Surgery -- Each service is deemed to include local anesthesia and routine postoperative care.
    - Simple Extractions (Does not include Surgical Extractions)
    - Surgical Incision and Drainage of Abscess
    - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Other Type II Services
  - Bacteriologic Studies For Determination of Pathologic Agents
  - Palliative (Emergency) Treatment of Dental Pain - Minor Procedure Deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.
  - Therapeutic Drug Injection
  - Accession and examination of tissue

Type III Dental Services

- Complex Oral Surgery
  - Surgical Extractions
- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure
  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus
  - Tooth Transplantation
  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption
  - Biopsy of Oral Tissue
  - Transseptal Fiberotomy
  - Alveoplasty
  - Vestibuloplasty
  - Removal of lateral exostosis maxilla or mandible
  - Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
  - Removal of Reaction-Producing Foreign Bodies Musculoskeletal System
  - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
  - Frenulectomy (Frenectomy or Frenotomy) Separate Procedure
  - Excision of Hyperplastic Tissue - Per Arch
  - Excision of Pericoronal Gingiva

- Sialolithotomy
- Excision of Salivary Gland
- Sialodochoplasty
- Closure of Salivary Fistula
    - If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Adjunctive General Services -- Each service is deemed a separate covered dental service only when medically required 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.
    - Anesthesia
    - Intravenous Sedation

- Endodontics -- For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative x-rays, local anesthesia, and routine follow-up care.
    - Pulpotomy -- Only for Deciduous Teeth
    - Endodontic Therapy
    - Endodontic Retreatment Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.
    - Apexification-Recalcification Procedures
    - Apicoectomy Surgery
    - Periradicular Services
        - Retrograde Filling
        - Root Amputation

- Other Endodontic Procedures
    - Hemisection (Including any root removal), Not Including Endodontic Therapy -- covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.

- 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 allowable charge for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable 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 3 months in a row (frequency combined with dental prophylaxis services). Total number of combined periodontal maintenance procedures and dental prophylaxis services not to exceed 4 in a 12-month period.
  - Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction.

- Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular Tissue, Per Tooth by Report
  - No more than 1 application per tooth in any 12-month period.

- Major Periodontics -- For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Surgical Services -- If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.
    - Gingivectomy or Gingivoplasty
    - Gingival Flap Procedure
    - Osseous Surgery
  - Clinical Crown Lengthening
  - Guided Tissue Regeneration
  - Soft Tissue Graft
  - Subepithelial Connective Tissue Graft
  - Distal or Proximal Wedge
  - Occlusal Guard -- No more than 1 in any 24 months in a row.

- Major Restorations - Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Inlay/Onlay Restorations
    - Benefits are based on the *allowable charge* of a metallic inlay or onlay.
  - Crowns
    - Benefits are based on the *allowable charge* for predominantly base metal.
    - For children under age 16 years, covered dental services for crowns on deciduous or primary teeth are limited to prefabricated stainless steel or prefabricated resin crowns.
  - Labial Veneers (Only for Anterior Teeth)
  - Other Restorative Services -- Only under unusual circumstances when required, as determined by us, for retention and preservation of the tooth. Service is deemed to include pins.

- Core Build-up, Including Any Pins
- Cast Post And Core
- Prefabricated Post And Core

▪ Complete Dentures And Partial Dentures

◦ Service is deemed to include all replacement teeth and all clasps and rests.

▪ Fixed Partial Denture Pontics

◦ Fixed Partial Denture Retainers - Inlays/Onlays, And Crowns -- Benefits based on the *allowable charge* for predominantly base metal.

- Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one *policy year.*

▪ Tissue Conditioning

◦ No more than 1 time in any 36 months in a row.

◦ Only if at least 12 months have passed since the insertion of a full or partial denture.

▪ Major Restorations --Maintenance -- For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one year follow-up care. Covered only if more than 6 months have passed since the initial insertion.

◦ Recement Inlays

◦ Recement Crown

◦ Recement Fixed Partial Denture

◦ Crown Repair

▪ Repairs To Complete Dentures, Partial Dentures, Or Fixed Partial Dentures

◦ Only if more than 6 months have passed since the initial insertion.

▪ Adjustment To Dentures

◦ No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.

▪ Denture Rebase Procedures

◦ No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.

▪ Denture Reline Procedures

◦ No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.

▪ Other Type III Services

◦ Diagnostic Casts -- 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.

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 *allowable 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 *allowable 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.

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 *allowable 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 shown in the Schedule, and starts 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 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.
- 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.

General Exclusions

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

- *treatment* which:
  - ◦ is not included in the list of covered dental services; or
  - ◦ has a date started before your or a *covered dependent*'s insurance begins; or
  - ◦ has a date started before any applicable waiting period has been served; or
  - ◦ has a date completed after your or a *covered dependent*'s insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.
- any *treatment*, the sole or primary purpose of which relates to:
  - ◦ the change or maintenance of vertical dimension; or
  - ◦ the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or

  - bite registration; or
  - bite analysis.

- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.

- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; *treatment* of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

- *treatment* which:
  - is not dentally necessary; or
  - does not have uniform professional endorsement; or
  - is experimental or investigational in nature.

- *treatment* which does not have a reasonably favorable prognosis, as determined by us.

- *treatment* provided primarily for cosmetic purposes.

- *treatment* received as a result of disease, defect, or *injury* due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.

- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent*'s job or any other job, and for which benefits are paid under any applicable Workers Compensation law.

- *treatment* of an intentionally self-inflicted *injury*.

- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.

- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.

- *treatment* of a provider who is a member of your or your spouse's *immediate family*.

- *treatment* for which a charge would not have been made in the absence of insurance.

- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.

- orthodontic *treatment*, unless such insurance is provided under the list of covered dental services.

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 dependent*'s 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 dependent*'s 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 90 days after the date your or your *covered dependent*'s 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 90 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
  - the date 90 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 dependent*'s 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:
  - 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 s*econdary 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*.

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.

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*.

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;

- 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 *plan* deductible any amounts it would have credited to its

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. All determinations and interpretations made by us are conclusive and binding on all parties.

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. However, you must give us proof within 1 year from the date of loss unless you are legally incapacitated.

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.

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 the statute of limitations in your state has expired, but, in any case, not more than 6 years after the time written proof of loss is required to be given.

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.

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.

Any such right of Subrogation or Reimbursement provided to Fortis Benefits Insurance Company under this policy shall not apply or shall be limited to the extent that the Florida statutes or the courts of Florida eliminate or restrict such rights.

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.

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
2323 Grand Boulevard
Kansas City, Missouri 64108-2670

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January 1, 2014

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COMPBENEFITS INSURANCE COMPANY

P. O. Box 8236 Chicago, IL 60680-8236 (800) 342-5209

CERTIFICATE
OF
GROUP DENTAL INSURANCE

This certificate outlines the features of the Group Dental Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION WITH OTHER BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

IMPORTANT CANCELLATION INFORMATION

Please read the provision entitled Termination, found on page 15.

DEFINITIONS

You will need to know what is meant by certain terms used in this certificate. They are defined below.

"You" and "Your" mean the certificateholder.

"We", "Our" and "Us" mean CompBenefits.

"Premium Due Date" is the first day of each calendar month.

"Effective Date" means the date the Policy begins.

"Eligibility Date" means the date the employee can become insured as defined under When You Can Be Insured.

"Benefit Year" for the first policy year begins on the Effective Date and ends on the 31st of December of the same year. Thereafter, the Benefit Year will be the calendar year.

"Covered Dental Expenses" means the kinds of expenses which can apply to meet the Deductible or for which Dental Benefits can be paid. Covered Dental Expenses include only certain charges for services or supplies which do not exceed the Reimbursement Rate when ordered by a dentist for dental care and treatment. The charges for services or supplies listed in the Schedule of Benefits are the only charges that are Covered Dental Expenses.

"Covered Dental Injury" means all damage to a covered person's mouth due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that damage.

"Deductible" means the dollar amount of Covered Dental Expenses that must be incurred and paid by you before benefits can be paid. The Deductible is applied chronologically by the dates on which CompBenefits receives claims for Covered Dental Expenses. If all or any portion of an insured's or member's Deductible for a calendar year is applied against Covered Dental Expenses incurred by an insured or member during the last three months of the contract period, the insured's or member's Deductible for the next ensuing contract period shall be reduced by the amount so applied.

"Dental Treatment Plan" means a dentist's report, on a form that meets CompBenefits's approval, which: (a) itemizes the dental procedures that the dentist will perform; (b) lists the charges for each procedure; and (c) is accompanied by supporting pre-operative x-rays and any other appropriate diagnostic material required by CompBenefits. Related procedures (such as cleaning, root planing, fillings and crowns) will be considered part of the same Dental Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within four months of one another.

"Dentist" means any dental or medical practitioner who: a) is properly licensed or certified under the laws of the state where he practices; and b) provides services which are within the scope of that license or certificate.

"Group" means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

"Participating Dentists Fee Schedule" is a schedule of maximum allowable charges that participating network Dentists have agreed to use when charging You or Your Dependent.

"Policy" means the Policy issued to the Policyholder.

"Policyholder" means the Group to whom the Policy has been issued.

"Reimbursement Rate" means the total dollar amount of reimbursement for a Covered Dental Expense as determined by combining actual charges and relative values of the services in the area. Factors CompBenefits considers when determining Reimbursement Rate include geographic area and actual billed rates for services provided. Upon written request, CompBenefits shall provide a general description of the methodology used to determine the frequency of determining, and the database used to determine the Reimbursement Rate.

BECOMING INSURED

Who Can Be Insured

All persons who are members of the Group can be insured. You are a member of the Group if:

1. You are an eligible employee or member of the Policyholder (defined by the Policyholder); and
2. If you are an employee of the Group, you work at least the minimum number of hours per week (defined by the Policyholder).

If You and Your spouse are members of the Group, either of You may choose to be covered for Dental Benefits:

1. as an employee; or
2. as a dependent.
   If one chooses to be covered as a dependent, the other must choose to be covered as an employee

When You Can Be Insured

You can be insured on the Effective Date if:

1. You are a member of the Group on that date; and
2. You have completed the initial waiting period, as shown in the Schedule of Benefits.

If You do not meet the above requirements on Effective Date, Your Eligibility Date will be the Premium Due Date which next follows the date You first become a member of the Group, or during any open enrollment period as may be determined and approved by CompBenefits.

When Your Insurance Begins

To be insured under this policy, You must enroll within 31 days of your Eligibility Date. If You enroll and meet the Actively At Work Requirement, Your insurance will begin at 12:01 a.m. on the Premium Due Date which is the same as or which next follows the date You enroll.

If You do not enroll within 31 days of Your Eligibility Date, You may not enroll until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

The Actively At Work Requirement

If you are an employee of the Group, to become insured under the Group Policy You must be actively at work. To be actively at work, You must:
1. be able to do the normal tasks of Your job on a full-time basis for a full work day on the day Your insurance is to begin;
2. be able to do such tasks at one of Your employer's normal places of business or at a location to which You must travel to do Your job; and
3. not be absent from work because of leave of absence or temporary layoff.

If You do not meet the above requirements, insurance will begin on the Premium Due Date which is the same as or next follows the day on which You do meet these requirements.

Insurance For Your Dependents

If You are insured by the Group Policy, You can also insure Your Eligible Dependents. If You and Your spouse are members of the Group, either of You - but not both may insure Your children who are Eligible Dependents.

Who Are Your Eligible Dependents

Your Eligible Dependents are:
1. Your spouse, if You are legally married; and
2. Your unmarried children who are:
   (a) up to the Dependent Age listed in the Schedule of Benefits; or
   (b) up to the Dependent Maximum Age listed in the Schedule of Benefits, dependent on You for support, and attending an accredited educational institute, college or university, or vocational/technical school on a full time basis; or
   (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions:
      (1) the child must have become incapable prior to his or her 19th birthday, or the Dependent Maximum Age if a full time student, and must be covered as Your Eligible Dependent when he reaches age 19, or the Dependent Maximum Age if a full time student;
      (2) the child must be chiefly dependent on You for support and maintenance;
      (3) the child must stay unmarried and in the condition described above;

(4) You must give CompBenefits written proof that the child is incapable; and
(5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof.

A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

For purposes of this Policy the following are excluded from insurance coverage: 1) a dependent child who can be insured as a member of the Group; or 2) a dependent who is on active duty with the armed forces of any country.

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1) the date of birth if a petition for adoption is filed within 31 days of the birth of such child; or 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid within 31 days of such date.

When Insurance For Dependents Begins

If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin at 12:01 a.m. on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You while You are insured will be an Eligible Dependent and will automatically be insured for 31 days following the moment of birth. If You choose to insure Your newborn, You must enroll for the child within 31 days of his date of birth or coverage for that child will terminate at the end of the 31-day period.

When Your Insurance Ends

Your insurance will end at 12:01 a.m. on the earliest of:

1. The date on which the Group Policy terminates.
2. The last day of the month which follows Your last payment to the cost of Your insurance if You stop Your payments.
3. The last day of the month which follows the date You are no longer a member of the Group.
4. The last day of the month in which Your employment terminates.
5. The day you enter into any naval, military, air force or any other armed service in any country.

When Your Dependents' Insurance Ends

Insurance for Your dependents will end at 12:01 a.m. on the earliest of:

1. the date the Group Policy ends;
2. the date the Group Policy is changed to exclude insurance for Your dependents;
3. the date Your insurance ends; or
4. the date ending the term that insurance is in force because of Your last payment to the cost of insurance for Your dependents if You stop Your payments.

Insurance for any one dependent will end on the last day of the month in which he ceases to be an Eligible Dependent.

DENTAL BENEFITS

The Dental Benefits described on the pages that follow apply to Covered Dental Expenses incurred:

1. by You while You are insured; and
2. for a dependent while You are insured for the dependent.

Benefits will be paid after Covered Dental Expenses during a Benefit Year exceed the Deductible. Covered Dental Expenses will include only those charges for treatment or services that begin and are completed while You and Your dependents are insured.

Beginning Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will begin:

1. for full dentures or partial dentures - on the date the final impression is made;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays and other laboratory prepared restorations - on the date final preparation of the teeth is completed;
3. for root canal therapy - on the date the pulp chamber is first opened;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

CompBenefits will not pay benefits for any service which started prior to the patient being insured. If a procedure is started before the expiration of the waiting period to which that procedure is subject, no benefit will be payable, even if the procedure is completed after the expiration of the waiting period.

Completion Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will be completed:

1. for dentures and partial dentures - on the date the final completed appliance is inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient; and
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays, and other laboratory prepared restorations - on the date that the appliance is permanently cemented in place; for all other services, on the date the service is performed.

3. for root canal therapy - on the date the canals are permanently filled;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

Waiting Periods

Benefits for certain services are payable only after a person has satisfied a waiting period. Waiting periods are identified in the Schedule of Benefits.

Benefits Payable

Based on your Plan design, Benefits are payable at either a) the lesser of the Reimbursement Rates or actual charges incurred by You or Your dependents for Covered Dental Expenses, or b) the lesser of the Scheduled Benefits or actual charges incurred by You or Your dependents for Covered Dental Expenses. To receive benefits, the expenses incurred must exceed the Deductible. The expenses used to meet the Deductible must be incurred within a Benefit Year. When the Deductible is met, CompBenefits will pay benefits for expenses incurred during the rest of the Benefit Year. The amount of the benefits will be equal to the insured percentage of the Covered Dental Expenses or the Scheduled Benefits for the Covered Dental Expenses that are more than the Deductible. The insured percentages or Scheduled Benefits that apply to Covered Dental Expenses are shown in the Schedule of Benefits. No benefits are payable for expenses listed in the section headed “Exclusions”. The maximum benefit which will be paid is explained in the section headed “Maximum Benefits”.

Estimate of Benefits

If Covered Dental Expenses for a procedure are expected to be more than $200, CompBenefits recommends You send to CompBenefits a Dental Treatment Plan for the procedure before treatment begins. The Dental Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials as requested by CompBenefits. CompBenefits will notify You and Your dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If You and Your dentist decide on a more expensive method of treatment than that predetermined by CompBenefits, We will not pay the excess amount. The maximum Covered Dental Expense to be considered for payment will be the most economical procedure, determined by CompBenefits, to accomplish a professionally satisfactory result.

Maximum Benefits

The total amount of Dental Benefits that will be paid for one person for expenses (other than orthodontic expenses) incurred in a Benefit Year will not be more than the Maximum Annual Payment shown in the Schedule of Benefits.

Benefits After Insurance Ends

If a procedure (other than orthodontic treatment) starts for You or a dependent and it has not been completed when Dental Benefits end, You or Your dependent will be entitled to benefits for Covered Dental Expenses incurred for that procedure during the three months just after the insurance ends.

Orthodontic Benefits (If Applicable)

* This is an optional benefit that is only available if purchased by the Policyholder. Orthodontic plan benefits shall only be provided for Dependents 18 years of age or younger. See Schedule of Benefits to determine if You are covered for this benefit.

The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances, incurred in any Benefit Year, will not be more than the Orthodontic Annual Maximum if an Orthodontic Annual Maximum is shown in the Schedule of Benefits. The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances during the entire time insured will not be more than the Orthodontic Lifetime Maximum shown in the Schedule of Benefits. Orthodontic treatment will begin on the date the bands or appliance(s) are first inserted. Any other treatment that can be completed on the same day as performed will be considered started and completed on the actual date that the treatment is performed.

Orthodontic benefits are paid in equal quarterly installments over the course of the entire Dental Treatment Plan. The benefit payment schedule will be calculated by:

1. determining the total benefit payable for the orthodontic treatment plan;
2. defining the amount of the initial payment as 25% of the total benefit; and
3. divide the 75% balance of the total benefit by the number of quarters that the orthodontic treatment will continue to determine the amount which will be paid for each subsequent quarter of treatment.

The first installment will be payable as of the date on which the orthodontic appliances are first installed. The subsequent quarterly benefit payments will be made for as long as the insurance remains in force provided that You submit proof to CompBenefits that treatment continues.

Major Restorative Limitations

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. a denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy, however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
2. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture

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if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

3. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
4. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
5. the replacement of teeth up to the normal complement of 32.

Exclusions

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
18. charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, CompBenefits will determine the amount. CompBenefits will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;
19. orthodontic plan benefits for persons 19 years of age or older.

COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

(b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A “Plan” is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, dental care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans; and 3) medical benefits coverage in group, group type, and individual automobile “no-fault” type contracts or group or group-type automobile “fault” contracts. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

“This Plan” is the part of the Group Policy that provides Dental Benefits.

“Primary Plan’’/’’Secondary Plan’’. The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

“Allowable Expenses” means a necessary, reasonable and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a Benefit Year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

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

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, 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, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce

(further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

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

(2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

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

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans". The benefits of This Plan will be reduced when the sum of:

(a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and

(b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made;

exceeds those Allowable in a Claim Determination Period. In that case, the benefits

of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits 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 reasonable cash value of the benefits provided in the form of services.

7. OVERPAYMENTS.

If the amount of the payments made by CompBenefits are more than should have paid under this provision, CompBenefits may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

NOTICE OF CONTINUATION OF GROUP DENTAL COVERAGE RIGHTS (COBRA)

If You are member of an employer Group with 20 or more employees and Your insurance terminates in accordance with the other terms of the Policy, You may elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under the Policy, and if such insurance is terminating due to any of the following Qualified Events:

1) Termination of Your employment (for reasons other than gross misconduct).
2) Reduction of work hours including lay-off.
3) Death of the insured person.
4) Divorce or legal separation.
5) A child ceases to be a dependent as defined in this Policy.
6) The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

However, no continuation of coverage will be provided if You are covered under another group dental care plan coincident with or prior to any of the above events occurring. Continuation of insurance will be retroactive to the date of termination. The maximum continuation of coverage period with respect to a reason described above is:

1) 18 months with respect to 1 or 2 above. If You are disabled as determined under Title II or XVI of the Social Security Act, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months.
2) 36 months with respect to 3, 4 or 5 above.
3) With respect to 6 above, lifetime coverage for You, whereas Your Eligible Dependents will be covered until the earlier of a) Your death; or, b) Death of the Eligible Dependent.

If, while insurance is being continued, further events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days. It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: a) the date of the Qualifying Event; b) the date of the loss of coverage; or c) the date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: 1) The end of the maximum continuation of coverage period; 2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; 3) Your becoming covered under another group dental care plan as an employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group dental plan; 4) Discontinuance of this Dental Care Benefit Provision; 5) The date Your employer ceases to provide any group dental plan.

GENERAL PROVISIONS

Representations and Warranties

In the absence of fraud, all statements made by the Policyholder or by an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or You, a copy of which

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has been furnished to the Policyholder or You or Your beneficiary.

Premium Rates

All premiums are payable in advance for coverage under the Policy in accordance with the premium rate schedules of CompBenefits in effect for each Premium Due Date. Premiums are payable to CompBenefits or Our authorized agent and must be paid by the Policyholder from the Policyholder's funds or from funds contributed by You, or from both. Premiums may be increased for a contract period on the anniversary date of the contract. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 60 days prior to the anniversary of the contract period.

Grace Period

Unless the Policy is terminated, a grace period of 31 days is allowed for payment of each premium due after the first premium. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will be entitled to collect all pro rata premiums then unpaid for the period any coverage under the Policy remained in force during such grace period.

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

How to Claim Benefits

You can get the forms You need for claiming benefits from the Policyholder. We will furnish said forms to the Policyholder. If the forms are not furnished before the expiration of ten working days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within 90 days of the date of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. When making a claim for Dental Benefits You must give proof of each

charge. It is important that You have copies of bills for all charges. The bills must be itemized to show the service for which each charge is made. You may have benefits paid directly to dentists. To do so, fill out and sign the claim form telling CompBenefits to pay Your benefits this way.

Notice and Proof of Claim

Written notice of dental treatment must be given to Us within one year after the date when such dental treatment occurred. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 8236, Chicago, IL 60680-8236, or to any authorized agent of Us, with information sufficient to identify the insured, shall be deemed notice to Us. Failure to give notice within that time shall neither invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

Benefits will be paid upon receipt of written proof on standard dental claim forms acceptable to CompBenefits. CompBenefits may also accept as proof of a claim, notification in any format that is commonly accepted in the industry at the time the claim is made. The proof must describe the event for which the claim is made. Proof of loss due to hospital confinement must be given to CompBenefits within 90 days after the end of the period for which the claim is made. CompBenefits will have the right, at its own expense, to examine the person whose injury or sickness is the basis of a claim, when and so often as it may reasonably require while a claim is pending.

Legal Action

No legal action shall be brought to recover on a claim prior to the end of 60 days after proof of loss has been filed. No such action shall be brought at all unless brought within six years from the end of the time in which proof of loss is required.

Conformity with State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time of Payment of Claims

Indemnities payable under this Certificate for any loss, other than loss for which this Certificate provides periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by CompBenefits or by any agent duly authorized by CompBenefits to accept such premium without requiring in connection

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therewith an application for reinstatement shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and CompBenefits shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Time Limit on Certain Defenses

After this policy has been in force for a period of two (2) years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.

Participating Provider Networks, if applicable

Certain plans offered by CompBenefits feature different levels of benefits based upon You utilizing a participating network dentist. Participating dentists have agreed to charge You or Your eligible Dependents based on a Participating Dentists Fee Schedule. Benefits payable to non-participating dentists may be based on either the Reimbursement Rate or the Participating Dentists Fee Schedule. Non-participating dentists may bill You for the balance of their charges. Please check Your Schedule of Benefits to determine if Your plan features a participating network option. If it does, please refer to the list of participating network Dentists prior to making an appointment.

AMENDMENT

The Certificate of Group Dental Insurance ("Certificate") is hereby amended as follows.

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Amendment are in conflict with the terms and conditions of the Certificate, the terms of this Amendment shall govern.

1. The following is added to Page one (1) of the Certificate:

   If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 342-5209.

2. The provision "Who Are Your Eligible Dependents" is hereby deleted in its entirety and replaced with the following:

   Who Are Your Eligible Dependents

   Your Eligible Dependents are:

   1. Your spouse, if You are legally married; and
   2. Your children: (a) up to the Dependent Age listed in the Schedule of Benefits; or (b) up to the Dependent Maximum Age listed in the Schedule of Benefits if the child is dependent upon You for support and is living with You or is a full-time or part-time student; or (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions: (1) the child must have become incapable prior to his or her 19th birthday, or the end of the calendar year in which the child reaches the Dependent Maximum Age if the child is dependent upon You for support and is living with You or is a full-time or part-time student; (2) the child must be chiefly dependent on You for support and maintenance; (3) the child must stay in the condition described above; (4) You must give CompBenefits written proof that the child is incapable within 31 days after his or her coverage would end; and (5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof. A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

   For purposes of this Policy the following are excluded from insurance coverage:
   1. a dependent child who can be insured as a member of the Eligible Group; or
   2. a dependent who is on active duty with the armed forces of any country.

3. The provision "Coverage For Children Placed For Adoption" is hereby deleted in its entirety and replaced with the following:

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1. the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or 2. the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3. the date the child is placed with You for adoption.

4. The provision "When Insurance For Dependents Begins" is hereby deleted in its entirety and replaced with the following:

When Insurance For Dependents Begins

If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You or a covered Dependent while insured will be an Eligible Dependent and will automatically be insured for 60 days following the moment of birth. If You choose to insure the newborn, You must enroll the child within 60 days of his date of birth or coverage for that child will terminate at the end of the 60-day period. The coverage for a newborn child of a covered Dependent terminates 18 months after the birth of the newborn child.

5. The provision "Exclusions " is hereby amended as follows:

Exclusions

Benefits will not be paid for:

17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are received under any workers' compensation act or similar law; or

6. The provision “Termination” is hereby amended as follows:

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder.

If cancellation is due to nonpayment of premium a notice of termination will be mailed to the Policyholder prior to 45 days after the date the premium is due. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

7. The provision “Legal Action” is hereby deleted in its entirety and replaced with the following:

Legal Action

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

8. The following provision is hereby added as follows:

Information regarding performance outcomes and financial data published by the Florida Agency for Health Care Administration is available electronically on the Internet at http://www.floridahealthstat.com. A link to this site is also available by visiting the CompBenefits web site at http://www.CompBenefits.com

Gerald L. Ganoni
President

SCHEDULE OF BENEFITS
Indemnity Plan

	In-Network	Out-of-Network
Waiting Period for Type I Services:	None	None
Waiting Period for Type II Services:	None	None
Waiting Period for Type III Services:	None	None
Waiting Period for Type IV Services:	12 Months	Not Applicable
Dependent Age:	26	26
Dependent Maximum Age:	26	26
Annual Deductible	$25 Individual $50 Family Waived for Type I	$50 Individual $100 Family
Maximum Annual Payment	$1,200	$1,200

	In-Network	Out-of-Network
Type I - Diagnostic and Preventive Services	**100%**	**80%**
Type II - Basic Restorative Services	**80%**	**50%**
Type III - Major Services	**50%**	**30%**

	In-Network	Out-of-Network
Type IV – Orthodontia	**50%**	**0%**
Orthodontic Annual Maximum:	$1,500	Not Applicable
Orthodontic Lifetime Maximum:	$1,500	Not Applicable

Orthodontic care will be provided when in the opinion of the Orthodontic Consultant a satisfactory result can be achieved.

Cross bite in permanent teeth will only be treated when, in the opinion of the Orthodontic Consultant, other conditions are present which would indicate that orthodontic treatment is necessary. Plan benefits shall cover 24 months of usual and customary Orthodontic Care. Treatment beyond said 24 months will not be covered.

Note: When using an out-of-network provider, benefits are payable based on the Prevailing Fee.

SCHEDULE OF BENEFITS
Indemnity Plan

Type I - Diagnostic and Preventive

Code	Procedure	Limitation
D0120	Periodic Oral Evaluation	Limit 1 per 6 month period
D0140	Limited Oral Evaluation – problem focused	Limit 1 per 6 month period
D0150	Comprehensive Oral Evaluation – new or established patient	Limit 1 per 2 year period
D0180	Comprehensive periodontal evaluation – new or established patient	Limit 1 per 2 year period
D0210	Intraoral – Complete Series, including bitewings	Limit 1 per 3 year period
D0220	Intraoral Periapical x-rays	Limit 4 per 12 month period unless
D0230	Intraoral Periapical x-rays, each additional film	in conjunction with operative procedure
D0240	Intraoral Occlusal	Limit 2 films per 12 month period
D0250, D0260	Extraoral x-rays	Limit 2 films per 12 month period
D0270-D0274	Bitewing x-rays	Limit 1 set in any 12 month period
D0330	Panoramic film	Limit 1 per 3 year period
D1110, D1120	Prophylaxis	Limit 1 per 6 month period
D1201, D1203	Topical Application of Fluoride, per tooth	Limit 1 per 12 month period; limited to children under age 16
D1351	Sealant, per tooth	Limit 1 per 3 year period; limited to children under age 16 for non carious molars only
D1510-D1550	Space Maintainers	Limited to children under age 16

Type II - Basic Restorative Services

Code	Procedure	Limitation
D2140-D2161	Amalgam Restorations	Current amalgam must have been in place for 24 months
D2330-D2335	Composite Resin Restorations-anterior	Current composite resin must have been in place for 24 months
D2391-D2394	Composite Resin Restorations-posterior	Current composite resin must have been in place for 24 months
D3220	Therapeutic Pulpotomy	
D3230	Pulpal therapy anterior, primary tooth	
D3240	Pulpal therapy posterior, primary tooth	
D3310-D3330	Root Canal Therapy	Limit 1 per tooth
D3346-D3348	Root Canal Therapy - retreatment-by report	Limit 1 per tooth
D3351-D3353	Apexification	
D3410-D3426	Apicoectomy	
D3430	Retrograde Filling	
D3450	Root Amputation	
D3920	Hemisection	
D4210, D4211	Gingivectomy or gingivoplasty	Per Quadrant - Limit 1 per 36 months
D4240, D4241	Gingival Flap Procedure including root planing	Per Quadrant - Limit 1 per 36 months
D4249	Clinical crown lengthening - hard tissue	Per Quadrant - Limit 1 per 36 months
D4260, D4261	Osseous Surgery	Per Quadrant - Limit 1 per 36 months
D4263	Bone replacement graft - first site in quadrant	Per Quadrant - Limit 1 per 36 months

Type II - Basic Restorative Services (cont.)

D4264	Bone replacement graft - each additional site in Quadrant	Per Quadrant - Limit 1 per 36 months
D4266	Guided tissue regeneration - resorbable barrier - per site, per tooth	Per Quadrant - Limit 1 per 36 months
D4267	Guided tissue regeneration – nonresorbable barrier – includes membrane removal, per site - per tooth	Per Quadrant - Limit 1 per 36 months
D4270	Pedicle Soft Tissue Graft	Per Quadrant - Limit 1 per 36 months
D4271	Free soft tissue graft including donor site surgery	Per Quadrant - Limit 1 per 36 months
D4273	Subepithelial connective tissue graft procedure	Per Quadrant - Limit 1 per 36 months
D4274	Distal or proximal wedge, procedure when not performed in conjunction with surgical procedures in the same anatomical	Per Quadrant - Limit 1 per 36 months
D4320, D4321	Provisional Splinting	Limit 1 per 12 month period
D4341, D4342	Periodontal Scaling and Root Planing, per quadrant	Limit 1 per 24 month period
D4355	Full Mouth Debridement	Limit 1 per 24 month period
D4910	Periodontal Maintenance	
D7111	Coronal remnants, deciduous tooth	
D7140	Extraction, erupted tooth or exposed root elevation and/or forceps removal	
D7210	Surgical Extractions - except removal of impacted teeth	
D7220	Surgical removal of impacted tooth - soft tissue	
D7230	Surgical removal of impacted tooth - partially bony	
D7240	Surgical removal of impacted tooth - completely bony	
D7250	Surgical removal of residual tooth roots cutting procedure	
D7260	Oral Antral Fistula Closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	
D7272	Tooth transplantation	
D7281	Surgical Exposure of impacted or unerupted tooth to aid eruption.	
D7285, D7286	Biopsy of oral tissue	
D7310, D7320	Alveoloplasty	
D7340, D7350	Vestibuloplasty	
D7410, D7411	Excision of benign lesion	
D7450, D7451	Removal of benign odontogenic cyst or tumor	
D7471	Removal of exostosis maxilla or mandible	
D7510, D7520	Incision and Drainage	
D7530, D7540	Removal of foreign body	
D7960	Frenectomy	
D7970	Excision of Hyperplastic tissue - per arch	
D7971	Excision of pericoronal gingiva	
D7980	Sialolithotomy	
D7981	Excision of Salivary Gland, by report	
D7982	Sialodochoplasty	
D7983	Closure of Salivary Fistula	
D9110	Palliative emergency treatment of dental pain	
D9220, D9221	Deep sedation/general anesthesia	Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by Us

Type III - Major Services

Codes	Service	Limitations
D2510, D2520, D2530, D2543 D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664	Inlays and Onlays	Replacements allowed only if more than 5 years have passed since the last placement of the inlay, onlay and/or crown
D2710, D2721, D2740, D2750-D2752 D2790-D2792	Crowns	Replacements allowed only if more than 5 years have passed since the last placement of the inlay,onlay and/or crown. For patients under 16 years of age, benefit is limited to plastic and stainless steel crowns
D2910	Re-Cement Inlays	
D2920	Re-Cement Crowns	
D2930-D2933	Stainless Steel Crowns, Resin Crowns	
D2950	Core Build-up including any pins	
D2951	Pin Retention – per tooth, in addition to restoration	
D2952	Cast Post and Core, in addition to crown	
D2954	Prefabricated Post and Core, in addition to crown	
D2980	Crown Repair, by report	
D5110-D5140	Complete Dentures removable	Replacements allowed only if more than 5 years have passed since the last placement of the inlay, onlay and/or crown.
D5211, D5212, D5213, D5214, D5281	Partial Dentures removable	
D5410-D5422	Denture Adjustments	Limit 3 once denture is 6 months old
D5510, D5520, D5610, D5620, D5630, D5640,	Repairs to full and partial dentures	Limit 1 per 12 months
D5650	Add tooth to existing partial denture to replace newly extracted functioning natural tooth	
D5660	Add clasp to existing partial denture	
D5710-D5761	Relining Dentures, Rebasing Dentures	
D5850, D5851	Tissue Conditioning - maxillary or mandibular	
D6100	Removal of implant, by report	
D6211, D6241, D6251 D6602-D6607 D6610-D6615	Fixed Partial Dentures non-precious metal pontics, crown abutments, and metallic retainers; benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 5 years old	
D6545 D6721 D6751, D6780, D6791	Cast Metal Retainer for resin bonded fixed partial denture	
D6930	Re-Cement fixed partial denture	
D6970-D6972	Post and Core in conjunction with a fixed partial denture	
D6973	Core Buildup for Retainer including any pins	
D6980	Fixed partial denture repair, by report area.	

Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Medical Child Support Orders**
- **Continuation of Coverage for Full-time Students During Medical Leave of Absence**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
  ~Your Rights under ERISA

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA should consult their benefit plan documents for the applicable claims and appeals procedures.

DISCRETIONARY AUTHORITY

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

1. Interpret plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

CLAIMS PROCEDURES
Definitions

Adverse determination: means a decision to deny benefits for a pre-service claim or a post-service claim under a group health and/or dental plan.

Claimant: A covered person (or authorized representative) who files a claim.

Concurrent-care Decision: A decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan: an employee welfare benefit plan to the extent the plan provides dental care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer: the offering company listed on the face page of your Certificate of Insurance or Certificate of Coverage and referred to in this document as "Humana."

Post-service Claim: Any claim for a benefit under a group health plan that is not a Pre-service Claim.

Pre-service Claim: A request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care Claim (expedited review): A claim for covered services to which the application of the time periods for making non-urgent care determinations:

could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an Urgent-care Claim. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a "Urgent-care Claim" will be treated as a "claim involving urgent care."

Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense.
- Name and address of the provider
- Diagnosis

- Procedure or nature of the treatment
- Place of service
- Date of service
- Billed amount

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Procedural Defects

If a Pre-service Claim submission is not made in accordance with the plan's requirements, Humana will notify the Claimant of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an Urgent-care Claim). If a Post-service Claim is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.
- In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

After a determination on a claim is made, Humana will notify the Claimant within a reasonable time, as follows:

Pre-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the Claimant of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the necessary information.

Urgent-care Claims (expedited review)

Humana will determine whether a particular claim is an Urgent-care Claim. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a Claimant to clarify the medical urgency and circumstances supporting the Urgent-care Claim for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the Urgent-care Claim.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information - but not less than 48 hours.

Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or

- The end of the period afforded the Claimant to provide the specified additional information.

Concurrent-care Decisions

Humana will notify a Claimant of a Concurrent-care Decision involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination.

Humana will decide Urgent-care Claims involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a Claimant of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an Urgent-care Claim, the notice will provide a description of the plan's expedited review procedures.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A Claimant, on appeal, may request an expedited appeal of an adverse Urgent-care Claim decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

On appeal, a Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent-care Claims	As soon as possible but no later than 72 hours after Humana receives the appeal request.
Pre-service Claims	Within a reasonable period but no later than 30 days after Humana receives the appeal request.
Post-service Claims	Within a reasonable period but no later than 60 days after Humana receives the appeal request
Concurrent-care Decisions	Within the time periods specified above depending on the type of claim involved.

Appeals Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination.*

- Reference to the specific plan provision upon which the determination is based.

- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.

- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under section 502(a) of ERISA.

- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the Claimant, will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination.

- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.

- Demonstrates compliance with the administrative processes and safeguards required in making the determination.

- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee's child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the group health plan; and (e) is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment enforcing

state Medicaid law regarding medical child support required by the Social Security Act section 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

CONTINUATION OF COVERAGE FOR FULL-TIME STUDENTS DURING MEDICAL LEAVE OF ABSENCE

A dependent child who is in regular full-time attendance at an accredited secondary school, college or university, or licensed technical school continues to be eligible for coverage for until the earlier of the following if the dependent child takes a medically necessary leave of absence:

- Up to one year after the first day of the medically necessary leave of absence; or
- The date coverage would otherwise terminate under the plan.

We may require written certification from the dependent child's health care practitioner that the dependent child has a serious bodily injury or sickness requiring a medically necessary leave of absence.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
Introduction

You are receiving this notice because you have recently become covered under a group health and/or dental plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's benefit plan document or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happen:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorce or legally separation from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment,

COBRA continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group heath and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gob/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.
IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

OPTION 1 - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

Category 1 Medicare eligibles are:

- Covered employees in active service who are age 65 or older who choose Option 1;
- Age 65 or older covered spouses; and
- Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

Category 2 Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

- Retired employees and their spouses; or
- Covered dependents of a covered employee, other than his or her spouse.

Calculation and Payment of Benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Continuation of Benefits
Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility
An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of Coverage

Of elected, continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months beginning the first day of absence from employment due to service in the uniformed services; or

2. The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other Information
Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information About the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called 'fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue Group Health Plan Coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims Determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with Questions

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

Treatment: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

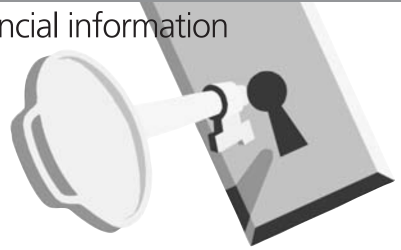
Payment: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.

Notice of Privacy Practices

for your *personal* health and financial information



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

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency

- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

Notice of Privacy Practices *(continued)*

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacy office@humana.com

Send completed request form to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Human by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.

Notice of Privacy Practices *(continued)*

- Send your opt-out request to us in writing:
  Humana Privacy Office
  P. O. Box 1438
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.
American Dental Plan of North Carolina, Inc.
Cariten Insurance Company
Cariten Health Plan
CarePlus Health Plans, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc.
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana MarketPOINT, Inc.*
Humana MarketPOINT of Puerto Rico, Inc.*
Humana Medical Plan of Utah, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

HUMANA®
Guidance when you need it most

GN14474HH 209

RFP No.: DMS 16/17-016
Attachment 1

HumanaDental

Schedule B Indemnity Dental Plan
Florida

Humana

FLHHB32HH

RFP No.: DMS 16/17-016
Attachment 1

COMPBENEFITS INSURANCE COMPANY

P. O. Box 8236 Chicago, IL 60680-8236 (800) 342-5209

CERTIFICATE
OF
GROUP DENTAL INSURANCE

This certificate outlines the features of the Group Dental Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION WITH OTHER BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

IMPORTANT CANCELLATION INFORMATION

Please read the provision entitled Termination, found on page 15.

DEFINITIONS

You will need to know what is meant by certain terms used in this certificate. They are defined below.

"You" and "Your" mean the certificateholder.

"We", "Our" and "Us" mean CompBenefits.

"Premium Due Date" is the first day of each calendar month.

"Effective Date" means the date the Policy begins.

"Eligibility Date" means the date the employee can become insured as defined under When You Can Be Insured.

"Benefit Year" for the first policy year begins on the Effective Date and ends on the 31st of December of the same year. Thereafter, the Benefit Year will be the calendar year.

"Covered Dental Expenses" means the kinds of expenses which can apply to meet the Deductible or for which Dental Benefits can be paid. Covered Dental Expenses include only certain charges for services or supplies which do not exceed the Reimbursement Rate when ordered by a dentist for dental care and treatment. The charges for services or supplies listed in the Schedule of Benefits are the only charges that are Covered Dental Expenses.

"Covered Dental Injury" means all damage to a covered person's mouth due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that damage.

"Deductible" means the dollar amount of Covered Dental Expenses that must be incurred and paid by you before benefits can be paid. The Deductible is applied chronologically by the dates on which CompBenefits receives claims for Covered Dental Expenses. If all or any portion of an insured's or member's Deductible for a calendar year is applied against Covered Dental Expenses incurred by an insured or member during the last three months of the contract period, the insured's or member's Deductible for the next ensuing contract period shall be reduced by the amount so applied.

"Dental Treatment Plan" means a dentist's report, on a form that meets CompBenefits's approval, which: (a) itemizes the dental procedures that the dentist will perform; (b) lists the charges for each procedure; and (c) is accompanied by supporting pre-operative x-rays and any other appropriate diagnostic material required by CompBenefits. Related procedures (such as cleaning, root planing, fillings and crowns) will be considered part of the same Dental Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within four months of one another.

"Dentist" means any dental or medical practitioner who: a) is properly licensed or certified under the laws of the state where he practices; and b) provides services which are within the scope of that license or certificate.

"Group**"** means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

"Participating Dentists Fee Schedule" is a schedule of maximum allowable charges that participating network Dentists have agreed to use when charging You or Your Dependent.

"Policy" means the Policy issued to the Policyholder.

"Policyholder" means the Group to whom the Policy has been issued.

"Reimbursement Rate" means the total dollar amount of reimbursement for a Covered Dental Expense as determined by combining actual charges and relative values of the services in the area. Factors CompBenefits considers when determining Reimbursement Rate include geographic area and actual billed rates for services provided. Upon written request, CompBenefits shall provide a general description of the methodology used to determine the frequency of determining, and the database used to determine the Reimbursement Rate.

BECOMING INSURED

Who Can Be Insured

All persons who are members of the Group can be insured. You are a member of the Group if:

1. You are an eligible employee or member of the Policyholder (defined by the Policyholder); and
2. If you are an employee of the Group, you work at least the minimum number of hours per week (defined by the Policyholder).

If You and Your spouse are members of the Group, either of You may choose to be covered for Dental Benefits:

1. as an employee; or
2. as a dependent.

   If one chooses to be covered as a dependent, the other must choose to be covered as an employee

When You Can Be Insured

You can be insured on the Effective Date if:

1. You are a member of the Group on that date; and
2. You have completed the initial waiting period, as shown in the Schedule of Benefits.

If You do not meet the above requirements on Effective Date, Your Eligibility Date will be the Premium Due Date which next follows the date You first become a member of the Group, or during any open enrollment period as may be determined and approved by CompBenefits.

When Your Insurance Begins

To be insured under this policy, You must enroll within 31 days of your Eligibility Date. If You enroll and meet the Actively At Work Requirement, Your insurance will begin at 12:01 a.m. on the Premium Due Date which is the same as or which next follows the date You enroll.

If You do not enroll within 31 days of Your Eligibility Date, You may not enroll until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

The Actively At Work Requirement

If you are an employee of the Group, to become insured under the Group Policy You must be actively at work. To be actively at work, You must:

1. be able to do the normal tasks of Your job on a full-time basis for a full work day on the day Your insurance is to begin;
2. be able to do such tasks at one of Your employer's normal places of business or at a location to which You must travel to do Your job; and
3. not be absent from work because of leave of absence or temporary layoff.

If You do not meet the above requirements, insurance will begin on the Premium Due Date which is the same as or next follows the day on which You do meet these requirements.

Insurance For Your Dependents

If You are insured by the Group Policy, You can also insure Your Eligible Dependents. If You and Your spouse are members of the Group, either of You - but not both may insure Your children who are Eligible Dependents.

Who Are Your Eligible Dependents

Your Eligible Dependents are:

1. Your spouse, if You are legally married; and
2. Your unmarried children who are:
   (a) up to the Dependent Age listed in the Schedule of Benefits; or
   (b) up to the Dependent Maximum Age listed in the Schedule of Benefits, dependent on You for support, and attending an accredited educational institute, college or university, or vocational/technical school on a full time basis; or
   (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions:
      (1) the child must have become incapable prior to his or her 19th birthday, or the Dependent Maximum Age if a full time student, and must be covered as Your Eligible Dependent when he reaches age 19, or the Dependent Maximum Age if a full time student;
      (2) the child must be chiefly dependent on You for support and maintenance;
      (3) the child must stay unmarried and in the condition described above;

(4) You must give CompBenefits written proof that the child is incapable; and
(5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof.

A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

For purposes of this Policy the following are excluded from insurance coverage: 1) a dependent child who can be insured as a member of the Group; or 2) a dependent who is on active duty with the armed forces of any country.

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1) the date of birth if a petition for adoption is filed within 31 days of the birth of such child; or 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid within 31 days of such date.

When Insurance For Dependents Begins

If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin at 12:01 a.m. on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You while You are insured will be an Eligible Dependent and will automatically be insured for 31 days following the moment of birth. If You choose to insure Your newborn, You must enroll for the child within 31 days of his date of birth or coverage for that child will terminate at the end of the 31-day period.

When Your Insurance Ends

Your insurance will end at 12:01 a.m. on the earliest of:

1. The date on which the Group Policy terminates.
2. The last day of the month which follows Your last payment to the cost of Your insurance if You stop Your payments.
3. The last day of the month which follows the date You are no longer a member of the Group.
4. The last day of the month in which Your employment terminates.
5. The day you enter into any naval, military, air force or any other armed service in any country.

When Your Dependents' Insurance Ends

Insurance for Your dependents will end at 12:01 a.m. on the earliest of:

1. the date the Group Policy ends;
2. the date the Group Policy is changed to exclude insurance for Your dependents;
3. the date Your insurance ends; or
4. the date ending the term that insurance is in force because of Your last payment to the cost of insurance for Your dependents if You stop Your payments.

Insurance for any one dependent will end on the last day of the month in which he ceases to be an Eligible Dependent.

DENTAL BENEFITS

The Dental Benefits described on the pages that follow apply to Covered Dental Expenses incurred:

1. by You while You are insured; and
2. for a dependent while You are insured for the dependent.

Benefits will be paid after Covered Dental Expenses during a Benefit Year exceed the Deductible. Covered Dental Expenses will include only those charges for treatment or services that begin and are completed while You and Your dependents are insured.

Beginning Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will begin:

1. for full dentures or partial dentures - on the date the final impression is made;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays and other laboratory prepared restorations - on the date final preparation of the teeth is completed;
3. for root canal therapy - on the date the pulp chamber is first opened;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

CompBenefits will not pay benefits for any service which started prior to the patient being insured. If a procedure is started before the expiration of the waiting period to which that procedure is subject, no benefit will be payable, even if the procedure is completed after the expiration of the waiting period.

Completion Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will be completed:

1. for dentures and partial dentures - on the date the final completed appliance is inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient; and
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays, and other laboratory prepared restorations - on the date that the appliance is permanently cemented in place; for all other services, on the date the service is performed.

3. for root canal therapy - on the date the canals are permanently filled;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

Waiting Periods

Benefits for certain services are payable only after a person has satisfied a waiting period. Waiting periods are identified in the Schedule of Benefits.

Benefits Payable

Based on your Plan design, Benefits are payable at either a) the lesser of the Reimbursement Rates or actual charges incurred by You or Your dependents for Covered Dental Expenses, or b) the lesser of the Scheduled Benefits or actual charges incurred by You or Your dependents for Covered Dental Expenses. To receive benefits, the expenses incurred must exceed the Deductible. The expenses used to meet the Deductible must be incurred within a Benefit Year. When the Deductible is met, CompBenefits will pay benefits for expenses incurred during the rest of the Benefit Year. The amount of the benefits will be equal to the insured percentage of the Covered Dental Expenses or the Scheduled Benefits for the Covered Dental Expenses that are more than the Deductible. The insured percentages or Scheduled Benefits that apply to Covered Dental Expenses are shown in the Schedule of Benefits. No benefits are payable for expenses listed in the section headed “Exclusions”. The maximum benefit which will be paid is explained in the section headed “Maximum Benefits”.

Estimate of Benefits

If Covered Dental Expenses for a procedure are expected to be more than $200, CompBenefits recommends You send to CompBenefits a Dental Treatment Plan for the procedure before treatment begins. The Dental Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials as requested by CompBenefits. CompBenefits will notify You and Your dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If You and Your dentist decide on a more expensive method of treatment than that predetermined by CompBenefits, We will not pay the excess amount. The maximum Covered Dental Expense to be considered for payment will be the most economical procedure, determined by CompBenefits, to accomplish a professionally satisfactory result.

Maximum Benefits

The total amount of Dental Benefits that will be paid for one person for expenses (other than orthodontic expenses) incurred in a Benefit Year will not be more than the Maximum Annual Payment shown in the Schedule of Benefits.

Benefits After Insurance Ends

If a procedure (other than orthodontic treatment) starts for You or a dependent and it has not been completed when Dental Benefits end, You or Your dependent will be entitled to benefits for Covered Dental Expenses incurred for that procedure during the three months just after the insurance ends.

Orthodontic Benefits (If Applicable)

* This is an optional benefit that is only available if purchased by the Policyholder. Orthodontic plan benefits shall only be provided for Dependents 18 years of age or younger. See Schedule of Benefits to determine if You are covered for this benefit.

The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances, incurred in any Benefit Year, will not be more than the Orthodontic Annual Maximum if an Orthodontic Annual Maximum is shown in the Schedule of Benefits. The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances during the entire time insured will not be more than the Orthodontic Lifetime Maximum shown in the Schedule of Benefits. Orthodontic treatment will begin on the date the bands or appliance(s) are first inserted. Any other treatment that can be completed on the same day as performed will be considered started and completed on the actual date that the treatment is performed.

Orthodontic benefits are paid in equal quarterly installments over the course of the entire Dental Treatment Plan. The benefit payment schedule will be calculated by:

1. determining the total benefit payable for the orthodontic treatment plan;
2. defining the amount of the initial payment as 25% of the total benefit; and
3. divide the 75% balance of the total benefit by the number of quarters that the orthodontic treatment will continue to determine the amount which will be paid for each subsequent quarter of treatment.

The first installment will be payable as of the date on which the orthodontic appliances are first installed. The subsequent quarterly benefit payments will be made for as long as the insurance remains in force provided that You submit proof to CompBenefits that treatment continues.

Major Restorative Limitations

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. a denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy, however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
2. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture

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if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

3. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
4. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
5. the replacement of teeth up to the normal complement of 32.

Exclusions

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
18. charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, CompBenefits will determine the amount. CompBenefits will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;
19. orthodontic plan benefits for persons 19 years of age or older.

COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

(b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A “Plan” is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, dental care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans; and 3) medical benefits coverage in group, group type, and individual automobile “no-fault” type contracts or group or group-type automobile “fault” contracts. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

“This Plan” is the part of the Group Policy that provides Dental Benefits.

“Primary Plan”/”Secondary Plan”. The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

“Allowable Expenses” means a necessary, reasonable and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a Benefit Year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

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

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, 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, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce

(further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

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

(2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

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

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans". The benefits of This Plan will be reduced when the sum of:

(a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and

(b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made;

exceeds those Allowable in a Claim Determination Period. In that case, the benefits

of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits 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 reasonable cash value of the benefits provided in the form of services.

7. OVERPAYMENTS.

If the amount of the payments made by CompBenefits are more than should have paid under this provision, CompBenefits may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

NOTICE OF CONTINUATION OF GROUP DENTAL COVERAGE RIGHTS (COBRA)

If You are member of an employer Group with 20 or more employees and Your insurance terminates in accordance with the other terms of the Policy, You may elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under the Policy, and if such insurance is terminating due to any of the following Qualified Events:

1) Termination of Your employment (for reasons other than gross misconduct).
2) Reduction of work hours including lay-off.
3) Death of the insured person.
4) Divorce or legal separation.
5) A child ceases to be a dependent as defined in this Policy.
6) The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

However, no continuation of coverage will be provided if You are covered under another group dental care plan coincident with or prior to any of the above events occurring. Continuation of insurance will be retroactive to the date of termination. The maximum continuation of coverage period with respect to a reason described above is:

1) 18 months with respect to 1 or 2 above. If You are disabled as determined under Title II or XVI of the Social Security Act, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months.
2) 36 months with respect to 3, 4 or 5 above.
3) With respect to 6 above, lifetime coverage for You, whereas Your Eligible Dependents will be covered until the earlier of a) Your death; or, b) Death of the Eligible Dependent.

If, while insurance is being continued, further events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days. It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: a) the date of the Qualifying Event; b) the date of the loss of coverage; or c) the date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: 1) The end of the maximum continuation of coverage period; 2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; 3) Your becoming covered under another group dental care plan as an employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group dental plan; 4) Discontinuance of this Dental Care Benefit Provision; 5) The date Your employer ceases to provide any group dental plan.

GENERAL PROVISIONS

Representations and Warranties

In the absence of fraud, all statements made by the Policyholder or by an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or You, a copy of which

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has been furnished to the Policyholder or You or Your beneficiary.

Premium Rates

All premiums are payable in advance for coverage under the Policy in accordance with the premium rate schedules of CompBenefits in effect for each Premium Due Date. Premiums are payable to CompBenefits or Our authorized agent and must be paid by the Policyholder from the Policyholder's funds or from funds contributed by You, or from both. Premiums may be increased for a contract period on the anniversary date of the contract. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 60 days prior to the anniversary of the contract period.

Grace Period

Unless the Policy is terminated, a grace period of 31 days is allowed for payment of each premium due after the first premium. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will be entitled to collect all pro rata premiums then unpaid for the period any coverage under the Policy remained in force during such grace period.

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

How to Claim Benefits

You can get the forms You need for claiming benefits from the Policyholder. We will furnish said forms to the Policyholder. If the forms are not furnished before the expiration of ten working days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within 90 days of the date of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. When making a claim for Dental Benefits, You must give proof of each

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charge. It is important that You have copies of bills for all charges. The bills must be itemized to show the service for which each charge is made. You may have benefits paid directly to dentists. To do so, fill out and sign the claim form telling CompBenefits to pay Your benefits this way.

Notice and Proof of Claim

Written notice of dental treatment must be given to Us within one year after the date when such dental treatment occurred. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 8236, Chicago, IL 60680-8236, or to any authorized agent of Us, with information sufficient to identify the insured, shall be deemed notice to Us. Failure to give notice within that time shall neither invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

Benefits will be paid upon receipt of written proof on standard dental claim forms acceptable to CompBenefits. CompBenefits may also accept as proof of a claim, notification in any format that is commonly accepted in the industry at the time the claim is made. The proof must describe the event for which the claim is made. Proof of loss due to hospital confinement must be given to CompBenefits within 90 days after the end of the period for which the claim is made. CompBenefits will have the right, at its own expense, to examine the person whose injury or sickness is the basis of a claim, when and so often as it may reasonably require while a claim is pending.

Legal Action

No legal action shall be brought to recover on a claim prior to the end of 60 days after proof of loss has been filed. No such action shall be brought at all unless brought within six years from the end of the time in which proof of loss is required.

Conformity with State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time of Payment of Claims

Indemnities payable under this Certificate for any loss, other than loss for which this Certificate provides periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by CompBenefits or by any agent duly authorized by CompBenefits to accept such premium without requiring in connection

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therewith an application for reinstatement shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and CompBenefits shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Time Limit on Certain Defenses

After this policy has been in force for a period of two (2) years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.

Participating Provider Networks, if applicable

Certain plans offered by CompBenefits feature different levels of benefits based upon You utilizing a participating network dentist. Participating dentists have agreed to charge You or Your eligible Dependents based on a Participating Dentists Fee Schedule. Benefits payable to non-participating dentists may be based on either the Reimbursement Rate or the Participating Dentists Fee Schedule. Non-participating dentists may bill You for the balance of their charges. Please check Your Schedule of Benefits to determine if Your plan features a participating network option. If it does, please refer to the list of participating network Dentists prior to making an appointment.

AMENDMENT

The Certificate of Group Dental Insurance ("Certificate") is hereby amended as follows.

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Amendment are in conflict with the terms and conditions of the Certificate, the terms of this Amendment shall govern.

1. The following is added to Page one (1) of the Certificate:

   If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 342-5209.

2. The provision "Who Are Your Eligible Dependents" is hereby deleted in its entirety and replaced with the following:

   Who Are Your Eligible Dependents

   Your Eligible Dependents are:

   1. Your spouse, if You are legally married; and
   2. Your children: (a) up to the Dependent Age listed in the Schedule of Benefits; or (b) up to the Dependent Maximum Age listed in the Schedule of Benefits if the child is dependent upon You for support and is living with You or is a full-time or part-time student; or (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions: (1) the child must have become incapable prior to his or her 19th birthday, or the end of the calendar year in which the child reaches the Dependent Maximum Age if the child is dependent upon You for support and is living with You or is a full-time or part-time student; (2) the child must be chiefly dependent on You for support and maintenance; (3) the child must stay in the condition described above; (4) You must give CompBenefits written proof that the child is incapable within 31 days after his or her coverage would end; and (5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof. A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

   For purposes of this Policy the following are excluded from insurance coverage:
   1. a dependent child who can be insured as a member of the Eligible Group; or
   2. a dependent who is on active duty with the armed forces of any country.

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3. The provision "Coverage For Children Placed For Adoption" is hereby deleted in its entirety and replaced with the following:

   Coverage For Children Placed For Adoption

   A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1. the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or 2. the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3. the date the child is placed with You for adoption.

4. The provision "When Insurance For Dependents Begins" is hereby deleted in its entirety and replaced with the following:

   When Insurance For Dependents Begins

   If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

   A child born to You or a covered Dependent while insured will be an Eligible Dependent and will automatically be insured for 60 days following the moment of birth. If You choose to insure the newborn, You must enroll the child within 60 days of his date of birth or coverage for that child will terminate at the end of the 60-day period. The coverage for a newborn child of a covered Dependent terminates 18 months after the birth of the newborn child.

5. The provision "Exclusions " is hereby amended as follows:

   Exclusions

   Benefits will not be paid for:

   17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are received under any workers' compensation act or similar law; or

6. The provision "Termination" is hereby amended as follows:

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder.

If cancellation is due to nonpayment of premium a notice of termination will be mailed to the Policyholder prior to 45 days after the date the premium is due. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

7. The provision "Legal Action" is hereby deleted in its entirety and replaced with the following:

Legal Action

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

8. The following provision is hereby added as follows:

Information regarding performance outcomes and financial data published by the Florida Agency for Health Care Administration is available electronically on the Internet at http://www.floridahealthstat.com. A link to this site is also available by visiting the CompBenefits web site at http://www.CompBenefits.com.

It is agreed and acknowledged that this Amendment shall be effective upon receipt of this Amendment.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

CompBenefits Insurance Company

SCHEDULE B

Plan Design Summary

Initial Waiting Period for Insurance: None
Waiting Period for Type I Services: None
Waiting Period for Type II Services: None
Waiting Period for Type III Services: None
Dependent Age: 26
Dependent Maximum Age: 26
Annual Deductible: $50 per person; max 3 per family; waived for Type I
Maximum Annual Payment: $1,000

TYPE I: PREVENTIVE DENTAL SERVICES

The maximum charge for TYPE I Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

PROCEDURE	MAXIMUM REIMBURSEMENT
Initial oral evaluation (Limit 2 per 1 year period)	$15.30
Periodic oral evaluation (Limit 2 per 1 year period)	$11.70
Emergency oral evaluation (Limit 2 per 1 year period)	$15.30
Complete Series X-ray (Limit 1 per 3 year period)	$30.60
Periapical - first film	$6.30
Periapical - each additional film	$6.30
Occlusal film	$8.10
Extraoral - first film	$10.80
Extraoral - each additional	$9.00
Bitewings - one film (Limit 2 per 1 year period)	$9.00
Bitewings - two films (Limit 2 per 1 year period)	$12.60
Bitewings - three films (Limit 2 per 1 year period)	$13.50
Bitewings - four films (maximum)	$16.20
Posterior - anterior or lateral skull and facial bone survey film	$21.60
Panoramic X-ray (Limit 1 per 3 year period)	$23.40

TYPE I: PREVENTIVE DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Bacteriologic studies for determination of pathologic agents	$18.00
Prophylaxis - adult (Limit 2 per 1 year period)	$18.90
Prophylaxis - child (Limit 2 per 1 year period)	$18.00
Sodium fluoride treatment (excluding prophylaxis) - child under age 16 (Limit 2 per 1 year period)	$15.30
Sodium fluoride treatment (including prophylaxis) - child under age 16 (Limit 2 per 1 year period	$21.60
Stannous fluoride treatment (excluding prophylaxis) - child under age 16 (Limit 2 per 1 year period)	$15.30
Stannous fluoride treatment (including prophylaxis) - child under age 16 (Limit 2 per 1 year period)	$21.60
Acid fluoride phosphate treatment (excluding prophylaxis) - child under 16 (Limit 2 per 1 year period)	$15.30
Acid fluoride phosphate treatment (including prophylaxis) - child under 16 (Limit 2 per 1 year period)	$21.60
Space maintainer - fixed - unilateral	$80.10
Space maintainer - fixed - bilateral	$108.00
Space maintainer - removable - unilateral	$100.80
Space maintainer - removable - bilateral	$109.80
Recement space maintainer	$13.50
Sealants, per tooth - child under age 13 (Limit 1 per 12 month period)	$6.30
Biopsy of oral tissue - hard	$45.00
Biopsy of oral tissue - soft	$30.60
D9110 Palliative (emergency) treatment of dental pain (Covered as a separate procedure only if no other service, except x-rays, is rendered during the visit)	$14.40

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TYPE II: BASIC DENTAL SERVICES

The maximum charge for TYPE II Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

PROCEDURE	MAXIMUM REIMBURSEMENT
Amalgam - one surface, deciduous (Multiple restorations on one surface will be covered as a single filling.)	$10.80
Amalgam - two surfaces, deciduous (Multiple restorations on one surface will be covered as a single filling.)	$16.20
Amalgam - three surfaces, deciduous (Multiple restorations on one surface will be covered as a single filling.)	$21.60
Amalgam - four surfaces, deciduous (Multiple restorations on one surface will be covered as a single filling.)	$24.30
Amalgam - one surface, permanent	$11.70
Amalgam - two surfaces, permanent	$18.00
Amalgam - three surfaces, permanent	$22.50
Amalgam - four or more surfaces, permanent	$28.80
Pin retention - per tooth (exclusive of amalgam)	$9.90
Silicate cement - per restoration	$15.30
Acrylic or plastic restoration	$16.20
Acrylic involving incisal angle	$22.50
Composite - one surface (Mesial-lingual, distal, lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.)	$15.30
Composite - two surfaces (Mesial-lingual, distal, lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.)	$22.50
Composite - three surfaces (Mesial-lingual, distal, lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.)	$30.60
Pin retention - exclusive of composite	$17.10
Composite involving incisal angle	$28.80
Acid etch in addition to composite	$14.40
Recement inlays	$11.70
Recement crowns	$11.70
Crown build-ups	$36.00
Sedative filling (Covered as a separate procedure only if no other service, except x-rays, is rendered during the visit)	$12.60

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Visal pulpotomy - excluding restoration	$20.70
Anterior root canal - one canal	$162.00
Sargenti root canal - one canal	$55.80
Bicuspid root canal - two canals	$198.00
Sargenti root canal - two canals	$76.50
Root canal therapy	
Two canals excluding restoration, traditional	$198.00
Three canals excluding restoration, sargenti	$101.70
Three canals excluding restoration, traditional	$243.00
Molar (3 8 41 canals) excluding restoration, traditional	$243.00
Molar (3-x4 canals), sargenti	$101.70
Apexification	$45.90
Apicoectomy - separate procedure (1 root)	$71.10
Apicoectomy - separate procedure (2 roots)	$90.90
Apicoectomy - separate procedure (3 roots)	$111.60
Apicoectomy - performed in conjunction with root canal therapy (1 canal)	$51.30
Apicoectomy - performed in conjunction with root canal therapy (2 canals)	$71.10
Apicoectomy - performed in conjunction with root canal therapy (3 canals)	$90.90
Retrograde filling per root - in addition to apicoectomy	$26.10
Apical curettage	$30.60
Root amputation	$38.70
Hemisection	$38.70
Provisional splinting - intracoronal	$18.00
Provisional splinting - extracoronal	$18.00
Occlusal adjustment - limited (Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment)	$14.40
Occlusal adjustment - complete (Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment)	$36.90
Distal wedge - separate procedure	$76.50
Distal wedge in conjunction with osseous	$51.30

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TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Scaling and root planing, entire mouth (Limit 2 per 1 year period)	$81.00
Scaling and root planing, limited (Limited 2 per 1 year period)	$30.60
Scaling and root planing, per quadrant (Limit 2 per 1 year period)	$14.40
Periodontal prophylaxis (Covered only for a combined maximum of two prophylaxis per 12 months, including prophylaxis and periodontal prophylaxis.)	$19.80
Gingivectomy - per quadrant (Limit 1 per 12 month period)	$51.30
Gingivectomy - per sextant (Limit 1 per 12 month period)	$33.30
Gingivectomy - per tooth area (maximum 4/quadrant) (Limit 1 per 12 month period)	$13.50
Gingival curettage - per quadrant (Limit 1 per 12 month period)	$16.20
Gingival curettage - per sextant (Limit 1 per 12 month period)	$11.70
Gingival curettage - per tooth area (maximum 4/quadrant) (Limit 1 per 12 month period)	$5.40
Gingival flap - per quadrant (Limit 1 per 12 month period)	$57.60
Gingival flap - per sextant (Limit 1 per 12 month period)	$63.90
Mucogingival surgery - per quadrant (Limit 1 per 12 month period)	$63.90
Osseous surgery - per quadrant (Limit 1 per 12 month period)	$95.40
Osseous graft - single site	$57.60
Osseous graft - multiple sites	$76.50
Osseous surgery - per sextant	$63.90
Osseous surgery - per tooth (maximum 3/quadrant)	$24.30
Pedicle grafts	$57.60
Free soft tissue grafts	$63.90
Vestibuloplasty	$79.20
Repair denture - no teeth damaged (Covered only if repairs or adjustments are done more than one year after the initial insertion.)	$26.10
Repair denture - replace one broken tooth (Covered only if repairs or adjustments are done more than one year after the initial insertion	$26.10

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Replace additional teeth - each tooth	$20.70
Replace broken tooth on denture - no other repairs	$18.90
Add tooth to partial, replace extracted tooth - no clasp	$36.00
Add tooth to partial, replace extracted tooth - with clasp	$45.90
Reattach damaged clasp on denture	$30.60
Replace broken clasp with new clasp on denture	$38.70
Each additional clasp with rest	$30.60
rebase upper or lower denture - partial or complete	$76.50
Repair or replace broken pontic	$27.90
Replace facing	$30.60
Recement bridge	$16.20
Extraction, single tooth	$14.40
Extraction, each additional tooth	$13.50
Surgical extraction of erupted tooth	$26.10
Surgical extraction - soft tissue impaction	$36.00
Surgical extraction - partially bony impaction	$45.90
Surgical extraction - completely bony impaction	$61.20
Root recovery (entirely covered by bone)	$28.80
Tooth reimplantation and/or stabilization	$47.70
Tooth transplantation	$51.30
Alveoloplasty per quadrant with extractions	$21.60
Alveoloplasty per tooth with extractions	$5.40
Alveoloplasty per quadrant with no extractions	$25.20
Alveoloplasty per tooth with no extractions	$7.20
Stomaloplasty - per arch, uncomplicated	$38.70
Stomaloplasty - per arch, complicated	$76.50
Frenulectomy - separate procedure	$33.30
Excision of hyperplastic tissue - per arch	$38.70
Incision and drainage of abscess - intraoral soft tissue	$22.50

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Incision and drainage of abscess - extraoral soft tissue	$34.20
General anesthesia - first 30 minutes (Covered as a separate procedure only when required for complex oral surgical procedures, as determined by the Company, covered under the Policy.)	$30.60
Therapeutic drug injection, by report	$11.70

TYPE III: MAJOR DENTAL SERVICES

The maximum charge for TYPE III Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

PROCEDURE	MAXIMUM REIMBURSEMENT
Diagnostic casts	$15.30
Inlay - Gold - one surface	$57.60
Inlay - Gold - two surfaces	$79.20
Inlay - Gold - two surfaces - Including Onlay	$95.40
Inlay - Gold - three surfaces	$85.50
Inlay - Gold - three surfaces - Including Onlay	$101.70
Onlay per tooth Addition to Inlay	$16.20
Inlay - porcelain	$26.10
Crown - Plastic (Acrylic) (Single Restoration Only)	$51.30
Crown - Plastic Prefabricated (Single Restoration Only)	$26.10
Crown - Plastic with Precious Metal (Veneer) (Single Restoration Only	$98.10
Crown - Plastic with Non-Precious Metal (Single Restoration Only)	$85.50
Crown - Plastic with Semi-Precious Metal (Single Restoration Only)	$89.10
Crown - Porcelain (Single Restoration Only)	$95.40
Crown - Porcelain with Precious Metal (Ceramic) (Single Restoration Only)	$180.00
Crown - Porcelain with Non-Precious Metal (Single Restoration Only)	$91.80
Crown - Porcelain with Semi-Precious Metal (Single Restoration Only)	$95.40
Crown - Precious Metal - Full Cast (Single Restoration Only)	$175.50

TYPE III: MAJOR DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Crown - Non-Precious Metal - Full Cast (Single Restoration Only)	$82.80
Crown - Semi-Precious Metal - Full Cast (Single Restoration Only	$89.10
Crown - Gold - 3/4 Cast (Single Restoration Only)	$98.10
Crown - Stainless Steel (Single Restoration Only)	$21.60
Temporary Crown for Fractured Tooth (Single Restoration Only)	$19.80
Cast Post & Core in Addition to Crown (Single Restoration Only)	$36.00
Steel Post & Composite or Amalgam in Addition to Crown (including build-up) (Single Restoration Only)	$26.10
Periodontal appliance	$57.60
Complete upper denture	$129.60
Complete lower denture	$129.60
Immediate Upper Denture (Temporary Only)	$135.90
Immediate Lower Denture (Temporary Only)	$135.90
Partial Upper w/o Clasps, Acrylic	$32.40
Partial Lower w/o Clasps, Acrylic	$32.40
Partial Upper w/2 Clasps, Acrylic	$79.20
Partial Lower w/2 Clasps, Acrylic	$79.20
Partial Lower w/Chrome Lingual Bar	$134.10
Partial Lower w/Chrome Palatal Bar	$145.80
Removable Unilateral, 1 Piece Casting per Unit	$28.80
Each Additional Clasp with Rest	$13.50
Additional Units Tooth or Clasp Beyond Ten	$14.40
Adjustments to Complete Denture (Covered only once per 12 consecutive months and only if done more than one year after the initial insertation of the denture.)	$8.10
Adjustments to Partial Upper Denture (Covered only once per 12 consecutive months and only if done more than one year after the initial insertation of the denture.)	$8.10
Adjustments to Partial Lower Denture (Covered only once per 12 consecutive months and only if done more than one year after the initial insertation of the denture.)	$8.10

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TYPE III: MAJOR DENTAL SERVICES (CONT.)

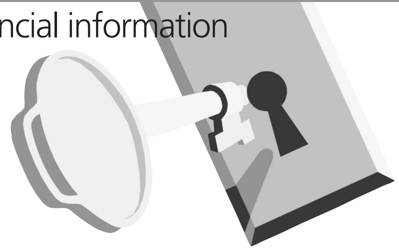
PROCEDURE	MAXIMUM REIMBURSEMENT
Relining Complete Denture (Office) (Covered only if relining is done more than one year after the initial insertion and then not more than once per two year period.)	$32.40
Relining Partial Denture (Office) (Covered only if relining is done more than one year after the initial insertion and then not more than once per two year period.)	$26.10
Relining Complete Denture (Laboratory) (Covered only if relining is done more than one year after the initial insertion and then not more than once per two year period.)	$47.70
Relining Partial Denture (Laboratory) (Covered only if relining is done more than one year after the initial insertion and then not more than once per two year period.)	$41.40
Cast Precious Metal - Pontic	$175.50
Cast Non-Precious Metal - Pontic	$82.80
Cast Semi-Precious Metal - Pontic	$89.10
Slotted Facing - Pontic	$70.20

TYPE III: MAJOR DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Slotted Pontic (Trupontic)	$70.20
Pin Facing - Pontic	$16.20
Porcelain Fused to Precious Metal - Pontic	$180.00
Porcelain Fused to Non-Precious Metal - Pontic	$91.80
Porcelain Fused to Semi-Precious Metal - Pontic	$95.40
Plastic Processed to Precious Metal - Pontic	$98.10
Plastic Processed to Non-Precious Metal - Pontic	$85.50
Plastic Processed to Semi-Precious Metal - Pontic	$89.10
Gold Inlay - Two Surfaces (Bridge retainers, initial placement or replacement.)	$79.20
Gold Inlay - Three or more surfaces (Bridge retainers, initial placement or replacement.)	$85.50

Notice of Privacy Practices

for your *personal* health and financial information



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

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency

Notice of Privacy Practices *(continued)*

- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

Notice of Privacy Practices *(continued)*

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacy office@humana.com

Send completed request form to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Human by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.

Notice of Privacy Practices *(continued)*

- Send your opt-out request to us in writing:
  Humana Privacy Office
  P. O. Box 1438
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.
American Dental Plan of North Carolina, Inc.
Cariten Insurance Company
Cariten Health Plan
CarePlus Health Plans, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc.
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana MarketPOINT, Inc.*
Humana MarketPOINT of Puerto Rico, Inc.*
Humana Medical Plan of Utah, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

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Guidance when you need it most

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