UnitedHealthcare PPO Dental

UnitedHealthcare Insurance Company

Certificate of Coverage

FOR: Harris County & Harris County Flood Control District

DENTAL PLAN NUMBER: P8096

ENROLLING GROUP NUMBER: 123456

EFFECTIVE DATE: March 1, 2011

Offered and Underwritten by

UnitedHealthcare Insurance Company

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call United HealthCare Insurance Company's toll-free telephone number for information or to make a complaint at:

1-**866-528-6072**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104

Austin, TX 78714-9104

FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your Premium or about a claim, you should contact United HealthCare Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telephono gratis de United HealthCare Insurance Company's para informacion o para someter una queja al:

1-**866-528-6072**

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104

Austin, TX 78714-9104

FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el United HealthCare Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

UnitedHealthcare Insurance Company

Dental Certificate of Coverage

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company ("Company") agrees with the Enrolling Group to provide Coverage for Dental Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy will take effect on the date specified in the Policy and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Texas.

Introduction to Your Certificate

You and any of your Enrolled Dependents, are eligible for Coverage under the Policy if the required Premiums have been paid. The Policy is referred to in this *Certificate* as the "Policy" and is designated on the identification ("ID") card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a *Certificate*, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Dental Services rendered after the effective date of the Policy, this *Certificate* replaces and supersedes any *Certificate*, which may have been previously issued to you by the Company. Any subsequent *Certificates* issued to you by the Company will in turn supersede this *Certificate*.

The employer expects to continue the group plan indefinitely. But the employer reserves the right to change or end it at any time. This would change or end the terms of the Policy in effect at that time for active employees.

How To Use This Certificate

This *Certificate* should be read and re-read in its entirety. Many of the provisions of this *Certificate* and the attached *Schedule of Covered Dental Services* are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your *Certificate* and *Schedule of Covered Dental Services* may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this *Certificate* or *Schedule of Covered Dental Services* may have been changed.

Many words used in this *Certificate* and *Schedule of Covered Dental Services* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Schedule of Covered Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in *Section 1: Definitions*.

From time to time, the Policy may be amended. When that happens, a new *Certificate*, *Schedule of Covered Dental Services* or Amendment pages for this *Certificate* or *Schedule of Covered Dental Services* will be sent to you. Your *Certificate* and *Schedule of Covered Dental Services* should be kept in a safe place for your future reference.

Dental Services Covered Under the Policy

Only Necessary Dental Services are Covered under the Policy. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is Covered under the Policy.

The Company has sole and exclusive discretion in interpreting the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Policy.

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes or amendments to the Policy.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services, which would otherwise not be Covered. The fact that the Company does so in any particular case will not in any way be deemed to require it to do so in other similar cases.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide required information may result in Coverage being delayed or denied.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill.

Contact the Company

Throughout this *Certificate* you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Company at the telephone number stated on your ID card.

Dental Certificate of Coverage Table of Contents

Section 1: Definitions

This Section defines the terms used throughout this *Certificate* and *Schedule of Covered Dental Services* and is not intended to describe Covered or uncovered services.

Amendment - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

Congenital Anomaly - a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Coinsurance - the charge you are required to pay for certain Dental Services payable under the Policy. A Coinsurance may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Coinsurance directly to the provider of the Dental Service at the time of service or when billed by the provider.

Coverage or **Covered** - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1.) when the Policy is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in Section 3: Termination of Coverage occur; and (3.) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Person – either the Subscriber or an Enrolled Dependent, while Coverage of such person under the Policy is in effect. References to you and your throughout this *Certificate* are references to a Covered Person.

Deductible – the amount a Covered Person must pay for Dental Services in a calendar year before the Company will begin paying for Benefits in that calendar year.

Dental Service or **Dental Procedures** - dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

"**Dependent" or "Eligible Dependent**" of an Employee or retired employee who is a member of an Eligible Class includes that person's:

• legal spouse;

• children up to age 26*. For purposes of determining eligibility, an Employee's "children" includes:

- natural children;
- legally adopted children (including children placed with adoptive parents pending finalization of
- adoption proceedings);
- stepchildren;
- children under age 19 permanently residing in the Employee's or retired employee's home and for whom the Employee or retired employee is the appointed permanent legal guardian or permanent legal custodian; and
- foster children under age 19 for whom the Employee or retired employee furnishes documents from the State of Texas
- children over age 26 who remain dependent on the Employee or retired employee for support and maintenance because the child becomes incapable of self support due to mental or physical incapacity. The incapacity must have commenced prior to reaching age 26 under the Plan or a

prior health Plan of the Customer (if the child was insured on the date of termination of the prior health Plan);

- unmarried grandchildren under age 26 for whom the Employee or retired employee furnishes (a) a certificate of financial dependency, (b) birth certificate on the grandchild, (c) birth certificate on the grandchild's mother or father indicating that the Employee is the biological or adoptive parent and (d) the grandchild is claimed as a dependent on your Federal Income Tax Return;
- All other individuals to whom the Customer is required by law to extend the coverage provided in the Plan shall also be considered Dependents to the extent they do not also qualify for coverage as Employees; and
- All former Employees' Dependents to the extent that the Customer provides for such coverage by Resolution of the Commissioners Court shall also be considered Dependents to the extent they do not also qualify for coverage as Employees.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

*For dependents reaching age 26, coverage continues until the end of the calendar month in which the dependent child turns age 26.

Eligible Expenses – Eligible Expenses are calculated by the Company based on available data resources of competitive fees in that geographic area.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Coinsurances and/or the Deductible for benefits, Dental Services for which the Coinsurances and/or the Deductible are waived are not considered to be Eligible Expenses.

Eligible Expenses are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by the Company.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent - a Dependent who is properly enrolled for Coverage under the Policy.

Enrolling Group - the employer or other defined or otherwise legally constituted group to whom the Policy is issued.

Experimental, Investigational or Unproven Services - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at

the time the Company makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - are defined as services provided outside the U.S. and U.S. territories.

Initial Eligibility Period - the initial period of time, determined by the Company and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Policy or any Policy, issued by the Company to the Enrolling Group, that replaces the Policy. The Maximum Benefit is stated in *Section 11: Covered Dental Services*.

Medicare – Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate; and

A. necessary to meet the basic dental needs of the Covered Person; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and

F. demonstrated through prevailing peer-reviewed dental literature to be either:

    1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or

    2. safe with promising efficacy

        a. for treating a life threatening dental disease or condition; and

        b. in a clinically controlled research setting; and

        c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental

Service as defined in this *Certificate*. The definition of Necessary used in this *Certificate* relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Open Enrollment Period - after the Initial Eligibility Period, a period of time determined by the Company and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Physician - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Plan Allowance - is shown as a fixed dollar amount or percentage of Eligible Expenses after the Deductible is satisfied and is the maximum benefit amount the Company will pay for each particular Dental Procedure shown. The Subscriber must pay the amount of the Dentist's fee, if any, which is greater than the amount of the Plan Allowance.

Policy - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents Covered under the Policy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent in accordance with the terms of the Policy.

Procedure in Progress - all treatment for Covered Dental Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Rider - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Coinsurances. Riders are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

Subscriber - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Waiting Period - period of time for which a Covered Person must wait, after the effective date of Coverage, before Dental Services listed in *Section 11: Covered Dental Services* will be Covered.

Section 2: Enrollment and Effective Date of Coverage

Section 2.1 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Section 2.2 Effective Date of Coverage

In no event is there Coverage for Dental Services rendered or delivered before the effective date of Coverage.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the date the Eligible Person joins the Enrolling Group .

Section 2.3 Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within the same calendar year you first become eligible.

Section 2.4 Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date specified by your Employer. Coverage is effective only if the Company receives any required Premium and is notified of the event within the same calendar year.

Section 2.5 Change in Family Status

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within the same calendar year of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next annual Open Enrollment Period.

Section 2.6 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a.) the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period; and (b.) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special

enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within the same calendar year coverage under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within the same calendar year of the marriage, birth, placement for adoption or adoption.

Section 3: Termination of Coverage

Section 3.1 Conditions for Termination of a Covered Person's Coverage Under the Policy

The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy. When your Coverage terminates, you may have continuation as described in *Section 9: Continuation of Coverage* or as provided under other applicable federal and/or state law.

Your Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber or Enrolled Dependent.

C. The date the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber.

E. The date specified by the Company that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information, including, but not limited to, false, material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. The Company has the right to rescind Coverage back to the effective date.

F. The date specified by the Company that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.

G. The date specified by the Company that Coverage will terminate due to material violation of the terms of the Policy.

H. The date specified by the Company that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to the Company staff, a provider, or other Covered Persons.

Section 3.2 Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the age listed under the definition of Dependent provided that:

A. the Enrolled Dependent becomes incapacitated prior to attainment of the limiting age; and

B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and

C. payment of any required Premium for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's Coverage under the Policy.

Section 3.3 Extended Coverage

A 30 day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the 30 day period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Policy was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Section 3.4 Payment and Reimbursement Upon Termination

Termination of Coverage will not affect any request for reimbursement of Eligible Expenses for Dental Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in *Section 4: Reimbursement*.

Section 4: Reimbursement

Section 4.1 Reimbursement of Eligible Expenses

The Company will reimburse you for Eligible Expenses subject to the terms; conditions, exclusions and limitations of the Policy and as described below.

Section 4.2 Filing Claims for Reimbursement of Eligible Expenses

You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service will cancel or reduce Coverage for the Dental Service.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Your name and address
- Patient's name and age
- Number stated on your ID card
- The name and address of the provider of the service(s)
- A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim
- Radiographs, lab or hospital reports
- Casts, molds or study models
- Itemized bill which includes the CPT or ADA codes or description of each charge
- The date the dental disease began
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call the Company at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

Payment of Claims. Benefits are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss. Benefits will be paid to you unless:

A. The provider notifies the Company that your signature is on file assigning benefits directly to that provider; or

B. You make a written request at the time the claim is submitted.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Dental Services instead of being paid to the Subscriber.

If the Services you received are covered by the Texas Department of Human Services ("DHS"), the Company will reimburse DHS.

If there is a court order providing for the managing conservator of a minor child, the Company will reimburse the conservator on the Subscriber's behalf.

Section 4.3 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 61 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action against the Company within 3 years from the date satisfactory written proof of loss was submitted to us, you forfeit your rights to bring any action against the Company.

Section 5: Complaint Procedures

Section 5.1 Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the Policy, you should contact the Company's customer service department at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any new information to support your request for claim payment

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 5.2 Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or dental experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 5.3 Exceptions for Emergency Situations

Your complaint requires immediate actions when your Dentist judges that a delay in treatment would significantly increase the risk to your health. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dentist should call us as soon as possible.

- We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.
- If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments or procedures that we do not consider urgent situations.

If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 6: General Provisions

Section 6.1 Entire Policy

The Policy issued to the Enrolling Group, including the *Certificate(s)*, *Schedule(s) of Covered Dental Services*, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

Section 6.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company without first completing the complaint procedure specified in *Section 5: Complaint Procedures*. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in *Section 5: Complaint Procedures*; you forfeit your rights to bring any action against the Company.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in *Section 4: Reimbursement*, is subject to the limitation of action provision of that Section.

Section 6.3 Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Enrolling Group will be used to void the Policy after it has been in force for a period of 2 years.

Section 6.4 Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Section 6.5 Relationship Between Parties

The relationships between the Company and providers and relationships between the Company and Enrolling Groups, are solely contractual relationships between independent contractors. Providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or Enrolling Groups.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided to any Covered Person.

The relationship between the Enrolling Group and Covered Persons is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company), for the timely payment of the Policy Charge to the Company, and for notifying Covered Persons of the termination of the Policy.

Section 6.6 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to

the Policy. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish the Company with all information or copies of records relating to the services provided to you. The Company has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Company agrees that such information and records will be considered confidential.

The Company has the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your dental records or billing statements the Company recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from us, the Company also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Company will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. The Company's designees have the same rights to this information as the Company has.

Section 6.7 ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Section 6.8 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Dentist acceptable to the Company examine you at the Company's expense.

Section 6.9 Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Section 6.10 Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Section 6.11 Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Section 6.12 Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Section 6.13 Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Schedule of Covered Dental Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Schedule of Covered Dental Services*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Schedule of Covered Dental Services*.

Section 6.14 Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Schedule of Covered Dental Services* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Schedule of Covered Dental Services*.

Section 6.15 Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Schedule of Covered Dental Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Schedule of Covered Dental Services* to the greatest extent legally permissible.

Section 7: Coordination of Benefits

Section 7.1 Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Section 7.2 Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

   1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

   2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under (1.) or (2.) is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

C. "Allowable expense" means a health care service or expense, including deductibles and coinsurances, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.

2. If a person is covered by 2 or more Coverage 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 expense.

3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.

D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

E. "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Section 7.3 Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, Subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1.) The parents are married;

2.) The parents are not separated (whether or not they ever have been married); or

3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1.) The Coverage Plan of the custodial parent;

2.) The Coverage Plan of the spouse of the custodial parent;

3.) The Coverage Plan of the noncustodial parent; and then

4.) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.(1.).

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage 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 Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.

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

Section 7.4 Effect on the Benefits of This Coverage Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay up to the allowable amount but never more than what this Coverage Plan would have paid as primary.

B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Prescription Drug (Medicare Part D) plan and receives non-covered prescription drugs because the person did not follow all rules of that plan. If the drug is a Part D drug covered by the Medicare Prescription Drug plan, Medicare benefits are determined as if the services were provided by a network pharmacy and covered under Medicare Part D.

Section 7.5 Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Company any facts it needs to apply those rules and determine benefit payable. If you do not provide the Company the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Section 7.6 Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Company 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.

Section 7.7 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 8: Subrogation and Refund of Expenses

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i.) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii.) your employer; or (iii.) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

You will cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by you are paid. You will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been fully compensated. You will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you. You will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

Refund of Overpayments. If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person,

B. All or some of the payment made by the Company exceeded the benefits under the Policy, or

C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the

Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 9: Continuation of Coverage

Section 9.1 Continuation Coverage

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law (under COBRA) and as outlined in *Sections 9.2 through 9.5* below.

Continuation Coverage under COBRA will be available only to Enrolling Groups which are subject to the provisions of COBRA. Covered Persons should contact the Enrolling Group's plan administrator to determine if he or she is entitled to continue Coverage under COBRA.

Continuation Coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by Coverage under the Policy will terminate as scheduled under the prior plan or in accordance with the terminating events set forth in *Section 9.5* below, whichever is earlier.

In no event will the Company be obligated to provide continuation Coverage to a Covered Person if the Enrolling Group or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation Coverage and notifying the Company in a timely manner of the Covered Person's election of continuation Coverage.

The Company is not the Enrolling Group's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law, as outlined in *Sections 9.2 through 9.5* below.

Section 9.2 Continuation Coverage Under Federal Law

In order to be eligible for continuation coverage under federal law, the Covered Person must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the plan on the day before a Qualifying Event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, stepchildren and grandchildren, a child born to or placed in adoption with a Subscriber during a period of continuation of coverage, or
- A Subscriber's former spouse.

Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law

If a Qualified Beneficiary's Coverage will ordinarily terminate due to one of the following Qualifying Events, he or she is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect to continue the same Coverage that he or she had at the time of the Qualifying Event.

A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours; or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Section 9.4 Notification Requirements and Election Period for Continuation Coverage Under Federal Law

The Subscriber or Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within 60 days of his or her divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period the Enrolling Group and its plan administrator are not obligated to provide continuation Coverage to the affected Qualified Beneficiary. A Subscriber who is continuing Coverage under Federal Law must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the Qualifying Event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

A Qualified Beneficiary whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Group's designated plan administrator on or before the 45th day after electing continuation.

Section 9.5 Terminating Events for Continuation Coverage Under Federal Law

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to be disabled at the time during the first 60 days of continuation Coverage may extend continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in *Section 9.3*. If the Qualified Beneficiary entitled to the additional 11 months of Coverage has non-disabled family members who are also entitled to continuation Coverage, those non-disabled family members are also entitled to the additional 11 months of continuation Coverage.

   A Qualified Beneficiary who is determined to have been disabled within the first 60 days of continuation Coverage for Qualifying Event (A.) must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If such notice is provided, the Qualified Beneficiary's Coverage may be extended up to a maximum of 29 months from the date of the Qualifying Event described in *Section 9.3*. A or until the first month that begins more than 30 days after the date of any final determination that the Qualified Beneficiary is no longer disabled. Each Qualified Beneficiary must provide notice of any final determination that the Qualified Beneficiary is no longer disabled within 30 days of such determination.

B. Thirty-six months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, in accordance with qualifying events (B.), (C.), or (D.) described in *Section 9.3*.

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the Qualifying Event, or if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date Coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation will end on the date such limitation or exclusion ends. The other group health coverage will be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this will not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F.) described in *Section 9.3*.

G. The date the entire Policy ends.

H. The date Coverage would otherwise terminate under the Policy.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in *Section 9.3* A. If a Qualified Beneficiary is entitled to continuation because the Enrolling Group filed for bankruptcy, in accordance with Qualifying Event (F.) described in *Section 9.3* and the retired Subscriber dies during the continuation period, the Enrolled Dependents will be entitled to continue Coverage for 36 months from the date of death. Terminating events (B.) through (G.) described in this *Section 9.5* will apply during the extended continuation period.

Continuation Coverage for Qualified Beneficiaries whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Section 10: Procedures for Obtaining Benefits

Section 10.1 Dental Services

You are eligible for Coverage for Dental Services listed in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services* of this *Certificate* if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Before you are eligible for Coverage of Dental Services you must meet the requirements for payment of the Deductible specified in *Section 11: Covered Dental Services.* Providers may request that you pay all charges when services are rendered. You must file a claim with the Company for reimbursement of Eligible Expenses.

Section 10.2 Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify the Company of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dentist should send a notice to the Company, via claim form, within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

Section 11: Covered Dental Services

Dental Services described in this Section and in the *Schedule of Covered Dental Services* are Covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist;

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure; and

D. Not excluded as described in Section 12: General Exclusions.

Covered Dental Services are subject to the satisfaction of any applicable Waiting Periods, Deductibles, Maximum Benefits, and payment of any Coinsurances as described below and in the Schedule of Covered Dental Services.

This Section and the *Schedule of Covered Dental Services*: (1) describe the Covered Dental Services and any applicable limitations to those services; (2) outline the Coinsurances that you are required to pay and any applicable Waiting Periods for each Covered Dental Service; and (3) describe any Deductible and any Maximum Benefits that may apply.

Deductible

Deductible is $50 per Covered Person per calendar year and $150 for all Covered Persons in a family.

The Deductible does not apply to: DIAGNOSTIC SERVICES and/or PREVENTIVE SERVICES.

The Deductible applies to any combination of the following Covered Dental Services: MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS, IMPLANTS.

Maximum Benefit

Maximum Benefit is $1,750 per Covered Person per calendar year.

Maximum Benefit applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS, IMPLANTS.

Any required Coinsurance, Deductible, Waiting Period or Maximum Benefit is waived for a Covered Person in their 2nd or 3rd trimester of pregnancy for the following Covered Dental Services: prophylaxis, scaling and root planing, periodontal maintenance, full mouth debridement.

Section 11.1 CREDIT FOR PRIOR COVERAGE

If you are a Covered Person that becomes Covered under this Policy due to a mid-year plan change, you will need to submit evidence of having satisfied any portion of your prior policy's Deductible in order to receive credit under this Policy's applicable Deductible(s). You will also need to submit evidence of the total benefits paid under your prior policy in order to have the amount applied to this Policy's applicable Maximum(s).

Waiting Periods apply to all Covered Persons. Covered Dental Services are subject to the satisfaction of the appropriate Waiting Periods, which will be waived for all Covered Persons who enroll on the Enrolling Group's Effective Date. All other Covered Persons are subject to the Waiting Periods unless evidence is provided to the Company of uninterrupted prior comparable coverage that satisfies the Waiting Period.

Section 12: General Exclusions

Section 12.1 Exclusions

The Exclusions in the *Certificate of Coverage, Section 12: General Exclusions, Section 12.1 Exclusions* are replaced with the following:

Exclusions

The Policy will only pay for Necessary Services received by you or your Dependents if those are listed as Covered Expenses in the Schedule of Covered Dental Services. No benefits are payable under this Policy for any expenses incurred for:

1. Any procedure started before the effective date or after the termination date of the Covered Person's insurance.
2. Any appliance delivered or placed more than ninety days after termination of the Covered Person's insurance.
3. Treatment by anyone other than a Dentist or Physician, except where performed by a duly qualified hygienist under the direction of a Dentist or Physician.
4. Treatment which does not meet accepted standards of dental practice, is experimental or cosmetic in nature or is not considered medically necessary. Personalization or characterization of dentures and facings on crowns and pontics behind the second bicuspid are always considered cosmetic.
5. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, splinting teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
6. Replacement of lost or stolen appliances or replacement of any appliance, prosthesis, crown, or bridge placed less than five (5) years before (temporary prosthetics are considered permanent and subject to this exclusion if not replaced by the permanent prosthetic within six (6) months).
7. Periodontal maintenance, unless following active periodontal therapy.
8. Prescribed drugs and medications or training in or supplies used for dietary counseling, oral hygiene or plaque control; sterilization charges; pulp caps or medicaments.
9. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof; (2) any hospital or institution that does not require the Covered Person to pay for such services in the absence of insurance.
10. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.
11. Treatment of congenital malfunctions or malformations.
12. Treatment of service not recommended by a Dentist.
13. Expenses resulting from injuries sustained or sickness contracted as a result of any war or act of war or participation in a riot or civil disturbance or while committing or attempting to commit a felony.

14. Charges for professional services rendered by any individual who is related to the Covered Person by blood, marriage or adoption.

15. Hospitalization for any procedure.

16. Orthodontic services unless orthodontics is a covered benefit under this Policy or any applicable rider.

Limitations - Benefits under this Policy are limited as follows:

1. Panoramic or full mouth x-ray series - once every 36 months.

2. Porcelain, porcelain with metal, or full gold crowns are covered only for individuals 14 years or older and on permanent teeth.

3. Replacement of crowns, gold restorative or cast posts - once every five years (if the tooth can be restored with less expensive materials, the benefit will be based on those materials).

4. If more than one type of service can be used to treat a dental condition, the benefit payment will be based on the least expensive service, which is within the range of professionally accepted standards of dental practice.

5. Replacement of dentures - once every five years and only if the original is unserviceable. When a permanent denture replaces a temporary one, charges for both are limited to the charge for the permanent one.

SCHEDULE OF COVERED DENTAL SERVICES

Please note that Texas does not allow a different level of payment of benefits or reimbursement, including deductibles, maximums or other cost sharing provisions, for covered dental care services based on whether the services are provided by a contracting or non-contracting dentist. However, within the same policy, the percentage may apply to a contracted rate and a fee expressed as "usual and customary."

BENEFIT DESCRIPTION & LIMITATION	**COINSURANCE** is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
DIAGNOSTIC SERVICES	
Bacteriologic Cultures	0%
Viral Cultures	0%
Intraoral Bitewing Radiographs Limited to 2 series of films per calendar year.	0%
Panorex Radiographs Limited to 1 time per consecutive 36 months.	0%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	0%
Diagnostic Casts.	0%
Extraoral Radiographs Limited to 2 films per calendar year.	0%
Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	0%
Intraoral Periapical Radiographs	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	0%
Intraoral Occlusal Film	0%
Periodic Oral Evaluation Limited to 2 times per calendar year	0%

BENEFIT DESCRIPTION & LIMITATION	COINSURANCE is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Comprehensive Oral Evaluation Limited to 2 times per calendar year. Not Covered if done in conjunction with other exams.	0%
Limited or Detailed Oral Evaluation Limited to 2 times per calendar year. Only 1 exam is Covered per date of service.	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per calendar year	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per calendar year	0%
PREVENTIVE SERVICES	
Dental Prophylaxis Limited to 2 times per calendar year.	0%
Fluoride Treatments Limited to Covered Persons one time per calendar year.	0%
Sealants Limited to Covered Persons under the age of 18 years and once per first or second permanent molar every consecutive 36 months.	0%
Space Maintainers.	0%
Re-Cement Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%
MINOR RESTORATIVE SERVICES	
Amalgam Restorations Multiple restorations on one surface will be	20%

BENEFIT DESCRIPTION & LIMITATION	**COINSURANCE** is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
treated as a single filling.	
Composite Resin Restorations – Anterior Multiple restorations on one surface will be treated as a single filling.	20%
Composite Resin Restorations – Posterior Multiple restorations on one surface will be treated as a single filling.	20%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	20%
ENDODONTICS	
Apexification	20% Subject to a 6 month Waiting Period.
Apicoectomy and Retrograde Filling	20% Subject to a 6 month Waiting Period.
Hemisection	20% Subject to a 6 month Waiting Period.
Root Canal Therapy	20% Subject to a 6 month Waiting Period.
Retreatment of Previous Root Canal Therapy	20% Subject to a 6 month Waiting Period.
Root Resection/Amputation	20% Subject to a 6 month Waiting Period.
Therapeutic Pulpotomy	20% Subject to a 6 month Waiting Period.
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration)	20% Subject to a 6 month Waiting Period.

BENEFIT DESCRIPTION & LIMITATION	**COINSURANCE** is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Pulp Caps - Direct/Indirect – excluding final restoration	20% Subject to a 6 month Waiting Period.
Pulpal Debridement, Primary and Permanent Teeth This procedure is not to be used when endodontic services are done on same date of service.	20% Subject to a 6 month Waiting Period.
PERIODONTICS	
Crown Lengthening	20%
Gingivectomy/Gingivoplasty	20%
Gingival Flap Procedure	20%
Osseous Graft	20%
Osseous Surgery.	20%
Guided Tissue Regeneration	20%
Soft Tissue Surgery	20%
Periodontal Maintenance	20%
Full Mouth Debridement	20%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	20%
Scaling and Root Planing	20%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	20%
ORAL SURGERY	
Alveoloplasty	20%

BENEFIT DESCRIPTION & LIMITATION	COINSURANCE is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Biopsy Limited to 1 biopsy per site per visit.	20%
Frenectomy/Frenuloplasty	20%
Surgical Incision Limited to 1 per site per visit.	20%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	20%
Removal of Torus Limited to 1 per site per visit.	20%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	20%
Simple Extractions	20%
Surgical Extraction of Erupted Teeth or Roots	20%
Surgical Extraction of Impacted Teeth	20%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth	20%
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	20%
Placement of Device to Facilitate Eruption of Impacted Tooth	20%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report	20%
Vestibuloplasty	20%
Bone Replacement Graft for Ridge Preservation - per site Not Covered if done in conjunction with other bone graft replacement procedures.	20%
Excision of Hyperplastic Tissue or Pericoronal Gingiva	20%

BENEFIT DESCRIPTION & LIMITATION	**COINSURANCE** is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	20%
Tooth Reimplantation and/or Transplantation Services	20%
Oroantral Fistula Closure Limited to 1 per site per visit.	20%
ADJUNCTIVE SERVICES	
Analgesia Covered when Necessary in conjunction with Covered Dental Services	20%
Desensitizing Medicament	20%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services.	20%
Local Anesthesia	20%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Services.	20%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	20%
Occlusal Adjustment	20%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	20%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	20%
Occlusion Analysis - Mounted Case	20%

BENEFIT DESCRIPTION & LIMITATION	COINSURANCE is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to 1 time per 5 years.	
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	20%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	20%
MAJOR RESTORATIVE SERVICES Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement.	
Coping Limited to 1 per tooth per 5 years. Not covered if done at the same time as a crown on same tooth.	50% Subject to a 6 month Waiting Period.
Crowns – Retainers/Abutments Limited to 1 time per tooth per 5 years. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 6 month Waiting Period.
Crowns - Restorations Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 6 month Waiting Period.
Temporary Crowns - Restorations Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 6 month Waiting Period.

BENEFIT DESCRIPTION & LIMITATION	**COINSURANCE** is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Inlays/Onlays – Retainers/Abutments Limited to 1 time per tooth per 60 consecutive months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 6 month Waiting Period.
Inlays/Onlays - Restorations Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 6 month Waiting Period.
Pontics Limited to 1 time per tooth per 5 years.	50% Subject to a 6 month Waiting Period.
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per 5 years.	50% Subject to a 6 month Waiting Period.
Pin Retention Not Covered in addition to cast restoration.	50% Subject to a 6 month Waiting Period.
Post and Cores Covered only for teeth that have had root canal therapy.	50% Subject to a 6 month Waiting Period.
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	50% Subject to a 6 month Waiting Period.
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	50% Subject to a 6 month Waiting Period.
Stainless Steel Crowns Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary	50% Subject to a 6 month Waiting Period.

BENEFIT DESCRIPTION & LIMITATION	COINSURANCE is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
anterior teeth.	
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement.	
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per 5 years.	50% Subject to a 6 month Waiting Period.
REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement.	
Full Dentures Limited to 1 per 5 years. No additional allowances for precision or semi-precision attachments.	50% Subject to a 6 month Waiting Period.
Partial Dentures Limited to 1 per 5 years. No additional allowances for precision or semi-precision attachments.	50% Subject to a 6 month Waiting Period.
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50% Subject to a 6 month Waiting Period.
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50% Subject to a 6 month Waiting Period.
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50% Subject to a 6 month Waiting Period.
IMPLANTS Replacement of implants, implant crowns, implant prosthesis, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to 1 time per 5	

BENEFIT DESCRIPTION & LIMITATION	COINSURANCE is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
years from initial or supplemental placement.	
Implant Placement Limited to 1 time per 5 years.	50% Subject to a 6 month Waiting Period.
Implant Supported Prosthetics Limited to 1 time per 5 years.	50% Subject to a 6 month Waiting Period.
Implant Maintenance Procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis Limited to 1 time per consecutive 12 months.	50% Subject to a 6 month Waiting Period.
Repair Implant Supported Prosthesis, by report Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	50% Subject to a 6 month Waiting Period.
Abutment Supported Crown (titanium) or Retainer Crown for FPD - titanium Limited to 1 time per 5 years.	50% Subject to a 6 month Waiting Period.
Repair Implant Abutment, by report Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	50% Subject to a 6 month Waiting Period.
Implant Removal, by report Limited to 1 time per 5 years.	50% Subject to a 6 month Waiting Period.
Radiographic/Surgical Implant Index, by report Limited to 1 time per 5 years.	50% Subject to a 6 month Waiting Period.

Contracted Provider Benefits:

When Coinsurances are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from contracted providers is determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

Non-Contracted Provider Benefits:

When Coinsurances are charged as a percentage, the amount you pay for Dental Services from a non-contracted provider is determined as a percentage of the usual and customary fee plus the amount by

which the non-contracted provider's billed charge exceeds the usual and customary fee. Payment to a non-contracting Dentist will never be greater than the actual fee charged for the Dental Service.

UNITEDHEALTHCARE DENTAL

NOTICE OF PRIVACY PRACTICES

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.

Effective: April 14, 2003

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.uhcspecialtybenefits.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care***. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers Compensation*** including disclosures required by state workers compensation laws of job-related injuries.

- ***Provide Information Regarding Decedents***. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information**. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health 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. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, **www.uhcspecialtybenefits.com**

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; United HealthCare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; United HealthCare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.

B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.

B. Reduction in the subscriber's hours of employment.

C. Death of the subscriber.

D. Divorce or legal separation of the subscriber.

E. Loss of eligibility by an enrolled dependent who is a child.

F. Entitlement of the subscriber to Medicare benefits.

G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
   - the determination of the disability; or
   - the date of the qualifying event; or
   - the date the Qualified Beneficiary would lose coverage under the policy; and
   - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the subscriber's Medicare entitlement; or
   - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
- The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the policy for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.

H. The date the entire policy ends.

I. The date coverage would otherwise terminate under the policy.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information About Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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*.

You are entitled to 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 Plan Administrator may make a reasonable charge for the copies.

You are entitled to 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 the summary annual report.

Continue Group Health Plan Coverage

You are entitled to 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. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. 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 do so 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 Plan 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 Questions

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*, *United States 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 the publication hotline of the *Employee Benefits Security Administration*.